

**Overweight nurses' experiences of their
interactions with overweight patients**

DEBORAH McGREEVY

**A thesis submitted in partial fulfilment of
the requirements of the University of
Brighton for the degree of
Doctor of Nursing**

June 2010

The University of Brighton

ABSTRACT

Overweight nurses' experiences of their interactions with overweight patients

This research study draws upon co-constructed data to describe and interpret overweight nurses' experiences of their interactions with overweight patients. Within the limited number of research studies that investigate the worldview of overweight nurses, it is suggested that overweight nurses may have more empathy with overweight patients, who often receive prejudicial and discriminatory care. The objectives of the study, using a qualitative hermeneutical methodology, underpinned by Gadamerian philosophy and a relativist ontological stance, were to describe and interpret the experiences and actions of overweight nurses in their interactions with overweight patients. Seven nurses from various nursing disciplines participated in the study and data were gathered through two semi-structured interviews and note-book keeping.

Two key themes were derived from the data: firstly, how the nurses developed their understandings of being overweight and secondly, how they acted upon their understandings in the interaction with their overweight patient. The nurses developed their self and Other understandings of being overweight through personal experience. They acted upon their understandings and managed their self in the interaction with their overweight patient by managing their guilt, dissonance and personal prejudices. They managed their sensitive conversations with their overweight patient by developing embodied empathy.

This study has generated new knowledge by proposing that the overweight nurses within this study combine: *Other understanding*; *Self understanding*; *Acknowledging-then-managing prejudice*; and *Being-with: holistic interacting* within their interactions with their overweight patients, which is defined as the new and original concept of *embodied empathy-in-action*.

TABLE OF CONTENTS

ABSTRACT	2
ACKNOWLEDGEMENTS.....	7
DECLARATION	8
CHAPTER 1: INTRODUCTION.....	9
Introduction	9
Rationale for research study.....	10
The research problem in practice	11
Significance of the research study.....	12
The aim of the research study	13
Research Question	13
Research Objectives.....	13
Research Method	13
Defining ‘overweight and obesity’.....	14
Defining ‘self’	15
Defining ‘Other’.....	16
Structure of the thesis.....	17
CHAPTER 2: BACKGROUND TO THE STUDY.....	20
Introduction to reviewing the literature.....	20
Method of searching the literature.....	21
Introduction to the findings of the literature review.....	23
Policies to address overweight and obesity in England.....	23
Attitudes of nurses towards overweight patients.....	27
Being an overweight nurse.....	31
Being an overweight patient	33
Being a sensitive communicator	35
Choosing the conceptual framework	37
Summary	41
CHAPTER 3: METHODOLOGY AND METHODS.....	43
Introduction	43
Locating self as researcher: what is my worldview?	43
What is the most appropriate approach to address my research question?	45
Undertaking qualitative research with my world view: my theoretical lens	46
Being a relativist?	46
Being a phenomenologist.....	48
Being an hermeneuticist.....	50

Research Design	56
Ethical permission to conduct the research study	56
Recruitment to the study	58
Issues of trustworthiness and research rigour	60
Introduction to the research methods	63
Semi-structured interview	63
Note book keeping	64
Drawing of Self and Other	64
Conducting the research study	65
The practicalities	65
Interviews and the hermeneutic circle	66
Limitations of the research study	68
Transcripts.....	69
Triangulation of methods and data sources	70
Finding an analytical framework	71
Closing the hermeneutic circle: analysing and presenting the data	74
Edited extract from my researcher journal 20 August 2007:	75
Making sense of the data	77
Summary	81
CHAPTER 4: PARTICIPANT BIOGRAPHIES	83
Introduction	83
Developing understandings	83
Being Alison <i>'We're only people at the end of the day, aren't we?'</i>	87
Being Beatrice: <i>'Sod the diet, I'll start again tomorrow'</i>	89
Being Erin: <i>'It's all to do with self esteem, isn't it?'</i>	94
Being Frances: <i>'No time for chopping coleslaw'</i>	96
Being Geraldine: <i>'I know that I wouldn't have been a good role model'</i>	100
Being Hannah: <i>'I don't really know what the answer is...'</i>	104
Summary	107
CHAPTER 5: OVERWEIGHT NURSES' EXPERIENCES OF THEIR INTERACTIONS WITH OVERWEIGHT PATIENTS	110
Introduction	110
Acting on understandings: managing <i>Self</i> within the interaction with an overweight patient	111
Managing guilt and dissonance.....	112
Summary	123
Acting on understandings: managing the interaction with an overweight patient	124
Managing personal prejudices	124

Summary	126
Managing sensitive conversations: developing embodied empathy	126
Summary	137
Summary of findings chapters.....	137
CHAPTER 6: 'GOING WHERE THEY ARE'	140
Introduction	140
The body in existential phenomenology.....	140
Introducing the original concept of 'embodied empathy-in-action'	142
Defining embodied empathy-in-action	143
Self understanding	148
Other understanding.....	159
Acknowledging-then-managing prejudice.....	166
Being-with: holistic interacting.....	168
Summary	175
CHAPTER 7: RESEARCHER REFLECTIONS AND REFLEXIVITY	176
Introduction	176
Effect of researcher on the participants	176
Reflections on writing.....	181
Integrating new literature in the discussion chapter.....	182
Embodied co-understandings	183
Reflections on the research methods.....	188
Summary	189
CHAPTER 8: CONCLUSIONS.....	190
Introduction	190
Achieving the aims and objectives of the study	190
Conclusions.....	191
How overweight nurses manage their self in the interaction with the overweight patient.....	192
How overweight nurses manage the interaction with overweight patients.....	194
Dissemination of findings	198
Presentations	198
Potential book and journal publications.....	198
What would I do differently if I did the study again?	199
Suggestions for further research	200
Original contribution to nursing knowledge and practice:	201
The last word?	201
REFERENCES	202

APPENDICES	221
Appendix 1: Letter of Ethical Research Committee approval	221
Appendix 2: Participant information sheet.....	224
Appendix 3: Participant consent form.....	229
Appendix 4: Letter of invitation to participant for first interview	230
Appendix 5: Follow-up letter to interview	232
Appendix 6: Transcript authenticity form.....	233
Appendix 7: Letter of invitation to participant for second interview.....	234
Appendix 8: Semi-structured interview schedule outline – first interview	235
Appendix 9: Researcher Journal (edited extracts 20.8.07 – 24.2.08).....	237
Appendix 10: Sample transcript (Erin).....	248

FIGURES

Figure 1: Diversity of disciplines contributing to debate about body and weight.....	40
Figure 2: Thematic structure of the data.....	80
Figure 3: Embodied empathy-in-action.....	146
Figure 4: Erin’s drawing of herself and someone she sees of ‘normal weight’	184

ACKNOWLEDGEMENTS

Firstly, I would like to thank my wonderful husband, Sean, my dear Mum and Dad, Evelyn and Malcolm Medley, Lorraine, Rich and Steve and all my family for your constant encouragement and for sacrificing precious time together so that I can follow my dreams. I love you all very much and I hope I make you proud.

To my friends Carol McCrum, Anne Viccars, Beverley Thorp and Jane Hentley, thanks for your support and being there when the going got tough. Thanks also to Dr Linda Finlay for your interest in my work and for providing inspiration.

To my supervisors, Dr Graham Stew and Dr Kay Aranda, I cannot thank you enough for your good humour, professional expertise and most appreciated support. One day, when I was flailing in an academic whirlwind, Graham passed me this:

*When you have come to the edge
Of all light that you know
And are about to drop off into the darkness
Of the unknown,
Faith is knowing
One of two things will happen:
There will be something solid to stand on or
You will be taught to fly*

(Edward Teller 1908-2003)

Thanks to both of you for teaching me to fly.

Finally, I offer enormous thanks to the wonderful women who participated in this study for sharing their experiences with honesty and humour. I will always be grateful to you and I hope that you will each, one day soon, have time for yourself to chop coleslaw, metaphorically or otherwise.

I dedicate this thesis to you all.

DECLARATION

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not been previously submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed

D. McCreary

Dated

23rd July 2010

CHAPTER 1: INTRODUCTION

Introduction

This thesis reports a qualitative study which explores overweight nurses' experiences of their interactions with overweight patients. My research study arose from a problem in practice when I discovered that many nurses working locally to me were not offering overweight patients the advice or support that had been clinically indicated as potentially health improving.

At the time of beginning my Professional Doctorate, I was employed as a Health Promotion Manager, working for a Primary Care Trust, and responsible for a multi-disciplinary public health and primary care team that focused on addressing local health priorities and inequalities in health. One of the key priorities for our geographical area was secondary prevention activity directed towards the escalating number of overweight adults with co-morbidities, such as high blood pressure or high blood cholesterol levels.

One of the major public health issues to emerge over recent years is that of the population becoming overweight and obese (World Health Organisation 2000). Obesity is measured by health professionals by using the Body Mass Index, sometimes combined with the individual's waist measurement. According to the Health Survey for England 2007, the prevalence of overweight and obesity for men, measured by their Body Mass Index (BMI) is considered to be high: an estimated 23.6% are obese; for women, there are an estimated 24.4% who are obese (DH 2009:56). The World Health Organisation (2000) describes the prevalence of obesity as a 'global epidemic' and this is causing anxiety for the UK government as increased prevalence will have a significant impact on levels of morbidity and mortality, with its associated effect on the health economy, and it may also impact negatively on an individual's quality of life. The Department of Health (2006:24) considers excess weight to be a health problem as it can place people in greater risk of conditions such as diabetes, heart disease, circulatory

disorders and cancer. Excess weight can also aggravate conditions such as osteoarthritis.

There are detractors from this argument, however, who suggest that being overweight is not harmful to health, provided that there are no co-morbidities such as high blood pressure (Bartlett 2003). I have decided not to pursue this argument in this study as it is not the focus of the research. I have also taken the decision to use the term 'overweight' for my own study although this may also refer to obesity.

Rationale for research study

The rationale for my research study arose from a problem in practice whereby some nurses were not referring overweight patients to a community-based weight management scheme. On discussing the reasons for this with the nurses concerned, it seemed that they felt uncomfortable raising the topic of 'being overweight', particularly if the nurse was overweight herself. I was concerned about the possibility of overweight patients not receiving appropriate clinically indicated care and I was also interested to explore what was the experience of the overweight nurse during the interaction between her and her overweight patient.

Focusing specifically on overweight and obesity can lead to a victim-blaming approach and there are numerous studies that suggest that overweight patients are on the receiving end of discriminatory practices and are often associated with the stereotypes 'lazy, stupid and worthless' (Schwartz et al 2003). Discrimination and bias occurs regularly towards overweight patients who can be additionally regarded as non-compliant, lacking in self control and as having a behavioural problem (Foster et al 2003; Cossrow et al 2001). Discrimination can lead to its own problems such as health care avoidance by overweight patients that may lead to missed appointments for fear of embarrassment or bullying behaviour by health care professionals (Schwartz et al 2003).

From a practical perspective, morbid obesity presents its own challenges for nursing care and there is a need to develop good sensitive communication strategies to prevent poor patient outcomes (Hahler 2002:252). Approaching the overweight patient can lead to its own dilemma for health care professionals who may feel that they lack the sensitivity, skills or knowledge to help patients who are overweight (Coombes 2002; Mercer and Tessier 2001). There can additionally be a 'mutual conspiracy of silence' where neither the patient nor the health professional initiates the sensitive issue of weight (Downey 2003:42-43).

Others feel that helping overweight patients is a waste of time and effort (Foster et al 2003; Wallis 2004). There are also health professionals who feel uncomfortable about providing advice and care to patients, particularly if they are overweight themselves (Schwartz et al 2003; Warner 1993).

The research problem in practice

In this unsettling context, members of my health promotion team had considered methods of helping patients who were overweight and who might welcome an opportunity to receive some practical support, whilst recognising that weight is a sensitive issue and that some may regard an approach as an invasion of personal space (Mercer and Tessler 2001).

A community weight management scheme was implemented and primary and secondary care nurses in their role as health educators (Jebb & Sritharan 2005) were invited to refer any appropriate patients. For the duration of the course, overweight patients who had been previously diagnosed with co-morbidities could attend for ten weekly group sessions; this course was led by a qualified dietician with health promotion skills.

Although some primary care nurses were comfortable with referring overweight patients to this group, many seemed reluctant. A qualitative study, undertaken by Wright (1998), suggests that there is a possible link between nurses' own weight

and their discomfort in discussing the issue of being overweight with patients. A quantitative study performed by Hoppe and Ogden (1997) found that the negative attitude directed towards overweight patients appeared to decrease as the nurses' age and/or BMI increased. The findings from these two studies were pertinent to the development of my research question; I felt that the issue of nurses' own weight, particularly in the context of the interaction with an overweight patient, merited further exploration.

My problem in practice initially arose when I inquired of a few primary care nurses in my own Primary Care Trust, the reasons for their own reticence in referrals and its associated requirement to initiate the discussion of weight. Nurses who appeared to be overweight, or felt that they were overweight, seemed anecdotally to have differing strategies for coping with this situation. Some felt that they could empathise with the patient more readily, whereas others felt that they might be viewed negatively by their patient. Many of the nurses declared that the topic of weight often seemed too sensitive to discuss and that they felt unprepared to deal with this type of conversation with an overweight patient. Moreover, some of the overweight nurses admitted to feeling that they were also unsupported in their struggles with their personal weight management.

Significance of the research study

On reflecting on the comments made by these overweight nurses, I wondered if overweight patients were receiving appropriate care and, furthermore, I was concerned that overweight nurses had, seemingly, not been given an opportunity to voice their own anxieties, concerns and experiences about being overweight – if it was indeed an issue that concerned them. Moreover, I made an assumption that they were sometimes placed in a potentially uncomfortable position with patients where they might be regarded as a poor role model.

I recognise that I have many assumptions and prejudices of my own, having been a nurse with experience of being underweight, normal weight and overweight, and I

endeavour to be transparent about these as I progress through the thesis. However, the main concerns that I felt were, firstly, the lack of voice of overweight nurses who might have much to offer in recounting their own experiences, positive or negative in their interactions with adult overweight patients; and secondly, the growing disquiet that overweight patients may be subject to discriminatory practice and prejudice insomuch that elements of their care may be neglected due to the reluctance of nurses to initiate conversations about the patient's weight.

The aim of the research study

The overall aim of the research study was to use a hermeneutical approach to gain a deeper understanding of overweight nurses' experiences of their interaction with overweight patients.

Research Question

What are overweight nurses' experiences of their interactions with overweight patients?

Research Objectives

1. To explore and describe how overweight nurses in this study manage their self in the interaction with the overweight patient;
2. To explore and describe how overweight nurses in this study manage the interaction with overweight patients; and
3. To offer insights from this study to other nurses and other health professionals, whether overweight or not, into these nurses' experiences of being overweight.

Research Method

Using a hermeneutical phenomenological approach based on Gadamerian philosophy, seven community and hospital-based nurses were interviewed twice

over a period of several months. During the second interview, participants were invited to draw a self portrait; the main purpose of this was to direct the conversation to their perception of their own body shape, rather than being part of the data gathering process. The participants were additionally invited to keep notes and to share these during the second interview, when the preliminary analysis was discussed and experiences co-constructed.

Defining 'overweight and obesity'

I use the term 'overweight' to represent both overweight and obesity for several reasons. Firstly, it can often be problematic to identify within which category a person falls and a person would need to be weighed and measured to determine which category is applicable; I did not wish to subject my participants to this. Secondly, the term 'obesity' might be emotive to those who are overweight and I wished to reduce the potential for distress to participants or others; some who are overweight might feel that their bodies are objectified and stigmatised and the term 'obesity' is often unpopular (Merrill & Grassley 2008; Thomas et al 2008). Moreover, it would be repetitive to use both phrases during the thesis so I use the term 'overweight' to represent whichever weight is over the prescribed rate as determined by the Body Mass Index (BMI).

Overweight and obesity is measured by health professionals by using the BMI and is also sometimes combined with the individual's waist measurement. The Department of Health (2006a) states that the BMI is the common method of evaluating individual people to see if they are under or overweight and involves comparing their weight to their height by dividing the weight measurement (expressed in kilograms) by the square of the height (expressed in metres). A BMI of below 18.5 is underweight, between 18.5 and 25 is an indication of healthy weight, 25 to 30 is overweight, a BMI of over 30 is referred to as obese, over 35 is known as morbid obesity, and over 40 indicates extreme obesity. Increased risk is also associated with a waist measurement that exceeds 94cm (40 inches) for men or 80cm (35 inches) for women.

Defining 'self'

There are many differing meanings attributed to the 'self' depending on the theoretical context. Stevens (1998:30), for example, identifies five key perspectives when referring to the 'self': biological; psychodynamic; cognitive experimental; experiential; and social constructionist. The *biological* perspective holds that social behaviour is underpinned by physiological and genetic processes (Darwin 1859). The *psychodynamic* perspective draws upon Freud's psychoanalytic thinking about a person with an emphasis on unconscious thought (Freud 1923). The *cognitive experimental* perspective is consistent with Mead's (1934) view that social psychology is 'the study of the experience and behaviour of the self in its dependence upon the social group to which it belongs' and Bauermeister (1999:2) who agrees that 'self' refers to the psychological being who is concerned with 'socially validated feelings and attitudes'. The *experiential* view represents the phenomenological, existential and humanistic traditions and is concerned with lived experience. Within this perspective, Gadamer (1975) argues that the notion of self is a fragment of tradition, hermeneutically related to the totality and is inconsistent with the Cartesian thinking in regard to the mind-body split (Lawn 2006:64). Finally, the *social constructionist* perspective is that people can only be properly understood in terms of their social practices and ways of thinking and being (Gergen 1991).

Other perspectives I could have chosen to underpin this study include the feminist perspective which takes a critical position on 'the woman question' and is committed to producing knowledge that will promote social and individual change (Letherby 2003:4). Rather than claiming to follow a political and feminist agenda, however, this study is principally concerned with describing and interpreting the lived experience of overweight nurses where the 'body' and 'self' are key concepts. Nettleton (2006) proposes that there are three main perspectives taken on the body: naturalistic, social constructionist and phenomenological. I considered the many different perspectives of the 'self' and the 'body' and took the strategic decision to

underpin this thesis with an embodied, relational and existential view of the self rather than the cognitive and psychological perspectives offered by authors such as Bauermeister (1998; 1999) and Mead (1934) which seem inconsistent with the phenomenological perspective.

In phenomenology, the self is 'scattered through the lived body and is active in all its parts' (Sokolowski 2000:127) and in this thesis I refer to the 'personal self' of the participants, as their being-in-the-world away from the professional environment as constituted through their identity as woman, mother, daughter and wife. I also refer to the participants, when nurses in clinical practice, as their 'professional self' which invokes the ethical codes of conduct dictated by the Nursing and Midwifery Council and where they are accountable for their actions, both internally and externally to their working environment. It is often argued that personal and professional identities are contingent upon each other (Aranda 2005) and this thesis is no exception.

In this thesis it is evident that, although the participants' personal and professional identities occasionally blend to form complex but significantly empathetic beings, their embodied identities can also repel each other, causing dissonance and great discomfort. In this thesis, therefore, by 'self' I am referring to the nurse participants' meanings of being-in-the-world as they inhabit overweight bodies and interact both with their patients and their social environment.

Defining 'Other'

The definitions of 'Other' are as pluralistic as the definitions of 'self' but I use the term 'Other' in the context of Gadamer's argument that 'understanding is part of a dialogue, a fusion of horizons and that it is the accommodation of the Other' (Lawn 2006:70). Heidegger (1962:155) also refers to the world as 'the world I share with Others'. A dialogue is formed between the 'I and thou' (Buber 1970) and cannot

exist unless between subject and subject. In this thesis I make the distinction between the 'I and thou' by referring to them respectively as 'self' and 'Other'.

Structure of the thesis

This thesis is formed of eight chapters. I have provided an outline of each remaining chapter in order to signpost the thesis for the reader.

Chapter 2: Background to the study

In chapter two, I discuss my methods of reviewing the literature; I critically appraise the relevant literature and identify gaps in research literature. The literature reviewed in this chapter is not exhaustive but aims to help the reader to understand why this study is justified and to place my research study into context.

Chapter 3: Methodology and Methods

In chapter three, I present my worldview and consequent decision making process when choosing, firstly, an appropriate and congruent methodology to address my research question and secondly, the methods of conducting the study. I describe the process of analysing my findings and debate issues of research rigour in phenomenological research studies. I also attend to the philosophical matters of epistemology, ontology and ethics within the context of my research study.

Chapter 4: Biographies

In chapter four, which is the first of two chapters that offer my findings, I invite the reader to meet my purposive sample of seven participants, all female nurses who are overweight. This chapter provides a brief biography for each nurse, offering each individual an opportunity to be given their own voice and to offer their personal story, with a minimum of researcher interpretation. This chapter demonstrates the

nurses' development of self and Other understanding through their personal experiences of inhabiting an overweight body. An un-themed summary of the biographies is provided.

Chapter 5: Overweight nurses' experiences of their interactions with overweight patients

I present the second findings chapter in two parts as the nurses talk about how they act upon their understandings of being overweight: firstly, how the nurses manage their self in the interaction with the overweight patient and secondly, how they manage the interaction itself. This chapter is an explicit and interpreted presentation of passages extracted from the transcripts and represents the fusion of horizons and shared understandings between participant and researcher and between overweight nurse and patient, building upon the biographies in chapter four.

Chapter 6: Discussion chapter – 'Going where they are'

In chapter six I discuss the findings of this study and consider how other literature might add meaning to my own research study and how my research findings add meaning to other literature. I introduce a new and original concept: *embodied empathy-in-action*.

Chapter 7: Researcher reflections and reflexivity

In chapter seven I reflect on both conducting the study and writing the thesis. I also explore issues of researcher reflexivity: I examine my influence upon the research process and explore ways my own assumptions, professional role and body weight might have impacted upon my study.

Chapter 8: Conclusions

In the final chapter I affirm how I have met the aims and objectives of the study, offering summaries of its significant findings and their implications for nursing knowledge and practice. I also discuss my previous and proposed methods of dissemination of my findings. Finally, I make explicit how this study makes an original contribution to nursing knowledge relating to practice.

CHAPTER 2: BACKGROUND TO THE STUDY

Introduction to reviewing the literature

In chapter two, I describe my method of searching the literature and demonstrate the relevance of my research study to other studies, setting my study in context and suggest its potential implications for nursing practice and knowledge. The issue of being overweight is not confined to the fields of nursing or medicine and so literature from other fields and disciplines, such as philosophy, social science, public health and psychology has also been accessed. Instead of claiming an exhaustive literature review on the issues of overweight and obesity in nursing I have reviewed eclectic and relevant literature that supports the undertaking of this research study and places it in context.

A literature review serves several purposes: it helps to define the research question by initially helping to identify a potential gap in knowledge or to extend prior studies, and it also provides a critical stance on research closely related to the study being reported. Moreover, it provides a framework for establishing the importance of a study (Creswell 2003: 29-30).

A positivist study, that employs a strong theoretical background, would be expected to have a literature review chapter presented in a separate section. However, for phenomenological studies, it is argued that a full literature review should not be undertaken prior to all data generation as it requires an assumption of the expected findings (Streubert & Carpenter 1995). It is, therefore, more traditional to present relevant literature at the end of a report of an inductive phenomenological study, where it becomes the framework for situating the findings of the study (Creswell 2003:31).

Beech (1999:45) argues that there are already previous influences from an enormous variety of sources in our daily lives but I consider that, in the Gadamerian tradition, a researcher should be prepared to be surprised by his or her research. My

theoretical naivety and conscious recognition that I was not able to predict the study's findings when setting out, meant that I could only investigate the literature, at the beginning of the study, that would inform me whether the study had already been undertaken and whether it would be likely to contribute in a meaningful way to nursing knowledge and practice. This thesis, therefore, will not adhere strictly to the conventional format of including a literature review with which to later compare the majority of the findings of my study. I have, however, regularly revisited the literature and included in this chapter relevant literature that has been published since the beginning of my study, to add further weight to the justification of conducting the research.

Over the period of the study, reviewing the literature has been an iterative process, rather than linear, and I have frequently revisited the literature and revised my searches as new concepts and issues have emerged. Conducting actual literature reviews also formed a significant part of my learning, both in process and content. Nonetheless, I recognise that it may have contributed to my assumptions and pre-understandings and I endeavour to make this clear in the analysis and discussion sections of this thesis.

Method of searching the literature

I began my search of the literature in October 2004 and publications have been monitored regularly since then in order to ensure that I have remained up to date. I have accessed mainly UK and USA nursing and medical databases as the issue of overweight and obesity is common to developed countries and these databases also include papers from European and Australasian journals. Recognising that there are differences in terminology for many of my key concepts, MeSH (Medical Subject Heading) terms were used for the Cinahl and Medline (1996) databases and Boolean logic was applied to other key words in other databases.

During the study I accessed the National Research Register and grey literature through the electronic library system and I also made contact with authors and researchers, such as Ian Brown, Lucy Yardley and Linda Finlay to be kept informed of progress on research studies that had some affinity to my own, whether for content or methodology; I also hand-searched for references in relevant papers or books.

I restricted my searches to papers written in or translated into English for practical reasons. I had to make judgements about what was relevant or not but, in the initial stages endeavoured to include all the papers that referred to health professionals (in a combination of terms) and their attitude towards weight and excluded any papers that were not directly relevant to the aims of my research study.

I initially conducted searches for Medical Subject Headings (MeSH) terms: *obesity, overweight, nurses, professional attitudes, staff attitudes*. Databases were cross-referenced in order to check for gaps and overlaps. There were seven results in DH-Data, three in BNI (British Nursing Index) (1994 to date), ten in Cinahl, 15 in Medline (1996 to date) and in the latter there were also 156 papers that included *obesity AND attitude*.

In addition, I investigated papers featuring the social and feminist contexts of obesity in the International Biography of the Social Sciences (IBSS) within BIDS (Bath Information Data Series) database (1990-2005) using keywords: *attitudes AND weight* (23 found, one of which also contained the keyword *feminism*).

In order to remain up to date, regular searches within BNI, Cinahl and Medline databases, combining MeSH terms in a variety of ways have been undertaken that included these terms: *nurse attitudes, overweight, attitudes, health personnel, obesity, self concept, patients, patient education, weight control, weight management, body mass index, practice nurses, body image, health behaviour, staff worker, nurse, practitioner, attitude, perception, prejudice, discrimination,*

preconception, health visitor, idea, opinion, professional, primary care nurses, communication, sensitivity, relationship.

Introduction to the findings of the literature review

The next section of this chapter discusses relevant literature that places this research study into context; it explains why this study is justified and how it will contribute to gaps in nursing knowledge and practice.

I have explored wider literature such as public health policies but also research studies concerning: the attitude of nurses towards overweight patients; being an overweight health professional; being an overweight patient; and sensitive communication. I considered that a review of these papers and publications would indicate whether there is a gap in knowledge and it would suggest whether my research question has already been addressed or if it was worthy of further exploration.

Policies to address overweight and obesity in England

At the time of the start of this research study I had been working in public health for many years and so this influenced my decision to include a review of hand-picked relevant governmental policies that have been published over recent years that specifically intend to address the matter of being overweight or obese. My research study does not address policy development but the policies mentioned in this chapter indicate that there is a gap in both governmental and nursing knowledge that merits further exploration and it is for this reason that I have included a brief review.

Over recent years, the government has published a number of documents in the forms of policies and guidelines that are concerned with general health and the matter of being overweight. In November 2004, '*Choosing Health: making healthy choices easier*', a Department of Health (DH) white paper document that

concerned itself with the health of the general population of England, was published. This document states that:

'NHS organisations have not been model employers and do not pay sufficient attention to the health of the people who work for them. A number of studies in the NHS have shown that patient care is affected by the experience of staff: staff that have positive attitudes towards their work are more likely to work effectively and efficiently.'

(DH 2004:168)

This document also sets out its intention to tackle what it describes as the 'epidemic of obesity' and states that concerted and systematic NHS action is required to prevent and treat obesity. However, it continues, there is reticence among health professionals about raising the issue of obesity with patients, suggesting that there is a need for improved information for health professionals and the public on how to prevent weight gain (DH 2004:139-140).

In May 2006, the 'Care pathway for the management of overweight and obesity' was published that included a 'Raising the issue of weight' tool for adults. However this tool simply advises health professionals to say:

'We have your weight and height measurements here. We can look at whether you are overweight. Can we have a chat about this?'

(DH 2006:24-25)

There is no advice provided in this document about how to initiate this conversation with sensitivity or how to approach the subject, particularly if the health professional is also overweight.

Moreover, there are more recent studies that suggest that nurses are still often keen to avoid weighing patients, particularly those who are overweight, perhaps in an effort not to offend or to cause detriment to the nurse-patient relationship and subsequent patient care (Lees 2009). It might be assumed, therefore, that if nurses

cannot bring themselves to weigh overweight patients there may be even greater reluctance to address the topic of weight.

The National Institute for Health and Clinical Excellence (NICE) published guidelines in December 2006 that recommended that all health professionals in primary and secondary care should offer advice to overweight patients based on individual preferences and needs. Nurses were advised to discuss weight, diet and activity at times when weight gain is more likely, for example, during and after pregnancy and around the time of the menopause (NICE 2006:6). The guidance continued with the suggestion of the health professional using their clinical judgement to decide when to measure weight and height and to tell the person how their weight affects their risk of long term health problems but offered no advice on how to raise the topic with the patient (NICE 2006:18).

In 2007, Foresight, a government-sponsored organisation, following a two-year project that examined the causes of obesity, predicted soaring levels suggesting that nearly 60% of the population in the UK could be obese by the year 2050 but offered no specific advice to health professionals in primary or secondary care (Foresight 2007). In the same year, the Department of Health (2007) published another document '*Lightening the load: tackling overweight and obesity: a toolkit for developing local strategies to tackle overweight and obesity in children and adults*'. This document states that nurses are 'potentially well placed to detect and manage obesity in high risk patients' and mainly refers to the previously mentioned DH and NICE documents for advice on how this might be achieved. Once more, there is no support for nurses provided in the form of guidance for approaching a patient on a sensitive topic.

In January 2008 the Department of Health and the Cross-government Obesity Unit published '*Healthy Weight, Healthy Lives: a cross-government strategy for England*' which discussed 'lifestyle epidemics' including obesity, declaring that nearly 25% of the population is obese. It states that 'the core of the problem is simple – we eat too much and undertake too little physical activity' although it also recognises four key contributing factors: human biology; culture and

individual psychology; the food environment; and the physical environment (DH 2008:vii-4). The health service is identified in the document as playing a key role in tackling excess weight and the 'NHS Choices' initiative offers website based advice on nutrition and exercise, although it is generic and not tailored to individual needs.

Personalised care for obese and overweight individuals is, once more, recommended and, again, refers to the NICE guidance published previously with regard to clinical care pathways for obese and overweight adults. The effectiveness of this pathway, which had been in circulation for over a year when the '*Healthy Weight: Healthy Lives*' document was published, was questioned:

'... the Government has received some feedback that suggests that GPs are not making full use of the clinical care pathway, nor their BMI registers... the Government will address this by evaluating and, if needed, updating the existing clinical care pathway for the management of weight problems, ensuring that professionals are able to use this important resource effectively ...and to implementing a systematic assessment of adults in England for risks of heart disease and other diseases.'

(DH 2008: 24-25)

The document recognised that:

'Therefore training will need to address the different needs of [NHS] ... staff groups, but importantly, it must also recognise how sensitive the issue of weight is and build both the confidence of staff to be able to raise the issue, and the know-how to influence behaviour change.'

(DH 2008:28)

In '*Healthy Weight: Healthy Lives: one year on*' published on 6 April 2009 it was suggested that support for health professionals was still being targeted as a priority:

'... to make sure that GPs and other health professionals are equipped to raise the issue of weight with their patients, to provide advice and, where necessary to refer people on to suitable services that will meet their needs.'

(DH 2009:42)

It is significant that over the last five years there appears to be a recognition by the Government that nurses have a key role in the prevention and management of obesity and yet it is only relatively recently that there seems to be a realisation that nurses and other health professionals are often reluctant to initiate the sensitive topic of weight. Furthermore, there seems to be a lack of practical support and training to assist health professionals to initiate sensitive conversations about overweight and, more specifically, there seems to be a lack of understanding of the perceptions of overweight nurses, the key health educators of the health care system, in this situation or context.

Public health strategies to curb the spread of the 'obesity epidemic' appear to be ineffective (Renehal et al 2008:71) and so there needs to be a better understanding of the factors affecting weight and how to provide more effective and holistic care for overweight patients.

Attitudes of nurses towards overweight patients

The next area of literature I explored was that of the attitude towards overweight patients of nurses and other health professionals. This is significant as I suggest that attitudes might affect the behaviour of nurses who have an ethical and moral responsibility to care for all patients without discrimination. I investigated literature in Europe, Australasia and the USA, all developed continents with escalating levels of obesity, and included literature with studies exploring nurses', doctors' and other health professionals' attitudes towards overweight patients.

In a research study in the USA involving 620 responses to a questionnaire sent to 5000 primary care physicians (response rate 12.4%) obesity was regarded as largely a behavioural problem; more than 50% viewed patients as awkward, unattractive, ugly and non-compliant (Foster et al 2003). The response rate to this study was relatively low and there is a potential limitation of the over representation by physicians who have an interest in obesity. However, if this is

the case, then the negative views towards obese patients are even more significant and concerning.

Loomis (2001) undertook a cross-sectional survey of 267 military physicians with responses from 214 (80%), 93% who said that they believed that they should be role models to patients and 25% regarded obese patients as lacking in self control. The authors identify one of the limitations of their study as having a lack of demographic data which made it difficult to compare their sample with the overall membership of the US Air Force. However, I do not consider that this affects their theme of stereotyping of obese patients. This theme of negative stereotyping is echoed in Cossrow et al's focus group study (2001) that investigated a non-clinical self selected sample of 17 female and 14 male adults in the USA who reported a variety of experiences of being treated differently or poorly because of their weight. The sample group was small and self selected so is likely to represent only those who have a specific interest in reporting negative experiences and is therefore open to the criticism of selection bias. Nonetheless, focus groups aim to offer a supportive environment in which rich data can be gathered and holding a specific interest in obesity may be beneficial to the study. In this group, women reported a greater number of negative experiences than men. The authors suggest that despite the best efforts of public health professionals the obesity prevalence continues to rise and that it is important to consider the experience of being overweight in a society that has many barriers to achieving what might be considered a healthy weight.

Schwartz et al (2003) found, in a self-reported questionnaire from a convenience sample of 389 clinicians and researchers at an obesity conference, that these health professionals associated obese patients with the stereotypes: lazy, stupid and worthless. The authors admit that they have no knowledge of how representative this is as a sample group and it only measured attitude rather than actual behaviour towards obese patients. Despite this small sample, the results can still be considered to be significant as these professionals work closely with obese patients. In this study, significantly lower levels of bias towards those who are

overweight were demonstrated by those who were: male; older; had a positive emotional outlook on life; weighed more; had friends who are obese; and who indicated they had an understanding of the experience of obesity.

Culbertson & Smolen (1999) suggested that, in a descriptive, correlational questionnaire survey of 73 self-selected students, who were also nurses, in the USA, 54% of the nurses felt that obese adults lack self-confidence, but 73% disagreed with the statement that most obese adults are lazy and 92% disagreed that most obese adults are pushy and aggressive. The sample is subject to selection bias, however, due to its self selected nature and the conclusions cannot be generalised as it is a small convenience sample. It is suggested that there are statistically significant differences between years of practice and nurses' attitudes towards personalities and lifestyles of obese adults. RN students who had worked fewer than 6 years had more negative attitudes than those who had worked 6-15 years and as age of the nurse increased, the negative attitude decreased.

Turning to research studies undertaken in the UK, it is suggested that there are also examples of discrimination towards overweight women in healthcare. In contrast to Schwartz et al's (2003) study, Wright's (1998) qualitative study of a small sample of ten, conducted using semi-structured interviews suggests that male doctors censured overweight female patients more than male patients and that they were more likely to withdraw treatment from women than men. For example, women were more likely to be refused a planned operation or told to go home and lose weight before surgery.

The sample is small so cannot be generalised to the nursing profession as a whole but interesting questions are raised. Wright suggests that further research should be conducted that focuses on the advice given to overweight patients - which is suggested by this study to appear less than empirically based (Wright 1998:307).

Hoppe and Ogden's study (1997) suggested similar findings to those of Culbertson and Smolen (1999) in that the negative attitude towards obese patients decreases as the age of nurses' and/or their BMI increases. In their quantitative

study 586 practice nurses (65% response rate) were asked to complete a structured questionnaire concerning their beliefs about obesity and current practice. The sample group is subject to potential selection bias as only one practice nurse was chosen from each practice and there is no reference in the report about how and why a particular nurse was chosen.

Significant differences between practice nurses with high/low BMI were found for age and year qualified. Practice Nurses with higher BMIs were significantly older and obtained their nursing qualifications earlier than nurses with lower BMIs. As the research suggests that older nurses are more empathetic to overweight patients, the selection criteria could skew the data. However, the researchers do make the distinction between nurses' ages and BMIs in their results, possibly to address this potential flaw.

The sample of 900 is large and received a good response rate so it can be considered to have considered the element of chance. The research also appears to be reliable as it is likely that using the same methodologies would result in similar data. The conclusions are plausible and coherent although alternative explanations for the data have not been explored; this may be that the structure of the questionnaire provides quantitative data that offers little qualitative data regarding experience and values.

This study was of particular interest to me as the practice nurses rated lifestyle factors as more important causes of obesity than biological factors. The nurses viewed obesity as preventable and treatable and weight loss as beneficial to health. Those nurses with a high BMI rated obesity as less preventable than those with a low BMI. The authors, Hoppe and Ogden (1997:145) reason that 'the results imply that nurses use rituals to govern current practice and that they will continue to use methods that are ineffective (as the likelihood of actual weight loss over the previous six months was low) but with which they are comfortable, such as the use of advice to eat less, rather than referral to a specific clinic.' The results also suggest a relationship between a health professional's own health status and their professional health promotion practices.

Following my original literature searches from 2004-2006, in which numerous studies suggested that discriminatory care towards overweight patients existed, a meta-analysis was conducted by Brown (2006) in which he also cites the studies: Wright (1998); Peternelji-Taylor (1989) Hoppe and Ogden (1997); Ogden and Hoppe (1998); Culbertson and Smolen (1999) and he concurs that, from these studies, there was a consistent suggestion that a proportion of nurses have negative attitudes and beliefs towards adult patients who are obese. This attitude can have a detrimental effect on the relationship between the nurse and the patient, particularly when the patient is not seen to be taking responsibility for their own health behaviour (Olsen 1997:517).

It can be seen therefore that there are negative attitudes towards overweight patients and assumptions are made that the state of being overweight can be caused by the greed, stupidity and laziness of the individual Schwartz et al (2003). Leach (2006:17) argues that this assumption does not take into account the psychology of obesity and that the lack of willpower and gluttony are not key issues for the majority of overweight patients. Leach (2006:17) states that she considers it likely that therapists will hold prejudiced views towards overweight patients but that, as long as the therapist is self aware, they should be able to keep these views away from the therapy process and she advocates honesty on the part of the therapist when interacting with a patient.

Being an overweight nurse

Health professionals themselves are not immune to being stigmatised if they are overweight (Drury 2002) and Reto (2003) laments the lack of data regarding the levels of overweight nurses; however, if the NHS can be considered to employ a representative sample of women living in the UK, then approximately 25% of its own workforce may be overweight and this will have an impact on the care given to patients if the nurses themselves are discriminating and are being discriminated against. Moreover, this demonstration of discrimination is not restricted to the

health professions as people who are overweight may experience discrimination in recruitment, travel and many other situations (Puhl 2001; Saporta and Halpern 2002) and so it may be difficult for nurses to divorce personal beliefs from cultural beliefs held by society when dealing with overweight and obese patients (Peternelji-Taylor 1989).

A quantitative postal study was undertaken in the USA (Miller et al 2008:259) with 4980 randomly selected registered nurses from one US state in each of six geographic regions. The number of responses to the questionnaire was 760; this represents a response rate of 15.25%, rather than the rate of 15.5% claimed by the authors. Although this appears to be a large comprehensive study, the actual percentages relate to small numbers of nurses. This study suggested that 54% of the nurses who responded to the survey were overweight, with a mean average BMI of 27.2. Additionally, 76% of the nurses who responded to the survey stated that they do not pursue the topic of weight with overweight patients even when they make the clinical judgement that the patient is overweight or obese. The authors suggest that:

'... education regarding patient communication and initiation of potentially sensitive topics may be helpful. Skill and confidence in initiating a non-threatening and non-judgemental dialogue may prompt nurses to be proactive in taking advantage of this opportunity for primary and secondary prevention.'

(Miller et al 2008:264)

Miller et al (2008:265) further suggest that nurses should be role modelling accurate, evidence based information. In their study 51% of the nurses declared that they were competent to provide professional advice and counselling for patients interested in weight reduction and that there were no real differences in the responses from the overweight or normal weight nurses. However, there was no information provided on whether this was evaluated but their study also investigates the overweight nurses' own lifestyle habits, which are not successful at managing their own weight. The authors suggest that further research should be conducted to evaluate how these nurses define a healthy diet and regular exercise.

Hicks et al (2008:349) replicated a previous study in the USA (Wells et al 2006) with a convenience sample of 150 university students, staff or visitors to explore the confidence level in receiving health teaching from either an overweight or normal weight Registered Nurse. This was undertaken by showing randomly selected participants two pictures that both depicted a Caucasian woman dressed in a white trouser suit, one of whom could be considered to be of 'medically recommended' weight and the other to be overweight. Participants were asked to indicate to the researchers how confident they would be to receive diet and exercise education from each of these women. Limitations of the study were identified by the authors; many participants claimed that they would require information on how qualified the nurse was to provide this education and as both nurses pictured were female there may be a gender issue. I consider that this is unlikely to have influenced the significance of the findings which suggest that 'weight-appropriate' nurses may inspire more confidence in their teaching. The authors contend that if patients feel less confident receiving diet and exercise education from overweight nurses, this has the potential to have significant effects on patients' success in following lifestyle advice (Hicks et al 2008:352).

Being an overweight patient

It stands to reason that overweight nurses must, by default, also be patients themselves at times. Some of the previously mentioned studies indicate that it is possible that life experience - or perhaps experience of being overweight - increases empathy with the patient. Nurses, whatever their own experiences regarding being a healthy weight or of being overweight, will have their own perceptions, whether positive or negative, regarding patients who present in their surgery with conditions that may or may not be related to their weight (Hoppe & Ogden 1997; Steefel 2002).

Turning now to an exploration of the patient experience, there are studies such as Merrill & Grassley (2008) who used an hermeneutical phenomenological

approach to investigate women's stories of their experiences as overweight patients. From this study of eight women, four major themes were identified: struggling to fit in; being dismissed; feeling not quite human; and refusing to give up. The study used a small sample, which is acceptable for a phenomenological study, and only included white women who volunteered to participate. Standards of trustworthiness for this study were derived from Lincoln & Guba (1985) and focus on the unique nature of these women's experiences and interpretations rather than generalisation and repeatability. The authors conclude that overweight women experience many aspects of healthcare as a constant battle and a struggle. Furthermore, they argue that 'nurses should have education in the care and management of overweight patients and they recommend that a patient-centred approach to treatment is based on respect for, and understanding of, the overweight patient'(Merrill & Grassley 2008:145). The authors suggest that 'further research should be conducted to identify therapeutic nurse-patient relationships that promote care and reduce stigma' (Merrill & Grassley 2008:145).

The reduction of stigma associated with obesity also features in the conclusions of a qualitative study conducted by Brown et al (2006a). Purposive sampling and semi-structured interviewing of 28 obese patients was conducted using a grounded theory approach. The study was small and aimed for data saturation to assist theory generation rather than statistical generalisation. A limitation of the study was that it did not include any obese patients who were not using primary care services or participants who were from the Black and Asian ethnic minority groups and so it was unrepresentative of the practice population being researched. The findings may also be biased as the participants may have chosen to participate if they possessed particularly strong views. Brown et al consider that this study 'did not uncover direct experiences of negative stereotyping or discrimination from the patient's perspective but it did find perceptions of ambivalence about first-line support.' The authors suggest that 'stigma-related thoughts are detrimental to quality of life and inhibit the interaction with health services' (Brown et al 2006a:672).

Overgaard (2002) used an hermeneutical approach to describe five persons' lived experiences of being overweight. Research rigour was addressed in this study by striving to show authenticity during the research process and descriptive adequacy within the findings. Overgaard (2002) proposes that nurses need to consider whether they wish to understand the person behind the weight, 'related to Gadamer's fusion of horizons where the nurse not only views the patient from one angle, but via the dialogue reaches a common understanding' (Overgaard 2002:10). Overgaard recommends that nurses understand the lived experiences of being overweight to avoid prejudice towards overweight patients (Overgaard 2002:11).

Throsby (2007:1561-1571) conducted a feminist qualitative research study using a discourse analysis approach and interviewed 35 English and Scottish patients who had undergone weight loss surgery. All the participants in the study experienced their body as 'fat-prone' and that 'life gets in the way' of taking responsibility for their lifestyle with illness or injury figuring in a number of interviews as a key turning point in their accounts of becoming overweight. The patients, however, refuse to consider their overweight body as an embodied moral failure and resist the dominant discourses of the 'obesity epidemic'. The author significantly suggests that there is a very limited vocabulary through which being overweight can be discussed.

Being a sensitive communicator

I could find very little literature that specifically addressed being a sensitive communicator with overweight patients in the earlier stages of my research study apart from a paper by Haynes (2004). Haynes offers her advice on initiating this topic and recommends that nurses ask legitimate questions in context when it has an obvious bearing on the matter in hand. I do not consider that this necessarily assists in opportunistic settings or in nurse-patient interactions whereby the patient seems resistant to discussions of weight. Haynes further recommends that the

nurse should build a 'trusting, caring relationship with the patient and should show empathy with the difficulties that the patient is experiencing.' (Haynes 2004:137). However, there is no advice provided on developing empathy with the patient. Studies mentioned previously would suggest that developing empathy for overweight patients is problematic for some health professionals and that this has various consequences such as health care avoidance on the part of the patient and possible discrimination towards overweight patients by health professionals.

I have since repeated my literature review and found three other relevant papers. Advice to nurses is offered by Haslam (2008:26) who suggests that 'best practice in obesity management is carried out in the last two minutes of any consultation, whatever the reason for the appointment' and that no nurse should 'let an obese person who has attended the surgery for an unrelated matter leave the surgery without being made aware of their high risk.' Nevertheless, there is no specific advice on how to initiate this sensitive conversation, particularly as the patient is on the verge of leaving their appointment.

A recent cross-sectional quantitative study conducted by Michie (2007:521) investigated 40 inner London General Practitioners' (GPs) and 47 Practice Nurses' communication about overweight with their overweight and obese patients. The study had only a 27% response rate and was taken from only two primary care organisations within one UK city so the results cannot be generalised and it does raise questions about sample representativeness. The GPs and Practice Nurses were asked to complete anonymised questionnaires about past practice and concerns. The study reports that where there was no identified medical problem 38% of GPs and 14% of practice nurses raised the issue of weight on less than 50% of occasions. When the issue of weight was raised only 9% of Practice Nurses did so in the context of presenting possible solutions to weight loss or in discussions of health promotion. It is significant that the study claims that 52% of GPs and 28% of Practice Nurses in this study had concerns about raising the issue of being overweight. The most common concern was that the patient would react emotionally to the message. This is even more significant as the study suggests

that ‘both GPs and Practice Nurses were likely to report that they communicated in a directive manner (e.g. telling patients they are overweight or should lose weight) than to judge directive communication to be good practice.’ The author recommends that nurses should increase their skills and confidence in communicating about weight.

Practical advice to caring sensitively for morbidly obese patients is offered by Vacek (2007) although it appears to be directed at nurses who are caring for patients who are already undergoing medical or surgical treatment, rather than initiating the conversation about weight. Nonetheless Vacek recommends that ‘sensitivity and empathy are vital to an obese patient’s unique needs and feelings and to establishing a trusting relationship between patient and nurse.’ (Vacek 2007:252).

Most recently Cook (2009:12) suggests that ‘brief interventions with open questions about which aspects of patient health bothers them most (such as fear of diabetes) will often elicit a response that can be used as an opening to a discussion about weight or lifestyle’ although Cook also admits that ‘finding a diplomatic way to approach people about the issue of their weight which does not alienate them is not an easy task.’

Choosing the conceptual framework

‘The original person is he who borrows from the widest number of sources.’

Watkins (1978:15)

A challenge presented itself in choosing and introducing the conceptual framework(s) within which to contextualise my literature review. The subject matter of managing weight or being overweight is prominent in a variety of disciplines, such as psychology, nursing and medicine, public health, sociology and feminist studies, to name a few (Figure 1) and I acknowledge the necessary eclectic nature of the literature employed from these disciplines in this thesis.

Whilst I understood that theory is necessary to ‘cradle your thinking’, I had not initially grasped that it is permissible to draw from any theory or concept that ‘adds value’ to your writings (Dillow 2009:5). This new perspective helped me to realise that I could use whatever tools I needed to tell these nurses’ stories.

This study is concerned with how nurses, who inhabit an overweight body, experience their interactions with their overweight patients and Nettleton (2006:107-136) proposes that there are three main perspectives taken on the body: naturalistic, social constructionist and phenomenological. In keeping with my methodology, I chose to employ the phenomenological perspective, where possible, although I also drew upon other philosophical, nursing, sociology and psychology literature that might assist me in integrating and making sense of the data later on in the study.

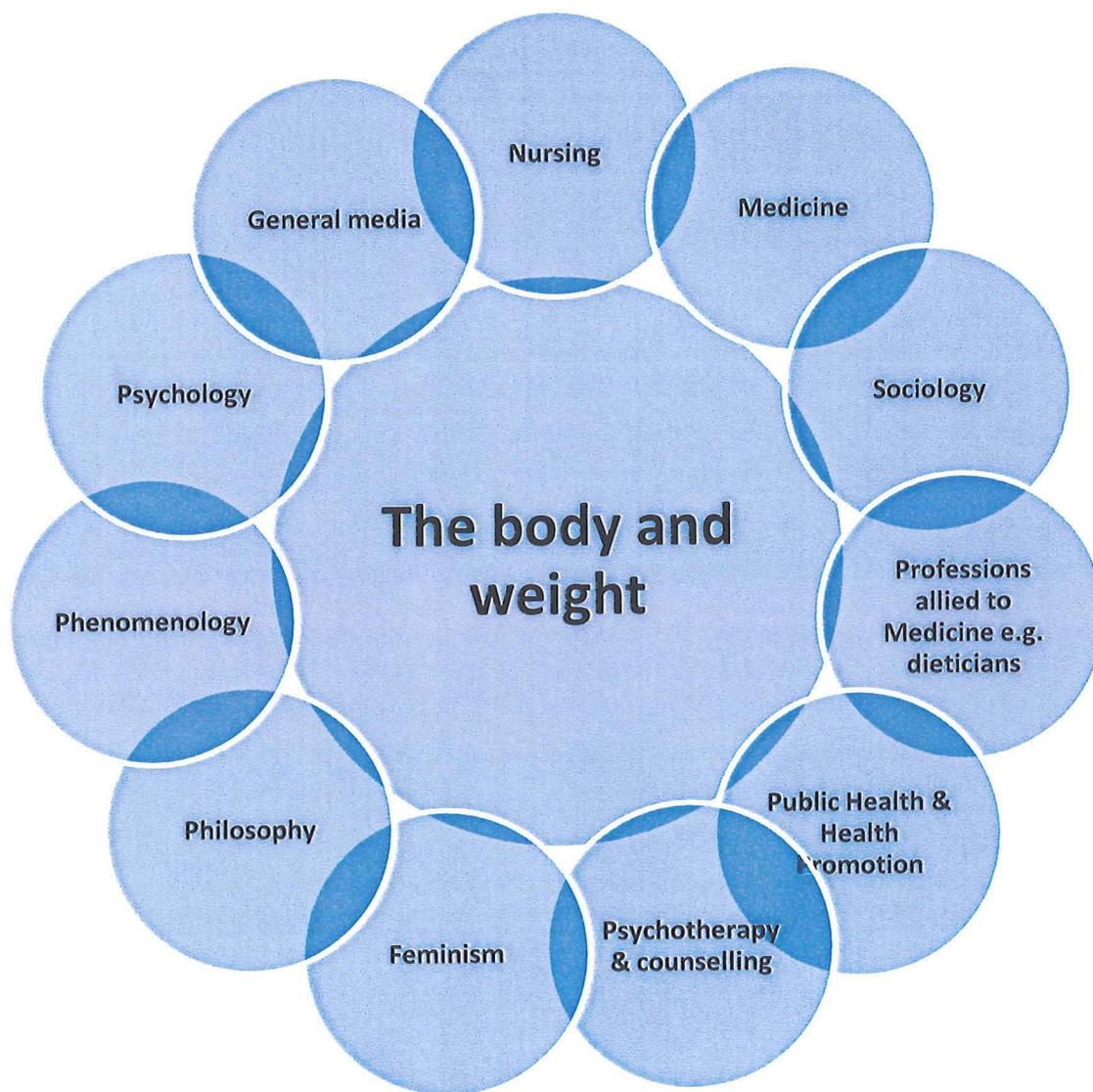
It did not seem possible, or indeed helpful, to adhere to a single theory and there are authors who agree that there is nothing to be lost in ‘theoretical pluralism’ if this helps to contextualise findings (Woolcott 2001:81). The literature I drew upon throughout the study was eclectic and diverse and I was necessarily unfaithful to a single concept as the findings were complex and unsuited to a narrow approach. Janesick (1994:215) reasons that there is a ‘preoccupation with the selection and defence of methods used in research to the exclusion of the actual substance of the story being told’; I believe that this also applies to the selection of theoretical frameworks used to underpin the discussion chapter of this thesis.

I cannot claim that the literature reviewed in either this chapter or the discussion chapter is exhaustive as the bodies of work that are concerned with the concepts drawn upon are immense. Nonetheless, I endeavoured to employ the key literature that provides meaning to my study and to which my study adds meaning. My aim was to share these nurses’ stories and so I have used the backdrop of whichever concept or theory that felt appropriate for a particular element of my discussion.

I also drew upon research studies which are unconcerned with the exact topic of my study i.e. overweight nurses’ experiences of their interactions with overweight

patients, as they can provide a helpful reference to similar methodologies or concepts even if employed for a different reason. It will be evident that I largely excluded literature deriving from, for example, feminist and public health theories, or concepts such as professional socialisation and professional identity, because their value in addressing my specific research question may have meant the exclusion of even more significant concepts. However, the data from this study are so rich that I cannot but acknowledge that there is enormous scope to return to the data following my doctoral studies for further analysis and discussion. Once my doctoral studies are concluded, it is my intention to explore the data from this study for further meanings in order to publish and disseminate my findings that may be of benefit to the nursing community.

Figure 1. Diversity of disciplines contributing to debate about body and weight



[Original in colour]

Summary

The literature accessed for this study is eclectic and derives from many different disciplines as the topic of being overweight is not confined to nursing. It is inappropriate for a researcher conducting a phenomenological study to predict its outcome and therefore the literature reviewed prior to data gathering specifically focused on the problem in practice. I did not seek out literature prior to the study that *might* relate to the findings although this literature is accessed and debated in a later chapter.

The government is concerned about what it terms the 'rising epidemic' of obesity (DH 2004) but appears to confine its advice for health professionals to offering simple phrases when initiating the sensitive conversation of weight with patients. Policies do not offer advice on how to broach the topic of weight with an overweight patient if the nurse is herself overweight - and there seems to be a generalised reluctance on the part of nurses of all weights to do this, which featured anecdotally in practice and within the literature (Michie 2007; Miller et al 2008; Cook 2009).

The studies accessed in the literature review additionally suggest that there is discrimination towards overweight patients and this can have an adverse effect on the nurse-patient relationship. This may lead to the possibility of health care avoidance on the part of the patient which may, in turn, affect their physical and mental health. Merrill & Grassley (2008:145) contend that overweight women experience many aspects of healthcare as a constant battle and a struggle. Overgaard (2002:11) recommends that nurses understand the lived experiences of being overweight to avoid prejudice towards overweight patients. Some of the previously mentioned studies indicate that it is possible that it is life experience, or perhaps experience of being overweight, that increases empathy with the patient (Hoppe & Ogden 1997; Steefel 2002).

Other studies suggest that the nurses' reluctance to initiate the sensitive conversation about weight with an overweight patient (Miller et al 2008; Michie

2007; Vacek 2007) might be contributing to discriminatory care. There is a growing number of people in the UK who are overweight and nurses are often best placed to help and support those who would like to manage their weight but there are reasons to suspect that the nurse's body size will have an effect on client confidence in the nurse's ability to provide health education on diet and exercise (Hicks et al 2008). Some studies suggest that overweight nurses may have more empathy with overweight patients (Hoppe & Ogden 1997; Wright 1998) – and it was my assumption, based on anecdotal evidence, that overweight nurses may also be more reluctant to initiate the conversation if they feel that they are poor role models.

Whether or not the sensitive topic should be raised and the effectiveness of such interactions is not debated or explored in this study. Accepting that there are times when nursing interventions are required for health reasons, means that overweight nurses find themselves in the sometimes uncomfortable position of initiating a sensitive communication with an overweight patient. This is an important element of this study. The previously mentioned studies do not provide an answer to my research question:

What are overweight nurses' experiences of their interactions with overweight patients?

Further studies are needed to provide more data on overweight nurses and their interactions with overweight patients. The significance of my own study is that it provides an insight into how these overweight nurses experience their interactions with overweight patients and how they manage their self in the interaction; additionally it explores these nurses' strategies for managing the interaction and for initiating sensitive conversations.

In the next chapter I have presented my personal worldview and my choice of an appropriate and congruent methodology to address my research question along with the methods I adopted to conduct the study.

CHAPTER 3: METHODOLOGY AND METHODS

Introduction

This chapter describes my choice for an appropriate methodology and methods to address my research question:

‘What are overweight nurses’ experiences of their interactions with overweight patients?’

I describe my journey as I move through the decision-making process for my final choices of methods, their congruence with my epistemological and ontological stance and provide details of my research design. This journey takes me from my choice of qualitative research to interpretivism, phenomenology and hermeneutics as it is essential for trustworthiness, credibility and authenticity that good quality qualitative research offers an audit trail of its epistemology, methodology and method (Koch 1994; Carter & Little 2007).

Locating self as researcher: what is my worldview?

A simple way of exploring your personal ontological stance is to ask yourself ‘What is the nature of reality?’ I do not believe that ‘the truth is out there’ in terms of a single truth as I believe that your reality may not be my reality. Rather, I lean towards holding a relativist stance and agree with Cresswell (1998:75) who suggests that reality is subjective and multiple. My own example of this is a door; to a prisoner the door might feel as though it is a symbol of punishment and the denial of freedom, whereas to a child a door may represent the portal to games, fun, family and security.

Epistemology is the theory of knowledge and so epistemological assumptions are concerned with ‘how we know, with the nature of knowledge, with what

constitutes knowledge, with where knowledge comes from and whose knowledge it is, and with what it is possible to know and understand and re-present' (Wellington et al 2005:101). I consider that knowledge is interpreted and it can be generated through experience, co-constructed by shared language and dialogue and is influenced by its context and position in time and space. The lens through which I conduct, analyse and discuss my hermeneutic study, is underpinned by Gadamer's perspectives of 'shared understandings'- his 'fusion of horizons', and Merleau-Ponty's stance on embodiment and intersubjectivity.

For the purposes of authenticity and transparency I need to share my own assumptions and experiences. I originally trained as a nurse and worked in public health in a variety of roles for 24 years. At the time of the inception of this research study I was employed in a Public Health Directorate as a Health Promotion Manager by a Primary Care Trust and I worked closely with primary care nurses. Since then my role has moved away from public health and primary care to the acute sector and I am now employed by an NHS Hospitals Trust. Throughout these times, however, my weight has altered depending on my lifestyle and levels of stress.

I was interested in the topic for this study for personal reasons as I have been the educator and the 'educated', a nurse and a patient, and there have been times where health intervention for my weight management has been either welcomed or found intrusive. I cannot help but hold the assumptions and prejudices (pre-understandings) and the mindset of an experienced public health professional but there is, for me, a conflict between knowing, and in this case the 'knowing' is contested, the morbidity issues associated with being overweight and undertaking the actions required to address my bio-medically undesired overweight status. I expected to have some issues in common with my participants and hoped that this would help rather than hinder the research generating process, although I also expected that this would cause some concerns for demonstrating research rigour to those holding a positivist or realist stance. I address these concerns later in this chapter.

What is the most appropriate approach to address my research question?

'Hermeneutics must start from the position that a person seeking to understand something has a bond to the subject matter.'

(Gadamer 1975/2004:295)

Having explained my personal reasons for being interested in this topic, the aim of my research study was to gain a deeper understanding of how these seven nurses experience their interactions with their overweight patients. The choice of research methodology generally falls into either qualitative or quantitative, or occasionally a blending of both, but this study was intended to generate data about experience and so was more suited to qualitative research methods 'the perceived paradigm', rather than quantitative methods 'the received paradigm'.

Researchers often debate whether one type of research is more rigorous than the other (Porter 1994:69) and, whilst the realist and positivistic methods that are usually quantitative in nature can offer hypotheses and numeric data, they can lack the rich data that informs the 'why' and 'how' questions. Many authors argue that 'neither one nor the other is mutually exclusive or superior to one another and that they should be regarded as complementary' (Silverman 2001:27).

I consider that experience and understanding are not tangible and discrete objects that lend themselves to measurement and so the methods that focus on generation of rich data are more suited to my research question. In fact, my research study responds to, and builds upon, other research studies that could be considered to be quantitative in nature, for example, Hoppe & Ogden's (1997) study. I firmly believe, therefore, that a qualitative research methodology and method are appropriate for addressing my research question and I agree with Crotty when he suggests that:

'Subjective meanings are important in people's lives and we may adopt qualitative methods of ascertaining what those meanings are.'

(Crotty 2003:15-16)

Having decided upon an overarching qualitative research methodology, I was left with the problem of which one to choose. There are many from which the researcher can gather rich data, such as grounded theory, ethnography or phenomenology, but the choice depends on the researcher's claims on knowledge (Cresswell 2003:8) and the resources available. I knew from copious amounts of reading, considering and discussing alternatives that I felt that meanings were constructed and that I wanted to focus on the individual's meaning of her experience of the interaction. I contend that human beings make sense of their world based on their personal perspectives and are contingent on factors such as time and context and so I felt that research based upon a realist ontology was less appropriate. I was not seeking to generate theory or to explore social processes (Mateo & Kirchhoff 2009) and so I discarded methodologies underpinned by realist ontological concepts, such as grounded theory. I also discarded ethnography, the study of a culture, as the resources available to me were insufficient to facilitate my immersion in the field and focused on a group of people rather than individuals.

As I felt that a study underpinned by a relativist stance would be a good fit for what I was trying to discover, the remainder of the chapter describes my journey through relativism, phenomenology and hermeneutics. I explain how I decided upon the best approach for my worldview which would assist me to gather data that focuses on experience, rather than facts and figures.

Undertaking qualitative research with my world view: my theoretical lens

Being a relativist?

Although I consider that I lean towards relativism, it is a provisional stance and there is a spectrum of views. Relativism attracts heavy debate from some quarters and there are strong critics. Speers (2005:188), for example, asserts that a relativist approach can be seen as morally vacuous and states that 'a number of

feminists are of the view that such an approach is fundamentally amoral and unethical' and that there can be no reconciliation between the 'concerns of both feminism and relativistic forms of analysis.' The suggested lack of morality within relativist hermeneutics is repudiated by Richardson & Fowers (1997:282-3) who state that 'in the hermeneutic view, a basic fact about humans is that they care about whether their lives make sense and what their lives are amounting to...' They continue:

'According to hermeneutic thinkers, our moral and political judgements are always tied to specific cultural contexts and issues. They can never be final or certain. But there is no good reason to think that all moral values are ultimately relative or invalid. Only a god could know that in any case. In place of the modern "quest for certainty" and liberal individualist ethics, hermeneutics puts the process of hermeneutic dialogue.'

Richardson & Fowers (1997:282-3)

Nightingale and Cromby (1999:228) also define relativism, perhaps a little roguishly, as being a 'bad thing'. Edwards, cited in Nightingale and Cromby suggests that relativists suffer a dilemma that occurs because relativism must treat everyone's views as equally valid... it offers no grounds for caring one way or another on anything moral, political or factual. Edwards states that this is a compromised position:

'While realists shoot themselves in the foot as soon as they represent, relativists do so as soon as they argue. To argue for something is to care, to be positioned, which is immediately non-relativist.'

(Edwards in Nightingale and Cromby 1999:7)

I recognise the complexity of the debate about where authors might be located on the ontological continuum between realism and relativism and there occurs much 'diversity and conflict among the practitioners of phenomenology' (Moran 2000:22). There can also be movement in stances, for example, Husserl, who is considered to be the founder of phenomenology, made many assertions that could be viewed to be realist in his quest for pure description and his use of epoché, the bracketing of assumptions, but who moved away from his realist stance in later years (Moran 2000:60/139). In an acknowledgement of claims by Heidegger and

Merleau-Ponty that there should be a pre-theoretical awareness of our being-in-the-world, Husserl developed his concept of lifeworld (Flynn 2006:23).

I spent a considerable amount of time deliberating over this debate but eventually came to the conclusion that I agreed with Richardson and Flowers (1997). I argue that perspectives are contingent on time and place and they are not fixed or static. It is inevitable that there will be complexities and contradictions as this is a facet of being human. I aim to offer transparency, authenticity and trustworthiness by offering a research audit trail. Each person that reads this thesis and my research publications will have their own interpretive lens (Ray 1994) and in line with Rolfe's relativist thinking, I believe that studies should be judged on their own merits (Rolfe 2006a).

Being a phenomenologist

Creswell (1998:51) describes a phenomenological study as being a description of the meaning of the lived experiences for several individuals about a concept or the phenomenon - and this had significant resonance with my research question. There are numerous qualitative approaches such as grounded theory, ethnography and phenomenology but on considering the appropriate methodology, phenomenology stood out as the most appropriate for exploring and interpreting how the nurses' made meaning of their experiences. What I rapidly discovered, however, was that phenomenology is a vast philosophical mire and I spent some time grasping the fundamental theories and concepts before I felt I could be sure of the most relevant approach, which I now describe.

There are different stances in phenomenology but they can be loosely divided into transcendental and existential. The founder of phenomenology, Edmund Husserl, a former mathematician conceived the 'science of science', of phenomenological reduction and of epoché, that is, of bracketing out our assumptions. Husserl's transcendental eidetic phenomenology consists of description and he proposed the concepts of '*we go to the things themselves*' and '*the world below*' (Taylor 1995). Husserl maintained that phenomenology is a method which allows us to contact

phenomena, the essence, 'as we actually live them out and experience them' (Valle & King 1978:6). Husserl employed a phenomenological reduction process whereby the prejudices and assumptions of the researcher are set aside, seeing the experience as the person having the experience sees it rather than as it is interpreted by the researcher (LoBiondo Wood 2002:134). Consequently, I felt that Husserl's worldview was incompatible with my own.

I rejected Husserl's descriptive mode of phenomenology and its Cartesian idealism (Moran 2000:226), and instead turned to examine the works of Martin Heidegger, who focused his life's work on the examination of Dasein 'being-in-the-world' in relation to time and spatiality. In his work 'Being and Time' (Heidegger 1962), Heidegger, an existential phenomenologist, states that interpretation of the world is impossible without pre-understanding. Heidegger stated that understanding is an ontological condition rather than an epistemological one and that understanding is a mode of 'being' rather than 'knowing'.

Heidegger's strong links to Gadamer as his tutor and philosophical mentor then led me to read Gadamer's works. Gadamer states that understanding is a condition of being human and that understanding is interpretation through the use of the hermeneutic circle (Schwandt 2000). I knew I would find it impossible not to acknowledge and engage my own experiences, and this is supported by Schwandt (2000:194) who suggests that 'socio-historically inherited bias or prejudice is not regarded as a characteristic ... that an interpreter must strive to get rid of or manage in order to come to a 'clear understanding.' Gadamer proposed that the hermeneutic process involves a circle through which understanding occurs and we hear what the text says to us (Gadamer 1975/2004:270). This forms an '*essential unity of understanding*' (Gadamer 1976:57).

My interviews with nurses provided taped recordings, narratives and text from which interpretations could be derived and I reasoned that the experience of being overweight required an element of interpretation, rather than simply a description of that experience. I also considered that the reflexive element of my research

must address the fact that I am a female with experience of being a nurse, a patient, and both what is considered to be 'normal' and overweight. I felt that it was inevitable that I would interpret my findings as I would not be able to compartmentalise my prior experiences, assumptions and prejudices, although, for the sake of research authenticity, would need to make them transparent. Phenomenology in nursing research attempts to see 'human experience in the complexity of its context' (Munhall & Oiler 1986:57).

Within phenomenology there are varying traditions and approaches; I felt more comfortable with interpretive approaches and so this led me to explore hermeneutics.

Being an hermeneuticist

On reading the literature I found that the terms 'hermeneutics' (deriving from Hermes, the messenger) and interpretivism are often used interchangeably in texts so I felt it necessary to attempt to untangle these concepts. Crotty (2003:67) suggests that 'the interpretivist approach seeks culturally derived and historically situated interpretations of the social life world'. He argues that 'an interpretivist, therefore, can be seen to be someone who attempts to explain the *meaning* of a phenomenon'. If I were to take this approach I would find it helpful in explaining the experience and understanding of being overweight in nurses.

Radnor (2001:4) suggests that 'interpretivists argue for the uniqueness of human inquiry', citing Erickson (1990:98) who says that 'different humans make sense differently'. Weber promotes the social theory of action that suggests that 'individuals attach subjective meaning to all human behaviour and in order to explain an action we must have an understanding, '*Verstehen*' of the intended subjective meaning i.e. the world as it is seen through others' eyes' (Radnor 2001:5). However, Weber was also interested in establishing causal explanations and his work blends the positivistic and interpretive approaches (Blaikie 1993:37). Interpretivism in this guise, therefore, felt epistemologically incongruent to me as

I believe that there is no objective truth; in particular, there can be no objective truth that can be applied to the experience of being overweight, which I believe should be regarded as subjective rather than objective. So, even within interpretive approaches, there were some elements that were more or less resonant than others for me.

Although not all phenomenologists will agree with my stance, I then turned to explore philosophical hermeneutics which I perceive to be, from a Gadamerian (and Heideggerian) perspective, primarily relativist. Epistemology is the study of knowledge and how we know what we know and I am of the firm belief that truth itself is relative to the standpoint of the judging subject such as in the case of 'beauty lies in the eye of the beholder'. Philosophical hermeneutics does not consider 'understanding as a way of "knowing" but as a "mode of being" and as a result of this ontological emphasis, the epistemological stance is not a dominant feature of this philosophy' (Annells 1996:708). This felt more ontologically comfortable for me and led me to the decision of using hermeneutics for this research study. A particularly appealing element of hermeneutics that felt appropriate for my research question is that:

'Advocates for this tradition argue that the researcher must grasp the meaning of everyday language by immersion in that culture, mediating between everyday language and technical language of social science in order to produce themes and concepts, with the researcher working 'bottom up' and adopting the position of learner rather than expert.'

(Blaikie 2000:138-9).

As a female nurse, with experience of being both what is considered to be of 'normal' weight and overweight, I felt that I might be able to empathise more with research participants, having a more clear understanding of their experience because of the commonalities that may emerge. I also share the historicity and language of nurses that would facilitate the interpretation, analysis and co-construction of our findings.

Morse (1994:125) maintains that the two central tenets for Gadamer's version of hermeneutics are that, firstly, our own preconceptions are part of our personal linguistic experience which makes understanding possible and secondly, people who express themselves and those that understand them are connected by human consciousness – 'universality' a 'fusion of horizons' - which makes understanding possible. Gadamer explains how a common understanding (or misunderstanding) occurs:

'We say...that understanding and misunderstanding take place between I and thou. But the formulation "I and thou" already betrays an enormous alienation. There is nothing like an "I and thou" at all – there is neither the I nor the thou as isolated, substantial realities. I may say "thou" and I may refer to myself over against a thou, but a common understanding (Verständigung) always precedes these situations. We all know that to say "thou" to someone presupposes a deep common accord. Something enduring is already present when this word is spoken.'

(Gadamer 1976:7)

The assertion of Gadamer that there is no space between the 'I' and the 'Thou' (also proposed by Merleau-Ponty 1962 and Buber 1970) is a highly significant feature within this thesis and I revisit this later on in the discussion chapter. I also agree with Gadamer that understanding is an ontological condition of being human and 'being-in-the-world' and that tradition, in this case the medical, social, and life-world, plays a part in interpretation. In 'Truth and Method' Gadamer holds that: 'the fact that our experience of the world is bound to language does not imply an exclusivity of perspectives.' He continues:

'If by entering foreign language worlds, we overcome the prejudices and limitations of our previous experience of the world, this does not mean that we negate our own world. Like travellers, we return home with new experiences. Even if we emigrate and never return, we can still never wholly forget.'

(Gadamer 1975/2004:445)

By this, I take Gadamer to mean that, although he states the importance of language in understanding each other and the potential fusion of our horizons,

there is always more than one world view for us to respect, whilst being true to our own experiences and perspectives. The hermeneutic circle and the fusion of horizons, therefore, play a significant role in philosophical hermeneutics. Gadamer proposes that all understanding is guided by a 'fusion of horizons' and that 'any text has its own horizon of meaning so interpretation is sited between the mutual horizon of the interpreter and whatever is being interpreted' (Lawn 2006:2). It would be easy to assume that the fusion of horizons is a negotiation or consensus but I do not consider that this is what is meant by Gadamer. Freeman describes this:

'Although Gadamer has been criticised for projecting understanding as a 'Fusion of Horizons', which is usually read as a form of agreement, there are indications throughout his work that agreement is not meant as consensus but rather the state one has arrived at as a result of the encounter. A "fusion of horizons" is a new horizon that presents itself as a result of new understanding and can occur whether one agrees with the words of the other or not.'

(Freeman 2007:925)

In fact, Gadamer himself (1975) says that to come to an understanding with someone about something doesn't mean that each has exactly the same position.

'In a conversation, when we have discovered the other person's standpoint and horizon, his ideas become intelligible without our necessarily having to agree with him.'

(Gadamer 1975/2004:302)

In my own study, this perspective was considered to be helpful as all views, whether frequent or held by only one or two of the nurses are presented. With regard to the 'fusion of horizons', as a 'good hermeneuticist' I felt it best to allow Gadamer to explain this for himself:

'The hermeneutic conversation, like real conversation, finds a common language, and that finding a common language is not, any more than in real conversation, preparing a tool for the purpose of reaching understanding but, rather coincides with the very act of understanding and reaching agreement... Even between partners of this "conversation" a communication like that between two people takes place that is more than mere accommodation. The text brings a subject matter into language, but that it does so is ultimately the achievement of the interpreter. Both have a share in it. Hence the meaning of a text is not to be compared with an

immovably and obstinately fixed point of view that suggests only one question to the person trying to understand it, namely how the other person could have arrived at such an absurd opinion... ..the interpreter's own horizon is decisive, yet not as a personal standpoint that he maintains or enforces, but more as an opinion...and that helps one truly make one's own what the text says. I have described this...as a fusion of horizons.'

(Gadamer 1975/2004:389-390)

The hermeneutic circle is a metaphor for an analytical process that involves understanding parts of the text (which does not necessarily mean solely the written word) and relating them to the whole and vice versa, causing a dialectical examination of parts of the data to understand better the whole (Cohen et al 2000:72). This process of *zum stehen kommen*, 'coming to understand', is a vital element of Gadamer's hermeneutics and it plays a significant role in the analysis of my data, more of which will be covered in a later section of this chapter.

Hermeneutics was originally employed as a method of interpreting a text such as The Bible or legal documents but the meaning of text evolved through the 20th Century to become a manifestation of any intentional act. Understanding is the key tenet of this philosophy:

'According to Gadamer, Verstehen (understanding) means to stand in for someone such as a lawyer speaking on behalf of a client. The very notion of understanding... carries with it an openness encapsulated in the notion of dialogue and dialogue has to be retrieved in hermeneutics, that is, our relation to texts in a tradition has to be understood in terms of our model of a dialogue with others.'

(Moran 2000:249)

Therefore Gadamer (1976:302) suggests that '*to understand is to understand differently*' and that a fusion of horizons does *not* mean reaching consensus. Gadamer (1975/2004:271) also argues that it is important to be surprised by your research: 'a person trying to understand a text is prepared for it to tell him something'. Moreover, like Gadamer, I believe that perspectives are contingent on historicity and context.

An example of this is taken from a previous research study that I conducted which was concerned with child accident prevention (McGreevy 1994). The study was

undertaken around the time of Shrove Tuesday ('Pancake Day') in the Christian calendar and I asked young children what scared them. After Shrove Tuesday the common response was the 'making of pancakes in the frying pan and the fat spitting onto them'. Prior to Shrove Tuesday, the responses were more usually 'dragons, monsters, ghosts and burglars'.

I believe that there are no absolutes and that, in this research study, the experience of being a nurse of whatever weight will be different for every person; there does not *need* to be generalisation or agreement on the meaning of being overweight and that views and perspectives, like my own are contingent on the time and place and other influencing factors. This further confirmed my decision to choose Gadamer's philosophical hermeneutics.

There is a theoretical concern regarding phenomenological research that can be addressed somewhat by the hermeneutic tradition and that is whether or not there should be theory at all emerging from the reflective analysis of the data (Morse 1994:123). Van Manen (1990) contends that phenomenologists do not aim to generate theory so I was unconcerned about being unable to generalise from the findings of my study and agree with Gadamer who argues that 'the aim of reflective insight theory is to express the meaning of a specific life-world experience and that it enhances human science by capturing the meaning of the human experience as universal' (Morse 1994:124). This is supported by Todres and Galvin (2005:2) who suggest that 'the transferability of insights...forgoes immediate empirical generalisation but gains the human authenticity of someone living their life.' Although I cannot generalise from my findings, the conditions and the meanings I propose from my findings *may* have resonance with others.

For me, another attractive element of phenomenology and its various branches was that it not only allows the researcher to research what is interesting and familiar to them, it really encourages this. Van Manen (1990: 43) explains that the researcher needs to be immersed in a phenomenological research project and that

there is a need to be deeply interested in the subject matter although this presents its own problems:

To truly question something is to interrogate something from the heart of our existence, from the centre of our being...we "live" this question... we "become" this question ... every form of research and theorizing is shot through with values.
Van Manen (1990: 43)

Finlay concurs that a 'high level of personal commitment to research that has personal significance and relevance to the researcher's life as a whole' plays a vital part of any study (Finlay & Gough 2003:134). An additional attraction of philosophical hermeneutics and the use of the hermeneutic circle for me is that it is considered suitable for nursing research that is committed to developing a pragmatic knowledge base for nursing (Draper 1991).

In summary, the first section of this chapter describes my process of decision-making that led me to use Gadamer's philosophical hermeneutics to underpin this phenomenological study because it would assist me to understand the meaning and the context of nurses' lived experience by interpretation (Doordan 1998). Additionally, the findings may create a deeper understanding of both the action and the context, helping to develop knowledge that supports nursing practice (Radnor 2001:4; Madjar and Walton 1999:8).

Research Design

Ethical permission to conduct the research study

I sought access to enter the research field from the Brighton East Research Ethics Committee branch of the National Research Ethics Committee and a favourable ethical opinion was granted to my study on 4th August 2007: REC reference number: 06/Q1907/76 (Appendix 1). I had to demonstrate that I had considered the potential for harm to participants, which included the time required to

participate in the study. The interviews took on average 60 minutes each and participants were also sent their own transcripts as an opportunity for any further comment, reflections or clarification.

There was an additional concern regarding the sensitive nature of the research study that some participants may find the sensitive questions emotionally painful which may surface psychological issues and problems for them. I had arranged free confidential counselling if any participant felt that they would benefit from this.

Participants were all provided with a full explanation of the research study prior to each of the interviews by using a Participant Information Sheet (Appendix 2). Signed informed consent was obtained (Appendix 3) and the participants were advised of the possible risks of participating and the support mechanisms in place should they require them. The participants were advised that they could withdraw from the interview process at any time without providing an explanation and without invoking any penalty or repercussions. Participant consent was renegotiated at each stage of data generation until the transcripts received their final review by participants.

Participants were reassured that they were anonymised at the point of data generation and all documentary notes, tape recordings and transcripts had no identifying information. They were advised that only I would have access to the data identification material and that this would be kept in locked storage in compliance with the Data Protection Act and Information Governance Protocols until after the study and a time prescribed by law, when it would be destroyed.

The Ethics Committee required some further clarification prior to granting approval for this research study and there was a need for me to offer reassurance regarding the research rigour of phenomenological methods of inquiry. The issues raised are discussed in the research rigour section of this chapter. In brief, however, it was necessary to emphasise that issues of reflexivity are imperative, as

is the necessity to be self-critical, in order to maintain high standards of professional investigation.

Recruitment to the study

There are standards for drawing a sample population that is representative and unbiased, so that the results should be repeatable and generalisable (Benner 1994:75). None-the-less, the validity of a phenomenological study should not be judged with reference to its sample size and selection or statistical power (Holt and Slade 2003:21) as it seeks neither generalisation nor replication. Creswell (1998:122) supports this decision and confirms that it is usual for phenomenological studies to involve less than ten participants, stating that the important criteria for inclusion in the study is having had the experience of the phenomenon under exploration. None-the-less, the members of the Ethics Committee were initially unconvinced by a phenomenological approach with low sample numbers, so I subsequently agreed to include up to ten nurses and eventually found seven willing participants who met the inclusion criteria.

The inclusion criteria were:

- Primary care nurse employed by the PCT
- Experience of working with overweight patients with simultaneous experience of being overweight (as defined by this study)
- Willingness to describe personal experiences

The exclusion criteria were:

- Primary care nurses who are directly managed by or who work directly with the researcher.

The sampling was purposive but not without practical and sensitivity issues as it would have been difficult to approach overweight nurses directly with a view to

their participation without causing possible offence. In order to recruit nurses who identified themselves as fitting the inclusion criteria, I offered a presentation outlining 'My journey on the Doctorate in Nursing programme so far' to large groups of nurses during their regular meetings and awaydays and discussed my need for participant recruitment as part of the presentation. This felt a less threatening way of approaching the recruitment as it offered all nurses, particularly those who met the inclusion criteria, information about the study and an opportunity to consider their participation without being directly approached.

I also distributed posters on local hospital and PCT sites that detailed the inclusion criteria although these did not attract any participants. All of my participants approached me directly with a view to participation, either after hearing my presentation or having been told of my research study by a nurse who had been present. Each potential participant who expressed interest to me directly was provided with full details of the study in a 'Participant Information Sheet' that included potential risks and benefits to participants. It also included a consent form which would be signed by both the researcher and participant. A consent form was required to be signed for each of the two interviews and participants were offered reassurance that if they chose to withdraw at any point in the research study process, this action would not require any explanation or invoke any form of penalty or repercussion. Samples of the letters of invitation to the first and second interviews and transcript authenticity forms can be seen in Appendices 4, 5, 6 and 7 respectively.

Seven nurses volunteered to take part in the study and their biographies are included in the next chapter. In brief, my participants were:

- Practice Nurse (1)
- Community Staff Nurse (1)
- District Nurse (1)
- Health Visitors (3)
- Cardiac Nurse Specialist (1)

Issues of trustworthiness and research rigour

Validity implies that there is a truth waiting to be found and is a realist and positivist concept (Porter 2007). In positivist research, validity is a key issue. However it is still important for hermeneutic researchers holding a relativist stance to demonstrate trustworthiness and research rigour. There are a range of views on how to demonstrate research rigour in these circumstances, such as Rolfe (2006a), who states that the reader should simply judge this for themselves or Koch (1994) who suggests that research rigour for qualitative studies can be achieved by addressing issues of reflexivity, offering authenticity and an audit trail. Lincoln & Guba (1985:296) also suggest that, where data is co-constructed, the study should demonstrate credibility:

The implementation of the credibility criterion ... is a two-fold task: first, to carry out the inquiry in such a way that the probability of the findings will be found to be credible is enhanced and second, to demonstrate the credibility of the findings by having them approved by the constructors of the multiple realities being studied.

Lincoln & Guba (1985:296)

In this study, I have chosen to follow predominantly the advice of Koch by including sections of my researcher journal and narrative within the thesis about my own potential and actual influences on the research and Lincoln & Guba by returning the transcripts to participants for their comments. I have also constantly striven to be consistent and to make explicit the rationale for decisions made with particular regard to the methods chosen and analysis. These, together, form a researcher audit trail for the purpose of assessing research rigour.

Furthermore, in order to challenge the positivist views which infer that qualitative research methods stand up less well to scrutiny in terms of validity and research rigour, it was essential for me to be transparent throughout the research process. By this I mean that I have been careful to state my own epistemological and ontological stances and to be overt about my own assumptions and prejudices as I

consider that all qualitative research methods are underpinned and influenced by the researcher's own experiences and assumptions.

Authenticity and research rigour in phenomenological research is supported by researcher reflexivity which Finlay (2002a:536) describes as a:

'... confessional account of methodology or as examining one's own personal, possibly unconscious, reactions. It can also mean exploring the dynamics of the researcher-researched relationship and how the research is co-constituted...it means acknowledging the existence of researcher bias and explicitly locating the researcher within the research process. At a more active level, it involves a more wholesale embracing of subjectivity, for example, by exploiting researchers/co-researcher's reflective insights and by engaging in explicit, self aware meta-analysis throughout the research process.'

Finlay (2002a:536)

De Witt and Ploeg (2006) additionally offer a framework for research rigour and trustworthiness of an interpretive research study and reason that this can be evaluated by:

'... balanced integration of philosophical concepts in the study, methods and findings and a balance between the voices of the study participants and the philosophical explanation; openness, related to a systematic, explicit process of accounting for the multiple decisions made throughout the study process; concreteness relating to the usefulness for practice of the study findings; resonance encompassing the experiential or felt effect of reading study findings; and actualization that refers to the future realization of the resonance of study findings.'

(De Witt and Ploeg 2006:215)

In response to the suggestions made by Finlay, De Witt and Ploeg and Creswell, I have striven to make clear my assumptions, decisions and the potential for me, in the role of the researcher, to influence the study. I have also made efforts to make explicit the balance between my voice and those of the nurses in this study.

Creswell also reasons that the researcher needs to be grounded in the philosophical principles of phenomenology but does understand that 'bracketing' the personal experiences of the researcher may be problematic so these need to be managed for the study (Creswell1998:55). There also needs to be critical

reflection on the part of the researcher to identify her own preconceptions and assumptions (Cohen et al 2000:86). This reflexive element of the study was of paramount importance for this study and I was advised by my supervisors 'to interrogate myself' before asking any interview questions of my participants. This helped me to surface my own prejudices and pre-understandings, something also proposed by Fleming et al (2003). I noted in my researcher journal at the time:

'My role as Health Promotion Manager might prevent me from having an unprejudiced eye regarding weight advice and subjective interpretation is the main criticism.'

(McGreevy 2006)

I was later intellectually comforted by reading Fleming et al (2003) who support Gadamer's view that you should acknowledge your prejudices and pre-understandings when analysing your data.

I have needed to reflect and interpret, as honestly as possible, individual statements that represent the diversity of perceptions and the different unities of understanding that have been generated by the data (Fleming et al 2003:76) and I understand that the social world cannot be explained in 'grand theories' (Denscombe 2002). 'Positioning statements are an honest way of admitting the researcher prejudices, as are reflective and interpretive accounts that are kept during the research process' (Payne and Payne 2004:191-2). In addition to admissions of the values of the researcher, Silverman (2001:233) argues that 'the issue of validity is appropriate for qualitative data and that this can also be resolved by including other criteria such as recognising the researcher effect and placing emphasis on *meanings* that are constructed by the interviewer and participant, rather than *facts* and absolute truth' (ibid:86). Realising my inability to bracket my assumptions and experience is what firstly led to me to explore the branches of phenomenology, some of which, such as Husserl's, were inappropriate to my relativist ontological stance, in an attempt to find a solution to my dilemma and secondly, the final decision to use the qualitative approach

underpinned by Gadamer's philosophical hermeneutics as my research methodology.

Introduction to the research methods

I designed the research study with my research question in mind and believed that semi-structured interviews were the optimum method for data generation that is co-constructed by both researcher and participant; I also asked participants to keep a note book for discussion at the second interview if they wished and during the second interview, to draw a picture of themselves in comparison with another woman who they perceived to be of normal weight.

I use the term 'data generation' rather than 'data gathering' or 'data collection' as the latter two terms imply that the 'truth is out there' to be collected. In this study, I felt that all the participants and the researcher possibly, or even probably, would have differing perspectives of the same phenomenon i.e. being an overweight nurse but that all perspectives should be heard.

Semi-structured interview

I felt that the most appropriate method of generating data that would answer my research question would be semi-structured interviews. Kvale (1996:5-6) defines the semi-structured life world interview as 'an interview whose purpose is to obtain descriptions of the life world of the interviewee with respect to interpreting the meaning of the described phenomena.' I avoided the use of fully structured interviews as, although they would lend themselves very well to descriptive and content analysis, they were less well suited to the interpretive analysis I felt was necessary for this study. Additionally, structured interviews could just as easily be distributed in the form of questionnaires but this would have had several consequences: they would not have provided the level of rich data I was seeking

and certainly would not have provided the flexibility for probing more deeply in certain areas; I also felt that they would have been, therefore, too prescriptive, too objectivist and I would have been tempted to pre-empt the responses by my questions – completely the opposite of Gadamer’s philosophy of being prepared to be surprised by your research.

At the other end of the interview scale, free-flowing narratives may have led to the generation of very interesting and surprising data – but this may not have addressed my interview question without spending a great deal of time on them. The transcription and analysis would have been very time consuming and much more labour intensive than even semi-structured interviews, which is what I decided was the most appropriate method.

Note book keeping

In addition to the interviews, I also offered the participants at the first interview a note book in which they could write notes or comments about anything they felt they would like to share with me at the second interview. Note-keeping was entirely optional, as was the sharing with me of the notes. Participants were reassured that they were not required to do this and could keep the notebook in any case, whether they chose to write notes for the study or not. Although only three participants returned the notebook, all the nurses had considered the first interview and their thoughts and the notes made formed part of the discussions in the second interview.

Drawing of Self and Other

During the second interview I asked each participant to draw a picture of themselves and a person that they perceived to be of normal weight. This was not undertaken to assess comparisons of how they perceived normal and overweight people as their self-confessed lack of drawing skills would have prevented this as being helpful data in that respect in any case – but what it did offer was an

opportunity for participants to discuss their own body shape and that of others in what I had hoped to be a less self-conscious way than simply asking the question of them face-to-face. It was a part of the interview that offered some light relief and laughter and I believe this also helped the bonding between participant and researcher. The drawings do not feature in the data analysis, therefore, but for reasons of transparency and to offer a research trail, a sample is included in chapter seven of this thesis.

Conducting the research study

The practicalities

The first round of interviews took place from February to March 2007 and the second round of interviews took place from May to June 2007. The time of day for the interviews varied but they were usually held at 10am, 12 pm or 3pm to allow sufficient time within working hours. Participants were made aware in the information provided to them that they should allow 90 minutes for each interview. Managers had previously given their verbal blanket consent for attendance at the interviews by any members of their staff who chose to participate during their working day.

I wrote to all the participants for both of their interviews, confirming the details of the time and place and I also included a consent form for each interview. The interviews took place in Primary Care Trust (PCT) premises, either in a meeting room or an empty office. Most of the participants were familiar with the PCT building. I had offered to meet with participants at a location and time convenient to them but, without exception, the participants preferred that I arranged and booked the accommodation and were happy to visit me in the local PCT administration offices. Participants frequently commented that it felt good for them to be away from their usual base and that there was also a strong likelihood

that they would be interrupted in their own workplace. I had prearranged to reimburse any travel costs if required, although none took up this offer.

I took care to make the room in which the interviews were conducted as welcoming as possible and arranged the furniture so that participant and I were sitting at 90 degree angles to each other rather than across a desk, which may have felt intimidating and confrontational. I hoped this arrangement would help to relax the participants. I ensured that the switchboard was notified and that signs were placed outside the door to deter any interruptions during the interview. I set up and checked that my recording equipment was operational and as unobtrusive as possible and ensured that I had my interview schedule to hand along with pens and paper for my notes and for the participants' drawings.

I offered the participants refreshments on arrival and chatted informally about their journey and other relatively trivial matters to help them feel at ease with me and their surroundings before we began the interview.

Interviews and the hermeneutic circle

For the first interview, I used an interview schedule (appendix 8) as a framework so that each participant and I discussed similar topics and issues, although follow-up questions may have varied. As I gained confidence and familiarity with the interview schedule, I found that I needed to refer to it less in the latter of the first interviews. The interviews, which were kept as conversational as possible, also lasted approximately the same length of time although one of the first interviews (Erin's) was shorter, for reasons I explain later in chapter seven.

The first interview consisted of questions that I considered may help to elicit experiences of their own history of weight and how this might affect the interaction with the overweight patient.

I divided the first interview into rough sections:

- setting the scene e.g. *'What does the term overweight mean to you?'*;
- sense of personal identity e.g. *Can you describe the history of your own weight?;*
- sense of self as a nurse e.g. *can you describe your experiences of working with overweight patients?; How do you think your weight influences you when you are interacting with overweight patients;* and
- attitudes towards the overweight patient e.g. *How do you feel about overweight patients?; How does their weight affect the way you care for them?*

Following the first interview I analysed the data by trying to absorb what the texts were saying to me. I could also review the seven interviews individually and as a 'whole' piece of text to see if there were issues explored or that emerged from some conversations that could be integrated into second interviews. In the second interviews I particularly wanted to discuss with each participant elements that I felt needed further clarification or expansion, and also general topics that the other participants had shared with me during other interviews, in the spirit of hermeneutical enquiry and co-construction of meaning.

I had identified through high level thematic analysis of the transcribed data from the first interviews, that there were issues of potential significance for the study that warranted further exploration such as:

- Tension of being overweight and yet talking to patients about being overweight
- Tension about not actually acting on your own advice and philosophies.
- Tolerance and empathy of nurses with overweight patients and yet also critical of overweight patients. (*'gentle hypocrisy'*)

- Reasons for being overweight – time deprived and busy and yet when presented with choices they would choose the less healthy food.
- Some nurses distanced their self from their body. ‘I am a body’ or ‘I have a body’
- Feelings of being ashamed or guilty.

Rather than having a specific interview schedule for the second interviews, I instead tailored my topics of conversation to the individual participant as, in some first interviews, these issues either had not been addressed at all or in any depth, whereas in others they had featured more strongly. The second interviews were consistently longer, lasting around an hour, than the first interviews which lasted around 35-45 minutes.

Following the first interviews, some participants mentioned that this was the first time they had ever really considered their own feelings about their weight, particularly in the context of giving care to overweight patients. Following the interviews it was very common for the participant to stay and chat about the research topic further – some hugging me and thanking me for listening to them.

Limitations of the research study

This study was undertaken in a small geographical area with a small number of participants. All the participants were women as there were very limited numbers of male nurses working in the area at the time and none came forward to participate. However this study does not seek generalisation so this may be considered less of a limitation than in a study underpinned by a more realist ontology.

Transcripts

I decided to pay for transcription services to accelerate this process. The transcriber was required to maintain confidentiality and the anonymity of the participants. No identifying information was passed to the transcriber of the participants, who were coded by letter and date only.

However, I needed to ensure my familiarity with the transcripts and so I listened to the recordings of the interviews whilst simultaneously reading the transcripts. This meant that I could check the content and the emphasis of speech, whilst also feeling myself to be 'back in the interview situation'. I could remember very clearly how each interview felt to me and I also had my field notes as an aide memoir. I repeated this exercise on many occasions.

Ahead of the second interview I posted the transcript of the first interview to each participant so that she would have an opportunity to consider her responses and further thoughts before the interview itself. This was not done to validate the transcripts but so the participants would have an opportunity to comment further on their previous responses and for purposes of authenticity and honest representation. There were a few occasions when the recording was ambiguous and, for example, 'slimming' had been mistakenly substituted for 'swimming' which would have had a significant outcome on the data analysis.

I also shared at the second interview my 'high level' or 'first thoughts' analysis so that data could again be co-constructed and a fusion of horizons explored by our conversations. In keeping with Gadamer's philosophy of the hermeneutic circle, as we discussed topics in general and then more specifically, the data that was generated did evolve and some issues were discussed in greater depth.

The hermeneutic circle was employed in my analysis, in my own and the participants' reviewing of the transcripts and in our discussions. I also returned the second transcripts for participants' comments. I was gratified by all of my participants as, without exception, all transcripts for both interviews were returned

to me. There were very few additional comments or amendments other than the odd word that had been misheard and required correction.

Triangulation of methods and data sources

In this study, underpinned by a relativist ontology, I was not seeking a single 'truth' so to seek validation by the use of triangulation of methods and/or data sources felt inappropriate. In studies underpinned by a realist stance the issue of triangulation as a validation tool is often a dominant feature but this has problems for researchers with a similar ontological stance to my own:

'At its worst, the logic of triangulation says that you use different methods, or data sources, to investigate the same phenomena, and that in the process you can judge the efficacy or validity of the different methods and sources by comparing the products. The idea is that, if you measure the same phenomenon from different angles and positions, you will get an accurate reading or measurement of it.' (Mason 2002:190-191)

I concur with Mason (2002:190-191) who continues: 'the use of triangulation in some studies is inappropriate as different methods and data sources would surface different phenomena or provide different versions or levels of answer and it implies that there is only one objective and knowable social reality'. Annells (2006) argues that there can be problems with the use of triangulation of methods in qualitative studies as it can lead to 'method slurring'.

I counter any suggestion of the need for triangulation for my study as I have provided accounts from my participants and I offer their voices in addition to my own. This is particularly evident in the findings chapters to follow, the first of which is the participants offering their stories in their own words. Other methods of data gathering would not make this study more valid or truthful as it is my view that the 'truth' is – and the stories provided are - provisional, contingent and not static or final. These nurses' stories are, like my own, subject to their feelings, environment, sometimes contradictory and often in a process of evolving. As the participants and I moved around the hermeneutic circle towards a 'fusion of horizons', all our stories became enmeshed and tangled, what Finlay & Evans

(2009:42) refer to as ‘embodied co-creation: *Did I say that or did she?*’ Galvin & Todres (2009a:314) also describe embodied interpretation as requiring a response to the question: ‘*whose experience is this?*’ where the experience neither belongs to the researcher nor the participant, rather reflecting a ‘meaningful-world-with-others.’

Finding an analytical framework

I started this research study with my own pre-understandings and assumptions. These would have been evident in the questions I asked of the participants – but without this pre-understanding I may not have known what to ask or our fusion of horizons may not have been attempted or even reached (Walsh 1996:234). So, although I did not ‘bracket my assumptions’, I did make myself aware of them by ‘interviewing myself’ prior to the first round of interviews with the participants. My analysis of the data continued as I interviewed participants, co-constructing data, and each interview revealed concepts and issues to follow up in subsequent interviews. Blaikie (2000:115-6) describes interpretivism as being concerned with understanding the social world by:

‘social actors interpreting activities together, and it is these meanings embedded in language that constitute their social reality’.

Blaikie (2000:115-6)

Benner states that ‘interpretive phenomenology cannot be reduced to a set of procedures and techniques - it must be plausible and offer increased understanding rather than reading into the text what is not there’ (Benner 1994:xviii). There is always the inherent danger in interpretation of going beyond the data. Benner quotes Dreyfus (1991 in Benner 1994:xviii) who says that it is more credible if the researcher gains a response from the research participant: ‘*You have put into words what I have always known, but did not have the words to express.*’ I was mindful of this when interpreting and co-constructing the data with my participants.

My initial analysis of the texts was naive and discomforting. I was, for some months, lost in the huge amount of data that my participants and I had generated. It felt more comfortable to seek answers within my data to questions such as those posed by other researchers, for example, Brown et al (2007) who had undertaken research studies on primary care nurses and their own attitudes, beliefs and own body size in relation to obesity management. It was tempting to respond simply to questions asked within others' research papers as, by doing so, I would have ignored the remainder of the very rich data generated by my own study, so generously provided by my participants. I felt that this was unethical.

I read and re-read the transcripts and felt very uncomfortable at having no analytical framework to follow. I found many frameworks to reject but could not find one that felt a 'good fit' for my study. I read Taylor (1995) and discovered that ready-made phenomenological methods of analysis had been a problem for researchers for some time.

I rejected Interpretive Phenomenological Analysis as a framework as it is I feel it is underpinned by a Cartesian conceptualisation of the individual as an owner of a set of cognitions, such as attitudes or beliefs, which is incompatible with the phenomenological concern for non-propositional knowledge (Willig 2001:65) and there were also problems for me with other phenomenologists' frameworks for analysis. Some of the more traditional Duquesne School phenomenologists such as Colaizzi, Giorgi, Van Manen and Van Kaam, presented me with ontological dilemmas. Colaizzi, for example, espoused the returning of transcripts to participants for checking and validity (Sanders 2003:301; Colaizzi 1978:59). Giorgi (1985) favoured the search for 'essence' deriving from the Husserlian school of thought and Van Kaam also sought consensual validation (Beck (1994). Some phenomenologists might disagree with my stance but all these frameworks felt incompatible with my desired approach as they 'prescribe techniques that are consistent with a view of what constitutes a scientific approach in the natural and social sciences by assuming that there are categories or essences lodged within the data waiting for the objective researcher to uncover them' (Rolfe 2006b:307).

I wondered whether I should analyse independently of a prescribed analytical framework and briefly considered the use of computer programmes to cope with the enormous amount of data. However it felt ontologically fractured to use computer programmes to analyse hermeneutic data and I remain unconvinced that Gadamer would have approved. I felt that computer programmes would be successful at finding words and phrases within the texts but would not be capable of contextualising the meaning and working within the hermeneutic circle. For me, there were simply no short cuts to this process of analysis.

I then discovered more recent authors, Fleming et al (2003) who offered a template for analysing Gadamerian-underpinned research although I was unable to find a worked example in either her own publications or the six publications I could find at the time that cited Fleming.

In the absence of any other analytical framework that exactly suited my approach I decided therefore to loosely base my analysis on Fleming's framework, discussed shortly. As I was also concerned about the use of themes as a means of generalisation where no generalisation can be claimed, I found that I agreed with Braun & Clarke who argue that:

'A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set. An important question to address...is: what counts as a pattern/theme, or what size does a theme need to be? There is a question of prevalence, in terms both of space within each data item and of prevalence across the entire data set. Ideally there will be a number of instances of the theme across the data set, but more instances do not necessarily mean the theme itself is more crucial...A theme might be given considerable space in some data items, and little or none in others, or it might appear in relatively little of the data set. So researcher judgement is necessary to determine what a theme is.' Braun & Clarke (2006:82-83)

I, therefore, felt able to justify the use of themes, but considered that they might derive from commonalities, or what Gadamer calls 'a common unity of understanding', that is the fusion of horizons between participant and researcher and the intersubjective space between the 'I and thou'. The common unities of

understanding emerged as the participant and I co-constructed the data in our two interviews and a fusion of horizons occurred.

None-the-less, I feel strongly that themes should not detract from an individual's stories; themes that become apparent from the common unities of understandings and the findings of this study are not to be privileged over the story of perhaps only one or two people. However, the use of thematic analysis allows me in my role of researcher to analyse and present the data in a systematic and meaningful way, as the data generated from this study was sometimes contradictory, messy and tangled.

Closing the hermeneutic circle: analysing and presenting the data

Each of the seven participants was interviewed on two separate occasions. Every interview was transcribed and a copy of each transcript returned to the relevant participant, not for validation as that would have been inappropriate, but for authenticity and credibility so that the perspectives of participants are represented as clearly as possible (Lincoln & Guba 1985:296; Fleming et al 2003:19).

In the meantime I listened to the tapes of the interviews many times until I was very familiar with them and, by employing the hermeneutic circle, I looked for common unities of understanding that I could discuss with my participants in the second interviews. Each common unity of understanding is a fusion of horizons between one or more of the nurses and me in the role of researcher. This common unity of understanding may lead to a theme even if only one nurse has raised a particular topic or issue. Passages that are presented in the findings chapter as themes are representative of the shared understanding and fusion of horizons between researcher and participant; had there not been a fusion of horizons I would not have been able to recognise or interpret them as part of the hermeneutic circle and develop them further into themes. I began by developing a hybrid analytical framework, based upon Gadamer's hermeneutic circle and adapted from

Fleming et al's and Braun & Clarke's own guides, later revisiting this as demonstrated in the edited extract from my researcher journal that follows:

1. Read and re-read whole text whilst listening to the recording of the interviews to gain a general understanding.
2. Clean up the participant's text to exclude fill-in sounds and phrases. They take up word count and do not, in my opinion, add or detract from the transcript's meaning.
3. Make notes on general themes emerging & make notes of personal thinking at the time (identifying my pre-understandings) about the transcripts. (I am doing this electronically).
4. Investigate every sentence or section to expose its meaning for understanding of the subject matter.
5. List all the emerging themes.
6. Every sentence or section is then related to the meaning of the whole text.
7. Summarise the themes that are emerging and my pre-understandings. Use participant letter and line numbers to refer back to themes for audit purposes.
8. Move between initial themes, the transcript and the whole to refine the themes.
9. Complete this process with all transcripts.
10. Look for common and unique themes in all the transcripts.
11. Identify passages that seem to be representative of the shared understandings 'commonalities' between researcher and participant (including those not necessarily shared between participants e.g. any understandings unique to one participant and the researcher).

Edited extract from my researcher journal 20 August 2007:

Following a comment made by one of my supervisors about the meanings being initially located at an individual subjective level - and suggestions about analysing these meanings for their contingency upon a given social and cultural context additionally – I realised that I needed to add other stages to my analytical method.

This is a potential weakness of following Fleming's framework without considering in depth the issue of hermeneutics and the fusion of horizons. Fleming discusses the 'gaining of understanding through dialogue with the participants' in terms of indefinite dialogues between the researcher and the 'text' – which, in Gadamerian terms refers to both the participant and the transcript.

Fleming et al do not mention in their paper (Fleming et al 2003) the engagement with a wider social and cultural context. It is my intention to follow the suggestions of Geertz (1973:69) in Cohen et al (2000:72-73) who describes the focus of attention alternatively 'between the most local of local detail and the most global [of theoretical] structure in such a way as to bring them into simultaneous view.'

Cohen et al (2000) describe this process in terms of seeing a 'stand-alone' statement having meaning - but when taken in a larger context it could have a different or greater meaning. This could be regarded as going 'beyond the data' (Cohen et al 2000:97) but adds the historic, temporal and contextual elements of which, I believe, Gadamer would have approved.

For example, some of my own participants refer to 'size zero' in their discussions with me. On face value this could be taken to mean someone at a size much less than to which it actually refers, albeit that it is still referring to someone with an extremely low Body Mass Index. In context, the size zero refers to an American dress size that equates to UK size 4. However, it is the high profile media debate regarding size that may be affecting the nurses' self image and their discussions with me regarding their own weight. Unless I, as a researcher, understand this social context and add its understanding to the hermeneutical circular process, I would not feel that I was interpreting the data in a way that takes all contexts into consideration.

Dumont in Cohen et al (2000:69) also points out that, 'while the researcher is going about the work of understanding what is meaningful for the participants, the participants are doing the same regarding the researcher's horizon.' I, therefore, added further elements to stages 4 and 6 of my analytical method so that the wider context is considered when scrutinising the text for descriptive and literal meanings:

4. Investigate every sentence or section to expose its meaning for understanding of the subject matter, *taking into account the social and cultural context of statements and meanings.*

6. Every sentence or section is then related to the meaning of the whole text, *taking into account the social and cultural context of statements and meanings.*

(adapted from Fleming et al 2003 and Braun & Clarke 2006)

In appendix 9, I offer further extracts from my researcher journal which describe the analytical process in greater detail and the themes that emerged over a period of several months.

Making sense of the data

The hermeneutic circle played an extremely significant role in analysing the data. By this I mean that I conversed with the participants on two occasions and then spent many hours ‘conversing’ with the texts, whether in the form of the transcripts, voice recordings, participant notes and drawings. I allowed the texts to ‘speak’ to me and revisited them time and time again over a period of almost three years to try to gain a deep understanding of how these nurses perceived their interaction with the overweight patient.

Initially, my naivety and enthusiasm to progress with the analysis led me to analysing the data fairly superficially; I separated the data into themes that loosely addressed each of the interview topics and I fell into the trap of undertaking content analysis rather than interpretation (Woolcott 2001:33). For example, within the interview, I asked the participants about their barriers to weight management, using this as a theme. This did not allow the depth of analysis required at this level of study; I swiftly realised that this was not at all sufficient to do justice to the very rich data gathered and co-constructed and was absolutely incompatible with the hermeneutic tradition.

...as a hermeneutical task, understanding includes a reflective dimension from the very beginning. Understanding is not a mere reproduction of knowledge, that is, it is not a mere act of repeating the same thing...

(Gadamer:1976:45)

I agonised over this for some time and finally came to the conclusion that I needed to keep revisiting the data until it made sense to me. I realised that there were simply no short cuts to this process. Even at the stage of writing the findings for the thesis, I accepted that the process of analysis could – and probably should – continue indefinitely, as each time I have returned to the data I have discovered new and exciting findings. It would be ethical, therefore, once the thesis has reached its natural conclusion for the requirements of the Professional Doctorate, to return to the data and to write up these, and any new finding that emerge, for inclusion in academic journals so as to do justice to the data.

I recognised from the iterative process of the analysing the data, moving back and forth between conversations with the participants, and the texts that arose from these, that I have developed a greater self-understanding. My pre-understanding that experiences of being overweight were mainly static was challenged and it was a surprise to me that there was sometimes quite strong movement in the emotions and positions of some of the nurses. For others there appeared to be less movement and more consistency in their stances but the summary of my findings was that overweight nurses bring their own experiences of weight and, sometimes conflicting, values and emotions to their interactions with overweight patients and that the dominant discourse and relationship with the patient appears to be one of professionalism and empathy.

It is inevitable that the quotations used and the biographies that I have presented reflect my own understanding of what happens in the interaction with the overweight patient. Over time and distance, this understanding will also inevitably change, as it would were any of the participants to offer their own understanding of the findings. Over a lengthy period of living with the data, of frustrations, false leads and dead ends, eventually I found that the text spoke to me in a more meaningful way. I began to understand the text - and the conditions in which I was relating to the text - in the way that was more consistent with Gadamer's concept of understanding:

... a person who "understands" a text... has not only projected himself understandingly toward a meaning – in the effort of understanding – but the accomplished understanding constitutes a state of new intellectual freedom. It

implies the general possibility of interpreting, of seeing connections, of drawing conclusions, which constitutes being well versed in textual interpretation... it still remains true that all such understanding is ultimately self understanding (Sichverstehen: knowing one's way around).

(Gadamer 1976:251)

Because I could not allow the analysis phase of the study to continue indefinitely, I persisted until I felt able to interpret and to make meaning from the data. I continued to use the hermeneutic process, examining parts of the transcripts and texts and relating them to the whole in a circular fashion. By doing this I was finally able to cluster the findings into sub-themes, recognising that a theme may only consist of one or two of the participant's comments, later refining these into four main headings as displayed in Figure 2.

In summary, these common unities of understanding were formed from the texts into the following themes:

- Developing understanding of self
- Developing understanding of Others
- Managing personal prejudices
- Managing sensitive conversations

Once I was comfortable with these common unities of understanding I spent some considerable time attempting to make sense of them for the purposes of clarity and for dissemination of my findings. As is the nature of qualitative research, there were some overlaps in the two overarching themes upon which I eventually settled:

1. *Developing understanding of self and Other*: how the nurse experienced and developed her understanding of herself and her overweight patient, which I have presented in chapter four.
2. *Managing the interaction*: how the nurses drew from these understandings to manage the interaction with the overweight patient, which I have presented in chapter five.

Figure 2. Thematic structure of the data

DEVELOPING UNDERSTANDING	
<ul style="list-style-type: none"> • Feeling physical discomfort – weight impacting upon daily life • Feeling emotional discomfort – feeling unattractive • Objectifying own body • Being objectified by others including health professionals • Eating for emotional reasons • Being accepting of own body • Being concerned about impact of being overweight on health • Being unable to sustain weight management 	Developing Self understanding of being overweight through personal experience
DEVELOPING UNDERSTANDING	
<ul style="list-style-type: none"> • Being overweight – personal experience • Being contingent /situated – attitudes change depending on personal situation/time • Being empathetic/relational: ‘going where they are’ • Being embodied and reflexive; effect of nurses’ weight status on patient • Being dialogic/hermeneutic – holistic understanding of patient 	Developing Other understanding of being overweight
ACTING UPON UNDERSTANDINGS	
<ul style="list-style-type: none"> • Acting a role – being detached • Acknowledging prejudice towards overweight patients • Setting aside prejudice towards overweight patients 	Managing personal feelings of guilt and dissonance in the interaction
ACTING UPON UNDERSTANDINGS	
<ul style="list-style-type: none"> • Being openhearted and disclosing personal experiences • Being embodied within the interaction – drawing on own embodied experiences and felt senses to generate empathy • ‘Being with’ the patient rather than ‘doing for’ – holistic approach • Being sensitive in approach to interaction • Avoiding the topic of overweight 	Managing patient’s feelings in the interaction

[Original in colour]

Although I have presented some of the nurses' thoughts on their effectiveness as health educators in the interaction with the overweight patient, this was one element of the analysis which was beyond the scope of this study; I felt that I could not attempt to interpret in any depth the health impact or outcomes in terms of effectiveness (i.e. whether the patient lost weight as a direct result of the interaction with the nurse) of the nurse and patient interactions and I did not conduct any part of this study with overweight patients.

Summary

My worldview contends that reality is multiple and subjective and so it was important to frame the research within a relativist concept. I continue to hold a strong interest in the topic of the research and I have personal experience of being an overweight nurse and health educator; this was used to co-construct the data with participants as we share similar backgrounds and experiences. I adopted a phenomenological approach, underpinned by Gadamer's philosophical hermeneutics, and I employed semi-structured interviews with seven nurses on two separate occasions; some of the nurses also kept notebooks to form part of the data.

A significant element of my chosen methodology of hermeneutics is that the researcher works by adopting the position of learner rather than expert – therefore, as Gadamer suggests, I did not presuppose the outcomes of the study and was prepared to be surprised by my findings. I wanted to learn how the nurses made sense of their worlds and to be reflexive, allowing concepts to develop through a cyclical process (Blaikie 2000:139). I therefore employed the hermeneutic circle during the data gathering stage, throughout the analysis and whilst writing up this thesis. My aim was, and is, to generate a 'fusion of horizons' between myself, the participants, the readers of this thesis and the texts (by which I mean the transcripts, data, literature and the thesis).

This research study does not seek reliability or validity in the sense that would be understood by a researcher with a positivist and realist worldview and I maintain that research rigour is achieved by offering the reader an authentic research audit trail. I have maintained a research journal throughout my research study which details my journey, decisions and actions taken. It is now for the reader to decide on their interpretation of my study, which may change and adapt according to time and context.

In the next two chapters I offer the findings of the study. I decided that the most authentic way of presenting the data was to do this in two ways:

In the first findings chapter I offer the participants an opportunity to 'speak for themselves' and offer their worldview in their own words in an attempt to avoid the privileging of the researcher's interpretation (any more than could be helped) at the expense of hearing the participants' own voices. Biographical accounts can be considered part of a consistent and coherent claim to knowledge-making if they report 'appearances in this time and place and offer possible insights that others can relate to in a way that deepens readers' understanding and that can be of use for application' (Holloway & Todres 2003:351). I intend this chapter to assist and promote the fusion of horizons between reader and participants.

In the second findings chapter I offer the themes in a systematic way which presents how the nurses managed their self within the interaction and the interaction itself with overweight patients. This latter chapter is a more explicit presentation of passages extracted from the transcripts which represent the fusion of horizons and shared understandings between participant and researcher.

CHAPTER 4: PARTICIPANT BIOGRAPHIES

Introduction

'It is always a past that allows us to say "I have understood."'

Gadamer (1976:58)

I have presented the findings of this study in two separate chapters. The first of the two findings chapters offers a narrative from each of the nurses as she makes meaning of her private lifeworld as an overweight women, developing her understanding of herself and others; the second of the two findings chapters (chapter five) follows a more conventional format and is concerned with how the nurse draws from her experience and understanding to manage her interaction with her overweight patient in her public lifeworld.

Developing understandings

This chapter is in biographical format and there are three key reasons for this. Firstly, I felt it was the most ethical approach to make every effort to do justice to the vast amount of rich and complex data that my participants have generated with me.

Secondly, I felt that it is relevant to Gadamer's concept of the hermeneutic circle to offer the reader the personal opportunity to engage with the text and gain a deeper understanding of the participants, forming their own interpretation of their experiences rather than imposing upon them the researcher interpretation (Rolfe 2006a).

Thirdly, this first findings chapter 'participant biographies' contains short narratives, 'storied representations' (Holloway 2005) that aim to provide an insight into the life-world and life experiences of these nurses outside the clinical environment, with a particular emphasis on their experience of being overweight. Ricoeur (1981) argues that 'it is only possible to understand meanings through narratives and that stories are constructed to make sense of our lived experience by organising disparate elements into

meaningful wholes, identities based on a living tissue of stories' (Ricoeur cited in Langdrige 2007:52-53).

I intend this chapter to suggest how the nurses have developed Self and Other understanding through their own experiences. Todres and Galvin (2005) suggest that two types of knowledge making can complement each other in qualitative research: narrative identity (breadth) and lived through experiences (depth). This chapter offers the breadth of the nurses' experiences as they construct their narrative identities and make sense of their own experiences in their private worlds, generated by allowing the nurses to tell their own stories of being overweight without direct focus on the interaction with their overweight patient. In the next chapter, the findings reveal in more depth how these nurses' use these understandings in the clinical setting, their public world. These findings were generated by more focused inquiry within the interviews about how the nurses used their experiences and understandings to help them to manage the interaction with their overweight patient.

Gadamer considers 'experience to be the quality of the undogmatic person who is open to new possibilities and that experience is really a form of self understanding' (Lawn 2006:64). Gadamer also persuades us that 'self understanding always occurs through understanding something other than the self, and includes the unity and integrity of the other' (Gadamer 1975:83). It is with this in mind, that I propose that this chapter helps us to see how each of the nurses develops her understanding of herself as she lives her life as an overweight woman. Furthermore, in concordance with Gadamer, I contend that, as the nurses describe their experiences of being overweight which lead to their self understanding, the narratives should also provide breadth and lead to their Other understanding and embodied empathy.

This chapter is my attempt to offer honest and authentic versions of my nurse participants' experiences of how it feels to be an overweight woman - who also happens to be a nurse. Although edited for repetitions and hesitations, each narrative is otherwise taken verbatim from the participants' transcripts and a sample transcript is provided in full in the appendix 11 for further reading and authenticity purposes. Occasionally I have inserted a word or two in parentheses to assist in the understanding of the context and to

improve the flow. Although direct (edited) quotations are used, I have not italicised these longer passages as I feel this would make it laborious for the reader.

I have deliberately chosen the most relevant and specific sections of their transcripts that I felt would represent their history and experience of weight as honestly and as meaningfully as possible. These narratives are important so that the reader has an opportunity to 'meet' and understand the participants, hearing from them in their own words. I also believe this may offer a greater depth of understanding and fits with Gadamer's underpinning philosophy in which the fusion of horizons between the researcher and the text, which can be either written or spoken or both, and the reader and the text – is facilitated, developing a 'common unity of understanding'. Gadamer explains:

'The common agreement that takes place in speaking with others is itself a game. Whenever two persons speak with each other they speak the same language...common agreement takes place by virtue of the fact that speech confronts speech but does not remain immobile. In speaking with each other we constantly pass over into the thought world of the other person; we engage him, and he engages us. So we adapt ourselves to each other in a preliminary way until the game of giving and taking – the real dialogue begins...and surely the elevation of the dialogue will not be experienced as a loss of self-possession, but rather as an enrichment of our self, but without us thereby becoming aware of ourselves...to understand a text is to come to understand oneself in a kind of dialogue...interpretation belongs to the essential unity of understanding.'

(Gadamer 1976:56-57)

One of the significant elements that bind the two following findings chapters is the complexity of the experiences of these nurses. Their own bodies can be simultaneously objectified by others whilst they are objectifying the overweight bodies of others. They can be discriminated against whilst also, sometimes, being discriminating of others who are overweight. Some of the nurses are very honest about their own prejudices of others who are struggling with their weight and there can be a fluctuation in their stances,

perhaps deriving from their underpinning desire to remain professional and detached but unable to submerge their own prejudices.

Another thread that links these two findings chapters is self and Other understanding, leading to embodied empathy and despite the seemingly contradictory stances, the nurses reveal their capacity to share understandings with their patients which, in clinical practice, helps them to initiate a sensitive conversation with their overweight patient about their weight and eating habits.

In summary, I consider it important, therefore, to offer the reader in this chapter the opportunity to understand as fully as possible the world view and experiences of these nurse participants in their lives outside of the context of nursing practice – of what ‘being overweight’ means to them and how they develop their understandings of their self and Others. This will assist the process of the hermeneutic circle and of forming a fusion of horizons between reader, researcher and participants through the text. It may also help Other understanding and empathy to develop in those who read this study and who may not share similar experiences to the nurses in this study.

I now invite the reader to meet my participants.

Being Alison *'We're only people at the end of the day, aren't we?'*

I'm a practice nurse. I work 30 hours a week in a fairly large general practice and I do a lot of disease management. I wasn't an overweight child. I was a bit overweight around I suppose 11-12... I was a size ten even after my children. I put on a bit of weight but not a lot of weight.

It all started happening...when I was about 40 and I changed jobs. I used to work in A&E. I was very busy and on my feet all day. I changed to practice nursing where you are a lot more sedentary... Then I had a hysterectomy and then I put on a bit more weight so...I've had about two goes about really trying to lose a lot of weight... I'm losing a little bit of weight but, no, I've struggled for the last 10 years. I have really struggled with being overweight. Whether it's the hysterectomy has anything to do with it, I don't know but I did put on weight after that. Obviously changing my job, it's bound to, I mean, you know, it's calories in and exercise out, you know? I'm sitting around in front of a computer in a small treatment room where I'm not moving around as opposed to a 12 hour shift running around A&E - it's bound to make a difference.

I think weight is more to do with... what you eat but it also has to do with the family disposition and some people just store their weight more than others do. I remember my husband, last year when we went on holiday, said 'I don't know why you are overweight; you don't eat anything.' I feel very uncomfortable with it...some days I'm fine. I can live with it and I can think 'well, this is me' and ...but, no, I think about it a lot and I strive to get rid of it, you know, do what I can... I've got a couple of very overweight friends and I was talking to one of them about this interview with you today and she said, 'People definitely treat you differently if you are overweight, they have less time for you.'... she said there is no doubt about it. I mean she is very overweight, very big and...she's a nurse too... [People] ...make judgements about what you do and what you don't do in your life - and how...because you are fat, you must be out of control. You must be stupid... but that's our society, I think that's the pressures that we have...

I think it all depends on your attitude to weight as well... I think being a woman and the pressure that's put on you, you do worry about it - and I think being a nurse you worry about your future health as well. I worry about it all the time. I personally...feel it's down to me and that I need to deal with it really and I don't think there was anything that would really help. I mean you could pay for me to go to Weight Watchers and... it's not really an incentive, to pay for me to go to a gym ... I do that anyway.

I went to see a specialist in Harley Street about my teeth, nothing serious, and he said to me, 'I'm overweight; I take these drugs every morning to take my blood pressure down. I know that I should be out there doing something about it but I don't. Why?' And ... I know why I should be doing these things. I know all the rationale behind it but I still

don't do anything about it. And that really made me think very hard because we all know what we should be doing.'

I'm a fairly confident person. But I do... feel ashamed next to my friends and colleagues that are slim. And ...I still get a sense of unfairness that I don't lead a very dissimilar life to a lot of people. I have to work so hard at it. It's unfair, it seems unfair. [My BMI's] 28-30. Well, I'm on Weight Watchers at the moment and I've just lost 8 or 9 lbs, but ... I just see myself as quite thick set, I suppose, and just got all this weight round my tummy... I've got really reasonable legs, I think they're completely different - it's just around here (points to midriff). I guess, yes, I see myself as just big and old.

I mean, I've been thinking about it again today and I ... think we all just need to learn to live with how we are...you can only do what you can do. You can try and eat healthily, that's what I always say to people, that's my mantra, eat healthily, do as much exercise as you can or you want to do and that's all you can do really.

I was going to have a hysterectomy and I thought, 'God!' You know what surgeons are like when you're on the table, the sort of remarks they make? And I actually went and had, which is terrible really, I had a series of sun beds before I went because I thought it's better to be brown and fat, it's so much better than white and fat isn't it? In the middle of winter, it was, and ... I really thought about it a lot - about, you know, being on that table and them opening me up and lying there a big blob, you know?

And I'm open about it. I'm not really ashamed about that I'm fat. I don't feel really ashamed. I think if I behaved really badly that I might, but I don't behave really badly. I am very conscious of it and I do try what I can to do something about it but I don't feel ashamed; people have to take me as I am, really. They can think of me what they like.

I think the main point is that everybody's different and not everybody's going out and overindulging, that everybody's different and... people have different attitudes to food; they have different ways they process food and it's not always a black and white situation. It's pretty grey! I think life's for living and you have to come to some kind of understanding with yourself that you're doing the best that you can under the circumstances - that you are experiencing at that time. And I think it would be nice if we could all learn to live with it and say 'hey, it doesn't matter' and, you know, I'm doing the best, but I worry about my weight every day. Every day I think about it and worry about it and wish I was slimmer... but, you know, providing life's going well and the job's going well and life at home's alright I kind of live with it and I remain positive and I live with how I am.

I don't know, I don't think there's an easy answer really...We're only people at the end of the day, aren't we?

Being Beatrice: *'Sod the diet, I'll start again tomorrow'*

I'm a 43 year old Community Staff Nurse, qualified since September 2005. I've always been big - I think it's [her BMI] around 35. I was a chubby child, then I was a slim teenager, then I was a chubby first time mum and I've yo-yoed really ever since. Yes, I do have issues with my weight, yes, I would like to be a nice size 12/14 but I also like my food. I think I'm a comfort eater and I eat when I'm bored. So if I could just not need the comfort and deal with the boredom it would probably be all right. I'm fine during the day when I'm at work. I'm better now than I used to be. I tend to bring my lunch with me so I don't tend to grab and run, but of an evening I'll have my dinner and then I can sit down and - lo and behold - if there are any biscuits present! But it's almost like I need something to do with my hands of an evening so I'm either comfort eating if I've had a particularly rubbish day or I'm bored watching a film and tucking into whatever happens to be available.

No, and I eat... well, I won't tell you what I eat - but it just... Well, I'll tell you one thing I've done; I have actually made up a cake mix... because you know when you were kids you used to put your fingers round the bowl?... I've actually made up a cake mix and eaten that because I've been feeling so hungry and you feel so bad afterwards. So I think, yes, a lot of it's psychological. I think that needs to be looked into and I think that's where the support needs to be. And I think with the job that we have, with the stress that we have and the time limitations that we have, I think that is where our psychological problems are going to 'develop' - I suppose, is the word, isn't it?

Why do I do it? I do it because I'm cheesed off and I want cheering so I will down three Mars bars, four Mars bars, whatever it happens to be. I've had a crap day at work and you go home and all you want to do is sit down and have something to eat and a cup of tea so I sit there with a pack of biscuits and a cup of tea. You know you shouldn't be doing it. I feel horrible. I think I shouldn't have bloody well had those. That's another six pounds I've probably put on just eating one packet of biscuits. Oh, blinking hell, sod the diet, I'll start again tomorrow.

[Eating] ...is very social, but again, saying that it's very social I think with some patients they are very often - not 'very often' - that's presuming - they can be very lonely and they can be on their own and so 'I'm going to sit in front of the TV and I'm going to sit and munch through four packets of biscuits' or whatever it happens to be so it can be both ends of the scale. It can be the sociable outing or family round sort of even or it could be the very lonely 'I've got nothing to do - I'm just going to sit here and eat.' ... I mean I can understand that, I mean ... this the meal on Saturday night, it was just so lovely being with people that you could sit and chat and you could just all gel in together. But I've had other occasions where I've been at home on my own and, yes, I have opened a bottle of

wine and it's just been nice just to sit there and chill out with this glass of wine and watch an absolutely load of rubbish on tele.

I spend half my day sitting down. Fitting exercise classes in...I find a struggle. It is time and if you're eating on the run it's easier to pick up a packet of crisps and a chocolate bar or a packet of crisps and a chunky sandwich than it is to think about grabbing a salad. I did look into gym membership. I think half the country has been to Weight Watchers or to Slimming World or somewhere, but again you're paying out x amount per week to be told something actually that mostly you know. It's getting it from the 'knowing it' to the 'doing it'.

Well, everybody's a size zero now, aren't they? ...because you're going into the general shops and you're struggling to find clothes that fit and that look nice and don't make you look like a sack of potatoes. And there's all this hoo-ha about they shouldn't have models that are a size zero but nothing seems to change. They don't seem to show that the fuller figure women can actually still look good. Sometimes when you do go into the shops looking for a size 18 or a size 20 and they say, 'Oh, we don't go that high, dear.' then you sort of get a condescending look. I don't like looking at myself in the mirror. I've got a small mirror, which is great because it's just 'shoulders upwards', that's brilliant. I also have a large mirror in the bedroom which I really do try not to look at - which is all right until you're going out of an evening and you think, 'Oh God! I hope I look all right in this!' - and then you catch your reflection in the mirror somehow and you think 'God, don't I look awful? I look like a barrel.'

I've yo-yoed from here to kingdom come, but it has made me more aware of my lifestyle and what I need to change. I've joined the gym and I'm seeing my personal trainer for the first time tomorrow night. I'm cutting back on my food intake and the type of food I'm having and also because I've had another recent scare, I've got to do something about it. I've decided I've just got to knuckle down and make those changes. Now my priorities have changed I would go for the healthy option, but that wouldn't stop me craving the chocolate bar or the whatever, but I would actually now turn round and say 'No I'll have the fruit.' I've got a nice little tub in my car which is full of nuts and berries and I take in four or five pieces of fruit, bananas, apples. I can eat an apple as I'm going along. It's not nice going without the chocolate, but...

I know people that can eat as much as they like and they haven't got a weight problem. They can't understand what this yo-yoing is like, or the fact that you've had a bad day [and] you need four bars of chocolate. Unless you've lived through, it you can't fully understand it.

Being Catherine: *'Big woman, big voice'*

I'm a 49 year old student District Nurse, seconded for twelve months by the Trust, through the university, to do my community specialist practice, BSc Honours Degree. Before that I was a Senior Community Staff Nurse; I'd been there for two and a half years and prior to that I was working in a hospital. I did neuro-intensive care.

I would like ideally to weigh about ten stone. I'm only five foot four and to weigh ten stone, to me, would be good, but I don't, I weigh thirteen plus and it's not good. The thinnest I've ever been was when my first daughter was six months old and I breast fed her. I didn't diet at all. I was very active, walked everywhere. I had a big Silver Cross pram, never used the car and I went down to 9 stone 6 pounds and that has been my lowest weight as an adult, ever. My husband was quite worried because he did say I looked very thin but I never really looked at myself then, I don't think. I had other things on my mind and not long after that was pregnant again with my other daughter and I think from then it's been a downhill slide and it's yo-yoed and I've been to various slimming clubs and this is the heaviest I've ever been. Really - and it's not good.

My husband and I last week walked up to these glass doors to go in a garden centre and he turned round and he said 'Oh, look at those two fat people coming towards us.', because we're both overweight. And that was such a shock. I tend to think if I don't look at it and I don't see myself then it's not there, it's not me. I'm still the normal weighted person I was ten years ago. I perceive a person of normal weight to have a waist and hips and I do not have a waist or hips and everything's going south and I feel that everything's fat and I think the thinnest thing is my fingers. I just feel as if I've gone width ways. As somebody said the other day, I'm not overweight, I'm undersized - so I think if I was five foot ten, I'd be thin!

So I've now got the stage where I need to lose this [weight]. I've got to do this so that's what I intend to do, [use] my will power. I feel awful. I don't like looking like this. I feel like a barrel on legs. It's soul-destroying. This is the heaviest - in fact I'm heavier now than when I was pregnant, and it's awful - I hate it. I really do hate it. I mean it is affecting my health. As I said, I am asthmatic - it affects my breathing, climbing upstairs and things like that. It is an extra effort and I know my blood pressures high, probably as a result of it, so...

I've been called 'tubby' and 'chubby'. Awful, awful and I laughed it off but it's stuck in my mind and I don't think I'll ever be thin but I'd like to be of a normal weight - and I'm not, you know? I know that I'm not valuing myself and I know I'm not taking care of me. I put the job first; I put the patient care first but if I'm not well in myself, because I don't

look after myself, then I won't be giving the patient care. I shouldn't be treating myself like this. I'm not respecting my body, so it's very difficult.

Because I felt so bad about being obese I thought, 'Oh, I'd better have something to eat.' so I ate a bar of chocolate. And I knew it was wrong. It's not even satisfying, I eat it so quickly. I've just got to eat it. When I feel down or have a bad day, I think I've got to have a piece of chocolate. It is just poor eating habits in the day and eating on the move, in the car. I've known to be eating my lunch at three o'clock in the afternoon and then you go home and you eat dinner at seven o'clock and, and being overweight, I've also recognised that I don't like eating late. I can't eat late because I'm still digesting it at midnight and it's not pleasant and that's when the heartburn comes in and the indigestion and it's awful.

You see, the thing is, that I follow all those healthy rules for cooking. You look at my basic diet it would be considered to be very healthy and nutritious. I eat all my fruit and veg, eat all the fibre, cook with low fat alternatives - and yet I'm overweight. The reason I'm overweight is, I snack and I snack on the wrong thing. I binge.

Accepting is very difficult, and especially when you're overweight and that is something I have found very difficult. I'm not happy with my weight, I'm not happy that I have to go and buy a size 18 clothes. It's not nice. It does depress me and then I think, 'Oh I need something to eat because I'm so depressed.'

Because I am overweight and I know that and I fluctuate all the time like a yo-yo. I have found it difficult for me to lose weight over the last five years because of an allergy I have for fruit and nuts and what I tended to do is when I'd put on excess weight I used to substitute meals with bowls of fruit, um, you know, very healthy and everything else and that tended to keep my weight down and now I can't and I think that this course in any case is... ur, I eat anything I see, so - chocolate, I've got to have some chocolate when I'm stressed. Which I know it's wrong and I know the body craves for it and I know all the, you know, ins and outs and you know, I know all the facts behind eating and, when you're stressed, you shouldn't drink tea and coffee and, you know, pick me ups, and sugar drives and ... but...(sighs)...

Well, I think a lot of it is the press, I think all these skinny models, it's cool to be thin and, you know, you go into the stores, the clothing stores and, you know, they don't do your size or they do do your size and it looks absolutely ridiculous because it looked better on a size 10, you know, I think, I think that's a problem and I think these patients feel the same as well, if they're isolated, you know, because for whatever reason for their, you know, they're obviously, you know, they've got a chronic disease or whatever reason they can't get out, then food is their only comfort.

I think the media have a lot to go on that and I really do think that the modelling world, they are trying to stop that, advertising these skinny women and there are a lot of the American women, celebrities, that are pathetically skinny. They're just, they're in need of a good hot dinner as they would say where I come from, or my husband would say, 'oh, no I can see the bones, I like my women with a bit more meat on.' But, but there's overweight and there's overweight. You know, there's like this Fern Britton on the TV, now, she has lost weight and is losing weight, but up until then she was a very large lady but she was funny. Yeah, [she] rode a bike, so, you know, to say that being overweight is unfit is not necessarily... Then you've got Paula Radcliffe who's like a string bean, the opposite, and there's Dawn French - look at Dawn French. Dawn French is quite happy with her weight and her height... She might have problems in later life with her heart and her joints and everything else, diabetes. You see, that's something else but I think we always think 'it's not going to happen to me, I'm not going to get diabetes if I'm overweight; I'm not going to have problems with my joints if I'm overweight, somebody else will.' So a lot of it is denial. There's something about her [Dawn French] that I think if she was thin, she wouldn't be funny and I think Jo Brand is the same; if she was thin she wouldn't be funny. And louder, well. I think we perceive the thin small woman as the mouse. But... we see a large woman, she's walks into a room and she takes over. Yes, yes, in my case, 'big woman, big voice'. So I think there is a lot to be said about big women, but I'm not happy with being this big and that's the difference. If you're happy with your weight, that's fine. It's not a problem, but I'm not happy with my weight.

But I think that the manufacturers have a lot to do with why we are like we are. You know, I don't ask - I've never asked - I've never filled in a form to say I want all this rubbish fats, hydrogenated fats...in my food that I go and buy. I have to read everything as it is because of my allergies, but all these convenience foods and things and I do think that it's the way we live. We were discussing this the other day...it's how we live today and we even discussed: 'Was it because women actually now go out to work more than they did say 30, 40 years ago when the children came home to a cooked meal, sat at the table, they ate fresh vegetables?'

No, no, I, we all yo-yo, you're either born thin and stay thin no matter what you eat, but then again I have also known thin people have high cholesterol and have heart problems and it's nothing due to being overweight and I've known overweight people not have any problems with high cholesterol, so that is very difficult.

Being Erin: *'It's all to do with self esteem, isn't it?'*

I'm a full time Health Visitor, I work primarily with families with children under the age of 5 years. I'm 31 and my BMI is about 28 now. I was quite a skinny child and ... I had quite an overweight mum actually who went on a diet when I was 12 years old and lost quite a lot of weight, she lost about five stone... I was watching all this and became quite engrossed in the whole diet thing and it actually [has] become a bit of a problem.

I was 12 and eventually I was diagnosed with an eating disorder - I was diagnosed with bulimia when I was about 16-17 and got treatment and got over it very, very quickly with cognitive behaviour therapy, so since then it is always something that I have to watch.

I've always been [overweight] certainly since I had my first daughter who's four and a half, I've been overweight but it's hasn't been a big issue with me. I then had my son eight months ago and since then it is a big issue because I know I'm not having any more children so I do want to lose the weight now. So at the moment I'm just, I've slimmed down, I can get into my pre-baby clothes but they're still a little bit on the tight size and I would like to lose another stone. So that's where I'm at the moment.

I was generally, I was quite big as a teenager until I got the treatment for the bulimia and then I started eating sensibly, and then it stayed quite stable until I had my daughter, so that was a period of about ten years. I maintained my weight, ate very carefully, exercised but I had the time, and then it's just, I've been about a stone, one to two stone overweight since then. I would like some time to exercise. I'd like somebody to look after my children so I could go and exercise.

I think for nurses it [managing weight] can be quite difficult. I think they're more prone to putting on weight for a start, because of shifts. I think shifts don't help when your body's all out of sync and you're eating all over the place. I always found that I had to watch that really quite carefully because if you're going off doing nightshift you could be eating during the day and eating at night as well to keep yourself going, but then, saying that, you're also up and down the ward all day if you're nursing, you're up and down the ward all day and... you're on your feet quite a lot so you should be burning a few calories. In... my job it's quite sedentary, it's sitting around quite a lot... What would help me? Oh, lots of things. Not having to work full time would help.

...obesity is going up all the time isn't it? ...there's too much junk food, too much access, there's too much money, I suppose, for people to buy these rubbishy things ... there's always been a pressure to be slim and to look lovely, and with husbands you worry about them meeting someone else. It's just sizes are going down, aren't they? You've got size zero girls now and ...it doesn't so much affect me now. I can look at things and see it for how it is, see it in...realistic context now, but when I was younger it did used to really

affect me, images, media images, magazines, I was constantly leafing through magazines thinking 'I want to look like that.' I think it harder for women, but I think it's becoming hard equally for men. I think there's more pressure on men too.... ...I know that there are quick ways of losing weight...I could have a healthier diet and it isn't going to take any time and it isn't going to take any money, but I don't actually. I think because a lot of the time I'm just too tired. I just want the convenience food because I'm just tired.

I think weight is a huge issue still at the moment, especially I think I said last time about size zero models and everything it seems to be more and more now a 'super-super skinny'. It's definitely...a massive issue for society. It's costing the NHS however much, you know, obesity and everything as well, so that's a huge drain. ... I think there are a lot of other factors in people's lives - it's not just about their weight. There are lots of things that affect their weight, you know, finances, time, stress, those kinds of things that you know if you don't deal with those things you're never going to be able to help someone to get their weight under control.

...It's all to do with self esteem, isn't it, and what the perfect ideal person is? I think a normal woman is quite curvy, should be anyway. I think I've got fat arms. I think I've got really big thighs and bum. I just see myself as a pair of thighs and bum, really, and quite chunky. I think my body is part of me, I see it as part of me, actually, I don't see it as a separate thing and it's all kind of tied up with how I'm feeling and my stress, because I can lose weight and put on weight so quickly and I know it's all to do with how I'm feeling about myself, about life, about everything really, so it's definitely intrinsically tied up with me. I wouldn't see it as a separate thing. For me, personally, I don't like the feeling of being unhealthy and sluggish and I don't like the look, I don't like looking in the mirror when I'm overweight. I don't like it when my clothes feel tight. It's physical and mental because, if I have lost a bit of weight and my clothes are feeling looser, I walk taller, I'm more confident, I look people in the eye more. I just feel so much better about myself. I notice other people, and just such change just from a few pounds.

There's one thing that springs to mind that might be quite interesting...I remembered just after I did the ... the interview last time, I was in Tesco's and ... one of the nurses from my workplace was there and ... I had a whole trolley, because I don't buy my fruit and veg at Tesco's, so I had a whole trolley full of rubbish because I had no fruit and veg in there, and it was all kind of kids food, frozen chips and such like. And I just, I remember piling it up and she was at the checkout next to me and I remember thinking, oh my God, she's going to think "she is so unhealthy, look at all that crap in her basket." So I thought that was quite funny. But then this nurse herself, thinking back she was actually overweight herself, I didn't actually look and see what she had but I think there's just this paranoia...

Being Frances: *'No time for chopping coleslaw'*

My background is in nursing and I was a midwife for about 5 years... and I went straight into health visiting and... I've been a Health Visitor since 1990 and in between times I've actually done a...BSc Honours degree and my post grad certificate in education and that's...led me ...on to become a Practice Educator... so I have a remit with education and I also have students but I'm also a Health Visitor at the same time.

The only time I was, I always thought I was big and looking back I know there was no way I was really big at all. I think at 15 I'd put on about a stone because I was like cramming for exams I just, you know, you just eat, don't you? So I went back to Weight Watchers, I started Weight Watchers when I was about 15 and so I, and you know you had this constant ... dieting and sort of like then be normal then dieting again and so it was this constant sort of dieting and dieting and dieting, keeping your weight in check and again you're ...young and you're ... looking for mates as well and things like that so obviously it's your best intentions to keep slim as well. And you also look better and you know, and it was, so that's what I did really.

Then when I went into nursing when I was 21 I and I'd always been still slim.[At] 21 I was even slimmer because I was walking all the time, so the amount of exercise I used to get just walking to work and walking round the wards and the huge 'Nightingale' wards and it was just, you just you burnt loads of calories off, so that was probably the slimmest that I've ever really been and you could eat, ... and because you ate, you know, there was ...a nice canteen, I worked at a private hospital, I trained in a private hospital so beautiful food, it was breakfast, dinner and tea, so it was structured, there was no sort of like cramming food in between so it was structured living, structured eating as well as lots of exercise, didn't drink, smoked, but didn't drink. I was smoking as well so that helped the weight because you would just have a cigarette instead of eating something which obviously dulls the appetite, and it wasn't until...I met my husband so I gave up, when I got pregnant, so it's always been good, my weight. Oh I'd been divorced before - you're getting my history now - and all I did was smoke and I lost loads of weight so I was the slimmest I've ever been at eight and half stone but I was not well, really, as in stressed and wasn't eating, so the cigarettes, do you see what I'm trying to say?

And then I met my husband who's lovely and I, yes I'm contentment, absolute contentment so you, you know, you used to again sort of yo-yo dieting, that's the word I'm looking for. So you'd diet, get it to a certain level and then be fine and then you think you can eat again and then you're back to sort of like yo-yo dieting because you've eaten far too much and it's this sort of like cycle and then I had the children and I stopped smoking, put on four stone, lost it all after that, then had another baby. Put on a stone feeding him because he just didn't feel very well and I had hardly put on weight in this

pregnancy because I wasn't having to give up the smoking and really kept myself in check and then had to eat loads to feed him and, because breast feeding's more important to me, so I then put on loads of weight, and I then lost a bit of it and then it's kind of like 'really can't be bothered to diet anymore', I'm fed up with sort of like, you know the lack of chewing, (laughter) do you know what I mean? So I just think 'oh when they've left home I'll diet, got a few years to go - only ten and eight, bless them, I'll have another couple. Yes, so hopefully we will probably get back to that yo-yo dieting and get back to that lovely body. (laughter) Sorry.

I feel that I'm overweight...because I'm heavier than I should be, so I think I'm heavier than, yeah, I'm heavier than I should be really...I should be lighter than I actually am, much, much lighter. My body mass index puts me at obese...It puts pressure on me that I should do something about it. I should be lighter than I am for my height. The pressure is on because I want to look better than I do and want to be healthy.

... I definitely know that I'm overweight and ... sometimes I get out the car and I think, 'gosh my legs really hurt' or 'my back really hurts' and it is because I'm overweight so I know that I need to do something about it, but then there's so many pressures on, on me but not just me, it's life pressures. Trying to sort the kids out, trying to have a full time job and it's just, it's, it's really hard and sometimes you have no time and I think if you're going to go on a diet you need to have time to plan it. I haven't the time for me to do it really, and to think about chopping up the salad and chopping up the coleslaw...

The biggest one is time, the problems of losing weight for me, yeah, time... I'm very busy in the day and I get home and although, you know, the fridge is full of sort of healthy stuff, there's also stuff that - I've got a son that's dreadful for eating, he's got a terrible diet and I've got another child who's fantastic at eating and really eats healthily so it's trying to find the balance between the two and so you kind of have stuff, some stuff in the house that is really not good and, like yesterday I'd been really good, had a salad for lunch which I'd chopped up, took the time to do the coleslaw, make the salad, put the really nice healthy protein stuff in it, bosh, got in at past six o'clock, I think it was and 'uh, right let's have a chocolate bar', because I'm absolutely starving and haven't got time to get anything before I go swimming, because I teach that as well. And then I feel, I feel like Mrs Blobby walking up the side of the swimming baths to actually go and teach swimming and I think 'what must people think?' So I really have got to take myself in hand...

I used to be really slim before I had the children. I probably had an issue with weight, but there were no kids in the house, there was no extra wine in the house. [I] used to smoke, and smoking kind of like replaces ... the meals so you were always kind of like slim and stuff like that...But then I had the children and ... I did lose, actually I breastfed my children up to when they were six months; my son didn't put on weight very well so I had

to add the calories and I added the calories, a lot of calories into the diet and he gained the weight, and by the time I got to six months and he'd given up on me and I'd given up breast feeding because he didn't want to, he just refused to have it, I was really ready to go back to Weight Watchers and I did really superbly well and I did really well with my daughter as well because I was so ready to, you know? 'This is it, you know, I can't even look another Mars bar in the face any more. So, yeah, so, I was really ready and really motivated to do it and I think you need to have that motivation; you really need to want to give, to actually either modify your diet or to cut down on the things that you know are bad for you.

...I'm digging myself a hole here, I'm not an alcoholic. No, but, yeah, you get in and you think, like, for example, a full-on day, you've had a full on day, getting the kids to school and getting them sorted out, you go all day at work and you can actually ... control your diet because you've got your salad and you've kept to the point there and you come home and then, as I say, then you're either picking them up from after school clubs, making sure they get home and eat something, then by the time you've done that you've got to get them to swimming, by the time you've done swimming and then get them home, then you've got to get them to bed, then it's you. It's my time and I sit down with a glass of wine to relax...

...I'm not a selfish person really, but I give too much and I need to learn to say 'no'. Yeah, and I don't say 'no' because... it's not that you like to be liked, but, yeah, I never say 'no' and safeguard myself, I never have a safety net. So, yeah, so I need to do that and I'm learning. I'm nearly 46 but I'm learning! I think that's it, yeah, and I, I think to actually go on a diet you have to say 'no', you can't have that piece of cake as well...

... I suppose it's me coming back to that small person again thinking, well, actually in fact I'm quite a small person, I'm a thin, it's that thin person that I want to be. I go round Marks and Spencer's and I think 'oh, I can get into that', and I think 'no, I can't.' I try it on and worry I can't get into it. So it's kind of like I think I'm probably thinner than I actually am. Does that sound stupid?

I think health wise actually ... I don't think it [being overweight] is good for your joints. There's heart disease in the family so I really need to start looking after myself, I'm nearly 50 if you think about it, three years to go this year. I might not look it, but I feel it. I sometimes feel it, and so, yeah, I think for all the right reasons I should lose weight. It's mainly to do with health. I'm sorry, just to, and to look good, actually look good in your clothes, because summer's coming up, so you won't be wearing the bulky stuff, so, and I'm just thinking, 'actually I really don't like that tyre around my stomach.'

It's like giving up smoking. I gave up smoking when I got pregnant actually, and I didn't expect to get pregnant, and I gave up smoking like that, which I've never been able to do

before, so I'm obviously kind of like this type A personality, not addicted, but, you know, and I enjoyed smoking and I think well, I see a lot of the mothers, some of my mums that smoke and they say 'well I can't give up', and I think 'well actually I gave up so you should'. So it's a bit like weight, if I lost the weight and then somebody said they can't actually do it, and you know how much effort goes into it and you can because you've done really well, then I think other people could. It's a bit hard isn't it?

... why am I overweight? Oh, because...I think you need to have the motivation to do it and you really want to do it, so when you go on a diet it's like, 'yes I'm going to give it up, I'm going to give that up. I'm just going to just stick to that and that's it, and I haven't got there yet with my head. My head isn't in the right sync yet.

...I keep thinking 'your body is your temple [name] and therefore you should only be putting things into it that is safe and okay for you do to so, and why are you sort of abusing it?' - because actually in a way it is abusing your own body really if you think about it.

Yes, and what I'm not thinking in the long-term, in the short-term, it's like 'I'm hungry I need to get something to eat', I need to sort out the family, etc, etc so I would do dah, de dah de dah um, I had a week off last week and I ate so much better because I had the time to chop up the salad and get everything ready and eat the nice food, um so yes, it is an abuse, really, I think, um you know because I'm at a greater risk of heart disease, there's heart disease in my family so I'm at greater risk of having a stroke and I'm at greater risk of having cancer because I'm overweight.

I can see that completely it's like, you know, 'yes, no, that's fine' and you know people have to accept me the way I am and yes, I am a bit bigger and you know, I'm not always going to be like this and in about a year's time I'm probably going to be so slim and by the time I'm 50 I'm definitely going to be very much slimmer than I am now, do you know what I mean? And then you think, you get into Next and you think right I'll try that dress on because really need to go out this weekend, blah, blah, blah and you get in the changing room and you think 'oh, no I've done it this time.' and that is, it's worrying.

Yes, I do feel ashamed of my body really, I mean yes, the top half's okay, you know, but if I went on a diet I'd lose my boobs; (laughter) I wouldn't lose my bottom, do you know what I'm trying to say? And I do feel you know, it is it is about eating too much isn't it so you should feel a bit ashamed really because that's a bit sort of like greedy.

... but it is, it is all about psychological barrier and again it comes back to deprived time...[and] a Mars bar's so chewy, much chewier than a pineapple chunk. You try it! (laughter)

Being Geraldine: *I know that I wouldn't have been a good role model'*

I'm a 48 year old Health Visitor and I visit all the families who are registered with our GP who've got children under five. I was tubby as a teenager, but not overweight. Lost it and was quite, absolutely fine in fact, until I had my first child when I was 26, must be a common tale, put on a bit of weight then but lost it, then had another child, put on a bit of weight then, lost it, then had a third child and put on a bit of weight but didn't lose it, so went to Weight Watchers for the first time in my life.

After a bit of a struggle got it off, and I became a Night Sister at the [name of hospital] and with the irregular hours and irregular eating that sort of thing, the weight slowly came back on again and of course I wasn't so active because I've got three young children and whatnot so during my 30s I gradually started to gain a bit of weight and I really, really struggled to keep it down, you know, like people do, you know? You sort of go on a diet for a bit and lose a stone and then think 'oh great'. Then you get back into eating and you put on a stone and a half. So that sort of happened during my 30s.

Then I got to sort of 40s and one of my teenagers was behaving very badly, very challenging behaviour he was exhibiting and I really did start to comfort eat then and put on, oh loads, absolutely loads. Well I say loads, about four stone I put on, and ever since then it really has been a struggle. I mean that's all over now and I'm now I'm addressing it again, and I'm trying Weight Watchers again and now I'm starting to lose it and I haven't put any more on and I have come to that very sad, hard place where I realise I can't eat what I used to eat. Took a long time to get to that point, doesn't it?

And I've actually come to that point where I've just realised I can't eat as I used to and I've got to change my lifestyle and you know, up the exercise and eat sensibly and all those things that are so common sense, aren't they, and you know you've got to do but somehow you manage to block it off all the time, don't you? So now I've got to that place and I'm back in control and I'm losing weight and I hope a sort of slim person will emerge at some stage. I mean, I've done loads of things, like we've got a dog now, we've got a dog a couple of years ago so I'm walking the dog every day, you know, any little glitches like, you know, it's suggested by doctors that you do these little glitches and it does work and you know - going to Weight Watchers I don't know if you've been at all - but you go into the meetings, it's very supportive isn't it? You know there are people there that have lost five, six, seven stone and still lost it and still keeping their, maintaining their weight and it's very supportive, yeah, here's hoping!

I think like most women I am a comfort eater and that is a problem and the fact that I've still got young children, I've got two more children now, I've got five children and whenever you've got young children you've always got biscuits and you know, 'crispies' and nuts and all those things and it is a temptation and I like cooking, my husband cooks

and one of my sons likes cooking so there's always nice things around to be eating and they're always saying 'come on, Mum, try this, what do you think of this?' and 'how does this taste?' and all the rest of it. So there's always that problem there where I don't have sort of full control of what goes in my mouth, if you know what I mean.

But it's... 'try this', and I will try it...not necessarily because I want it [but] because I want to encourage them and that's kind of a barrier as well, but ... I think time is a problem as well, getting time to fit in this exercise and I mean I do do the hours, walk with the dog but it's a real struggle and other things have to go like housework and things like that and really I want to do something in the evenings but I'm tearing round doing my housework then because I work like everybody else.

I've gone through a period of being quite large and feeling very uncomfortable and not being able to sort of run up the stairs without getting out of breath and all that sort of thing and you know, also I don't want to have diabetes, heart disease and those sorts of things. I mean the heart disease is quite prevalent in my family, my father's side and I don't want those things I want to be healthy.

I mean you're much more likely to [be ill] aren't you, if your waist size is over 37 [inches] to be going on towards heart disease and diabetes and things like that? ... all the lesser things come automatically ... with weight, don't they? The aching knees and the aching hips and the out-of-breath and the sweating and the sores underneath your rolls of fat and sore bits under your boobs and stuff like that - that does come, doesn't it? And I know they're not such a health issue as the more serious factors but it still makes you ... a jolly tired person, an uncomfortable person...

... I've got two young children, I mean they're four and six, I've got to have energy to be able to run around with them and you know how it is when you're overweight, you've got no energy or anything you're just exhausted the whole time, and I can't be like that, you know it's just too much to cope with...you're going to the park and they're both boys and they're both very lively and they want to go cycling and all that sort of thing. Well when I was very overweight, I just couldn't cycle. It was just too much like hard work so ... a big need for me is to be able to function without feeling unwell and really, really tired.

... I've never looked huge, I don't think. I mean perhaps my patients would say otherwise, but you know how it is. I don't know if you've got the same body image but as a fat person I always think myself quite thin? I never have the problem that I think myself fat. I mean, it's really when I get to the point when I'm feeling breathless and unwell that I think 'gosh I must lose some weight.' Yeah, when I look in the mirror I just, I don't really see a fat person...

... my husband likes me plump and round, he says, - he'd better! And my little ones always say to me when I'm dieting, 'oh don't get too thin mummy', as if, you know, we

like to cuddle you, you're all soft. so for me... I've never been a great one for idolising thin people and... I mean really you know, from my point of view the thing that influences me most is to be healthy and to feel comfortable really.

I mean, I've got a teenage daughter and she sometimes says 'oh I'll do that, I'll do this, I'll do that' and I say 'hey you're just lovely and you're just so lovely and healthy and you've got all this energy and you've got beautiful shape' and you know, I really physically steer her away from all those thoughts of being thin and all that sort of thing. I mean, not that she's fat, she's very beautiful, she's a size ten, but, you know, I just think it can be quite harmful to be sort of idolising these sort of models and celebrities that are hugely thin and really it's not the size or the shape you are, it's how you feel isn't it? - how healthy you are and how comfortable you are, that really is my overriding message I think, always, even to my children, to everybody is to be healthy and comfortable.

There was one thing actually I thought as I was driving here about my career prospects because I did like the sound of a job a few months ago very much and it was to do with reducing obesity in children. I didn't apply for it because I thought, I just can't, I'm too fat, I'm going to sit at the interview at they're going to look me, this person with a BMI of about 31 and think, 'what sort of a role model is that?' so I didn't go for it, and I would have really liked to have gone for it and I just wish that I had lost more weight before the deadline because then I would have applied for it definitely. I don't think, I know that I wouldn't have been a good role model. I mean I couldn't myself personally have sat in front of those children and said 'do this, this and this and you'll be lovely and slim' when I myself am too plump... I'm quite disappointed with myself really because I would have like to have gone for that job really but I just... too silly...

My mother-in-law, I mean I love her dearly, it's no problem, but she does have quite a little thing about weight, she's very slim herself, you know, petite size 8 and always has been through her entire life, even when she was pregnant she was telling me gleefully, but at Easter time she always pointedly sort of hands over, with great ceremony these Easter eggs to my husband and all my children, I've got five children, so it's six times this ceremony takes place and then she turns to me and says 'but I bought you some flowers' Every time I think 'oh, actually I can't eat flowers, I'd much rather have chocolate'...she's never referred to the fact that I'm overweight, never, but she's quite proud of herself, you know, as I was saying she's told me lots of times how she never put on any weight at all when she was pregnant whereas I put on four stone...there's a little part of me that giggles inside because I find it sort of slightly amusing because you know, in my whole sphere, in my whole world, you know, not giving me chocolates doesn't influence my weight in one iota... obviously she thinks I'm far too big for her liking!...I have no aspirations to be a size 8 either actually...and I couldn't even, get anywhere near a size 8, so it wouldn't bother me at all, but... it is slightly amusing.

You eat automatically when you're hungry but you eat purposefully when you're not, but for different reasons and you can go precisely to that place, can't you, because we all comfort eat...well it's just so easy isn't it? And you're not necessarily hugely overeating, it's a lot of snacking, it's slightly larger meals, it's the wrong food.

... the less healthy food is very satisfying, isn't it? You know, I'm a fat eating... you know... when you have to eat vegetables, as you do on some of these diets, it's loads of vegetables isn't it? I will eat avocados because they're high in fat. It's just that lovely satisfying feeling as it sort of trips down your throat, isn't it? That lovely slidey, nice feeling and that nice sort of satisfied feeling in your tummy. I mean it just feels so lovely and there are also lots of different sort of nice textures as well. I mean crisps [have] got a lovely texture, haven't they? I know people say you can eat crispy vegetables - but it's not the same is it?

I think of myself as a slim person, well, not as fat as I am anyway! I'm always going to have to struggle with weight. I mean I'm resigned to that fact now. I'm never, ever, I don't think, going to eat normally... I just like food too much. I'm just too food orientated... and I'm always going to be having to watch what I eat, struggle with it, probably will be slim for a while I'm motivated and then I'll put on the weight again but and then I'll have to lose it again...I think I'm always going to be like that...I've got some very, very slim friends and they just don't think about food, they don't feel hungry - well, I'm never going to be like that...I mean, my stomach's rumbling now.

...I have heard ... other fat people being called fat lazy slobs because they sit on the sofa. I have to say my husband's a bit like that. If he sees someone really overweight he says 'oh they're awfully lazy'. And I say to him 'well, I'm not lazy; I never sit down during the day, I'm on the go all the time' - and as I said I take a lot of exercise and I think that's a horrible stereotype to call fat people 'fat lazy slobs' or 'couch potato' or sort of imply that somehow their condition is purely because they're sitting round on their backsides when they're not, because even very overweight people are often quite busy, aren't they?...and quite energetic in what they do. And we've got a dog and you can't stop walking a dog just because you're overweight. I still walk him twice a day and they're hour long walks so I don't only just sit around and when I'm overeating, I'm overeating on the move, thank you very much! I don't sit down and do it!

Being Hannah: *'I don't really know what the answer is...'*

I'm the Cardiac Nurse Specialist working in Primary and Secondary care my remit is everything from prevention of heart disease, unstable angina right through to acute events and palliative care at the end with heart failure, so that's my remit really.

I was an obese school child, so I've always been big, I've always been big, I could never buy my school uniform locally because it didn't fit, ever since secondary school, not primary school. But I've got a bit of a mixed background from the home situation, foster homes and things, so at primary school I was always fit, but as I got older I met my real mother, who I went back to live with when I was eight. Her death certificate says 'morbid obesity' so she was huge. So it's sort of a family trait as well, although that's no excuse, but... there are a lot of us about, and I'm one of the slim ones! Which is what I keep telling myself, so yeah, so all my teenage photographs that I was sort of size 16/18 as a school child, so always big. The only time I was slimmer was I went to Weight Watchers when I was getting married and I lost...it worked for about a week...I lost stones.

I don't know that I do know what my triggers are. I eat badly in as much as I don't eat three meals a day. I don't eat until I go home in the evening. I have the odd apple, because I'm not hungry during the day. I eat in the evening, which is awful - and I never tell my patients to do that - but it's just the way it is really. I've never eaten breakfast in my life I don't think, other than when perhaps when we're on holiday, so...

I don't think shift work on the wards helped with eating patterns over the years. I worked on the ward for 25 years so ...you grabbed a snatch of something whenever you could. The only good thing to say about working on the ward is that I haven't got a sweet tooth at all. I hate chocolate and the ward is full of chocolate always, always full of chocolates and biscuits and so that's never been an issue.

[My weight does not bother me] no, not now, [it] has done in the past, but I'm sort of -not 'resigned' to it, that's not the right word really - but I've decided not to worry about it, so long as it doesn't get any more then that's fine. But that is a cop-out, I know it's a cop out because I always said 'well, while it doesn't impact on my health, I won't worry about it' - and I'm on antihypertensive therapy now and it hasn't made the slightest bit of difference. So it's rubbish, really, so I don't really know what the answer is...

...it's not that I feel that I can't diet because I have in the past. I mean... I went through when I was younger... you get lots of yo-yo dieting and losing stones and all the rest of it. But just through starvation rather than actual sensible eating.

...My mum had a lot of issues with how people treated her because of her weight as opposed to, obviously she has huge health issues because of it, but ... I don't know why I

don't take notice really because she had huge sort of social implications because of it, so, which were very difficult, so I actually have a lot of sympathy for people who are overweight, because I understand what rubbish and what crap they get from other people.

... it's only the youngsters, isn't it, that you have to worry about, peer pressure of the teenagers and even younger than teenagers, but I don't think generally people are pressured to be too slim. Although as a culture we are quite obsessed by it, aren't we? ...I think maybe with the younger men coming up that it's going to be as much pressure for them, isn't it? Because, once upon a time ...they weren't into image, [it] wasn't an issue with them particularly. Once they've got their girl, you know, that was it. But, I mean, I've got grown up sons and there is pressure for them to be smart and, they've more toiletries than I have now.

I don't think it's [weight is] a health issue at all. I think it's more it's being sociably acceptable isn't it, it's being part of that... being identified in the right way. It's much more a social issue.

I think that's sort of a half and half issue really, I think, and in some ways I think, it definitely is - weight is a health issue. Obviously there is lots of research out there to show how bad for your health it is both for orthopaedic as well as cardiovascular, etc ... but equally I think it can be bad for your health obsessing about it sometimes. The other side of that coin which is, sounds a bit of a cop-out but I think it is true, that people do obsess about it and you know, have food issues because of it...

I don't think money would make any difference really, I have to say. In fact the more expensive things probably the less healthy sometimes, aren't they, because they're richer and creamier and whatever, so I don't know. I think from, I think from, going to a personal perspective I think probably, the biggest issue is not so much how much I eat because over the course of 24 hours I eat less than some people, but I don't do enough exercise and I think that's more of an issue, it's more of an exercise thing. But, and I never really been in the... I've never done any... I avoided PE like the plague when I was a kid, because I was always too big to take part...I felt, [I] didn't want to get undressed so I think that's from a personal perspective - that's more my issue rather than a food issue.

...I care about what other people think to a certain extent, obviously not from a professional perspective, but ... I'm sort of happy with myself I think.

... having children, that's the only time I've ever been in hospital - something else I avoid like the plague! So... the only example I can probably think of is when I went to my GP saying these are my blood pressure recordings, I want some treatment. And he basically said - I think it was an awkward consultation from his perspective because he immediately said to me, 'well, I don't know what I should be telling you that you don't already know and it was quite, he felt quite uncomfortable with it. So he just said 'I

should be telling you, of course, you know, lose weight and cut down on salt, but you know all that – end of conversation.’ So that was the end of the conversation. Well he wasn’t wrong, was he, really, in a way? I did know and I didn’t want to and possibly just in that particular consultation that I went in with that hat on anyway because I checked my own blood pressure. I knew it had gone up, I’d gone and got myself a 24 hour monitor and done it myself and just presented him with the results, knew what prescription I wanted... So he was probably wrong footed from the beginning really, so that was, but that’s only time I think anyone’s ever mentioned it. So, and as I said to you earlier, it didn’t make the slightest difference anyway because I did know and it hasn’t made any difference...

And even the fact that my husband was diagnosed diabetic last year - so we immediately adjusted our diet from the diabetic’s perspective. Well, actually I thought we would have to adjust it quite a lot ... because I didn’t really know a lot about catering for diabetics, but actually our diet hasn’t changed much at all, because I was under quite a lot of misconceptions there, because we don’t have, I don’t have a sweet tooth so there’s no sugars, it’s just the carbohydrate really that you’ve got to watch, so it didn’t make the slightest bit of difference to my weight. Interestingly my husband lost three and a half stone - mine didn’t move an inch! He’s had to have an entire new wardrobe!

...I don’t have a pair of scales in the house. They’ve been banned for years so I’ve no idea how much I weigh. In fact the only time I ever get myself weighed is if I have to go to outpatients, so ... no, I’ve no idea of my BMI, but I can... I know which colour band I’m in so that’s sufficient.

The only time I’ve ever really, really, really lost weight deliberately, well, anyway, and deliberately or otherwise really, was getting married and that was the only time, I had to have my picture taken, because there are no photos of me.

I’ve got lumpy legs. ... I mean ... we’ve all got insecurities, obviously, about what we look like and there are certain times of the, you know, events and whatever that you’re worrying about it, but most of the time I don’t even think about it really. Just ‘this is me and that’s the way I am’ and I sort of I’d say sort of probably 85% of the time I’m quite happy in my skin ... and I’m happy the way I am... Yeah, I don’t know that I know the answer really, because ... I mean, I know it’s all in the papers and things but just in real life people do have body image problems no matter what their body image is, don’t they, so nobody thinks theirs is right, you know? No-one’s happy.

Summary

In this chapter I have offered the reader the opportunity to understand as fully as possible the world view and experiences of these nurse participants in their lives outside of the context of nursing practice as they make meaning of 'being overweight'. I intended this chapter to assist in the process of employing the hermeneutic circle and of forming a fusion of horizons between reader, researcher and participants through the text.

In the previous pages, the nurses have described how it feels to be an overweight woman who also happens to be a nurse. I have deliberately not 'themed' the passages as for this chapter, it would detract from the personal story of each nurse. Nonetheless, there are commonalities in their narratives as the nurses talk about their struggle with weight management and some talk about their lack of self esteem, their busy lives, and their concerns for the effect of being overweight on their own health. In common with my own experiences, the nurses tell of many factors that affect their weight, such as major lifestyle changes including childbirth, getting married, having financial or family worries and changing to shift work or more sedentary jobs. They also disclose the factors that cause them to overeat or make unwise food choices such as being busy, being stressed, being tired, being bored, being sociable, feeling isolated or in need of comfort. Some nurses admit that they turn to convenience or 'junk food' for comfort, readily eating this in preference to a healthier option. Some nurses have great self insight and understand that they do not value them self as much as they should – or as much as they value others such as family, friends and patients. They worry that their being overweight will cause health problems and most of them are concerned about hereditary, potential or existing health problems.

Some nurses' experiences about being overweight are complex as they can move their stances between feeling uncomfortable to feeling defiant about their weight and they veer from disliking their body to being reluctantly accepting. One common concern, however, is one of feeling that it is unfair that they cannot control their weight as easily as some other people do. Another concern is that others regard them as out of control, lazy, stupid, that they make judgements about them and that they are treated differently. One of the

nurses was worried about the effect of her weight on her relationship with her husband and whether this would lead to his infidelity.

The nurses also worry about being judged outside their own working environment as well as when they are practising nursing and often feel ashamed and upset about their weight, especially when wanting to buy or wear something particularly aesthetically pleasing for a special occasion. They talk about the negative influence and effect of the media and the celebrity culture on, not just on their own lives and feelings about being overweight, but also of those of their children and families.

The nurses often use the term 'struggle' to portray their relationship with their weight management and six of them admit to 'yo-yo' dieting - even though they also admit to understanding that diets are ineffective, with most people regaining their weight when the diet is completed, which may have a significant impact on their interactions with their overweight patients. Some talk of making small changes to their eating and lifestyle habits as a more effective method of weight control but simultaneously talk of using well known slimming clubs¹ where the emphasis is often on weight reduction rather than weight management in the longer term.

The nurses seem to be very worried about the effect of their weight on their health and well-being, their relationships with others both professionally and personally and the effect on their own self esteem. Despite providing numerous reasons for being overweight, each of the nurses can often be quite unforgiving of herself and regard it as her own fault that she is overweight because, although she is knowledgeable about the choices she should make, she does not take or maintain the necessary actions.

I feel it is important to share these stories with the reader as it is likely that the overweight patients for whom they care may share similar issues and this increases the possibility of empathy with these patients even if they do not share similar experiences. I have

¹The cynic might say that slimming clubs have a vested interest in members regaining their weight once they meet their 'target'. The community weight management scheme, to which I was inviting nurses to promote to their overweight patients, focused on support for long term lifestyle changes rather than 'going on a diet'.

presented this findings chapter as participant biographies in an unconventional conventional format but I considered it to be appropriate to offer the reader a sense of temporality and context as these nurses talk about their experiences of being overweight in their personal lives and to suggest how they have might developed their understandings of being overweight for both themselves and others. I consider that these narratives add breadth to our own understandings of how it feels to be an overweight woman and how the understandings of these nurses might underpin their empathetic perception for themselves and the overweight patients for whom they care.

In the next chapter I present the findings of my study as themes of the nurses' experiences, when related particularly to their working life and more specifically their interactions with the overweight patient. This is a more conventional and recognisable format of presenting findings where themes deriving from Gadamer's 'essential unities of understanding' are presented in turn. In the following chapter I have interpreted how the overweight nurse manages herself, given her history of struggles with her own weight management, in the interaction with her overweight patient and how she manages the interaction itself.

CHAPTER 5: OVERWEIGHT NURSES' EXPERIENCES OF THEIR INTERACTIONS WITH OVERWEIGHT PATIENTS

Introduction

In the previous chapter, containing the abbreviated biographies of the nurses in this study, the participants are purposely given their own voice to describe their experiences and to suggest how they have developed understandings of self and Others, leading to empathy for their overweight patients. I also intended that the first findings chapter would underpin this more conventionally presented chapter and would offer the reader an opportunity to familiarise his/herself with each individual before portraying the findings that are predominantly situated within the clinical setting. The previous chapter offers the knowledge product of narrative identity that helps the nurses to make sense of their experiences in their private worlds, prior to this second findings chapter (five) which illustrates the findings of the research when very specifically related to their public world, that is, in clinical practice.

The hermeneutic circle was employed during both interviews and was accompanied by the fusion of horizons between the participant and myself as our common unities of understanding of the topic were explored and shared. In intended harmony with Gadamer's philosophies of historicity and contextuality, I felt that it was inevitable that these descriptions would be likely to be shaped by my preconceptions, our experiences of being overweight women and nurses in the present day, our conversations, our proximity in terms of age, gender, working experiences and that we are similarly subject to social norms and values.

Gadamer contends that anything that is interpreted, whether it is a conversation, a text or other event within our world, has its own horizon of meaning. Given that my ontological stance dictates that my own preconceptions are an inherent element of the process of analysis - and that all understanding is interpretation, this chapter moves on from using the largely unedited nurses' own descriptions and interpretations of their worldview of being overweight, to the use of specific examples of their experiences of being

overweight and the influence this has on the interaction with an overweight patient. I felt that this was an authentic and honest way of expressing our fusion of horizons, what Gadamer describes as an 'essential unity of understanding' (Gadamer 1976:57) as described in the previous chapters.

To demonstrate the nurses' understandings or horizons, the next chapter is illustrated by quotations I have chosen from their transcripts. All transcripts have been retained and a sample of a full transcript is also presented in appendix 10 for authenticity purposes.

In summary, this chapter presents how these nurses manage their *self* and how they manage the *interaction* with an overweight patient by drawing upon their experiences and understandings of self and Others. It is my intention that this chapter, along with the previous chapter, will offer an insight into the many complexities of being overweight that these nurses experience in their own lives and within their interactions with overweight patients.

Acting on understandings: managing *Self* within the interaction with an overweight patient

In the last chapter the nurses described how they make sense of their private lifeworld as they inhabit an overweight body. They cannot detach these interpretations from their public lifeworld and they bring them to their interaction with their overweight patient.

There are seemingly many emotions that manifest in the descriptions of the nurses in this study. These nurses can feel confident, self-conscious, empathetic, critical, sympathetic, hypocritical, honest, detached and ashamed of their weight - and there sometimes seems to be a movement between these stances, the causes of which are likely to be multi-factorial and complex. I use quotations extracted from the transcripts to attempt to portray the link between the nurses' own experiences and how this influences their perception of the interaction with the overweight patient.

Managing guilt and dissonance

When interacting with an overweight patient and a conversation about weight and healthy eating is an objective, some of the nurses in this study appeared to be conscious of their own weight status and how this might impact on their professional credibility. Being overweight, whilst simultaneously nursing overweight patients, caused internal conflict, varied levels of dissonance, and feelings of being hypocritical for some of these nurses:

I think, yeah, I think patients, some patients would sort of turn round and say 'Well, you're overweight. What are you doing sitting here telling me I'm overweight?' ...I think some patients do see it... some people, some patients ... will probably find it easier to talk to me because I'm overweight whereas all my colleagues are stick thin. Well, most of them are quite slim. But I think some people would feel 'Well, who are you to tell me ... or give me advice on what I should be doing when you are not doing it yourself?'

(Alison 1:275-282)

Some nurses are good role models. I think the very obese nurses probably are not. The reason for this is because it is a bit like 'Do as I say, not as I do.'

(Frances 1:274-285)

Erin compared the discomfort with her weight by drawing upon her experience of the way she dealt with the dissonance caused by her own problems with breastfeeding and her role in simultaneously caring for mothers who were trying to breastfeed:

...perhaps being overweight myself I might shy away from it, from talking about it [weight] because it makes me feel uncomfortable...because... I know how I feel about it myself. And it's the same with breastfeeding, and ... my feelings about breastfeeding, my personal experiences. Once I tackled those issues about how I felt about it myself, I could then deal with it constructively with other people...

(Erin 2:812-819)

In our first interviews, Erin and Geraldine each disclosed their discomfort at not feeling that they are good role models:

I'd like to see myself as a role model, but no, because I don't, I can say to someone, what you need to do is, you need to exercise, you need to eat more healthily and I know that I need to do that myself. (Erin 1: 298-300)

'I always feel that I should not be sort of plump because I'm a nurse, oh, yeah, definitely.' (Geraldine 1:149-151)

This feeling of being hypocritical was a common unity of understanding between many of the nurses in the study and one to which I can relate. Beatrice described how this feels for her in an extract from her notebook:

I think the ... main thing that I've written down is my perception of me as a person, and as a nurse... I'm not quite sure what the word is. It's almost 'taking the Mickey'. I'm telling somebody that they need to lose weight, whereas they could quite honestly turn round and say to me 'Well, look at yourself in the mirror, love!' (Beatrice 2: 509-513)

During our second interview, as we were co-constructing the data, I suggested the phrase 'gentle hypocrisy' to Frances as she expanded on the challenges of discussing the topic of weight and how she addresses them:

Mmm... It is a 'gentle hypocrisy' and that's what causes that tension about you know, and it, it... That's a lovely way of putting it because it is, it is, you know? How could I possibly give you advice if I'm big? Although as I say it doesn't bother me about sort of saying something if I have to because I, you have to confront in my job anyway so if it's there, and the opportunity has arisen, then I don't see that I shouldn't be saying something because that's part of my job, but again it's that, 'yes, but you're big as well, [name].'

(Frances 2: 800-807)

Sometimes the nurses felt very self-conscious and objectified their own body during an interaction with an overweight patient:

As a nurse, it's the same thing because it's so tied up with me ... I feel less confident at work, less able to concentrate, I suppose, because I'm constantly thinking "oh, I feel really fat today" so it affects me the same way [at work] as it

affects me in normal life. A lot of the time I can overlook it but I do kind of sit on the floor at people's houses and think, "Do my thighs look really big?"

(Erin 2:793-797)

There is a sense of guilt that these nurses feel in overtly not taking care of themselves or taking their own health education advice. They manage this internal conflict by retreating into what they feel is their 'professional' persona and using their uniform, metaphoric or actual, and by detaching themselves from direct emotional involvement with the patient:

...I think you deal with it by separating yourself, separating you and your job. That's how I deal with it. I don't, as I say, when I go out to work I am [name] the Health Visitor, I'm not [name] the mum, the wife, the sister, the daughter, I'm just the Health Visitor and I'm not really me, I'm just a Health Visitor...there's no actual uniform for me, but I still feel like I am wearing a uniform...and that's how I deal with any of the hypocrisy that I do, you know? - what I say to people and don't actually do myself.

(Erin 2:935-953)

Hannah compared this situation with acting and distancing her personal self from her professional self by playing a role:

...You almost have to pretend you're not 'you' when you're speaking sometimes to the patient. In your mind the patient doesn't perceive you as being this overweight person that's telling them about it...you're in a uniform most of the time but, you know, it's almost like that uniform is like a shield isn't it? That you're a different person when you're wearing [it]... When you're wearing the uniform and that you take on a different role. I mean it's acting in a way, in a way it's acting, it's not necessary the real you all the time. I'm very good at self deception sometimes.

(Hannah 2:611-629)

This distinction between being a professional and being your own person is manifested by the attempt to ignore personal experiences and detachment when interacting with overweight patients:

I know the risks of drinking alcohol, you know? I know the risks of eating fatty food and ...I wear two hats. I do wear two hats. We shouldn't, I shouldn't, but I think we do as, as because I'm not just a nurse, I am...a woman, I'm a wife, I'm a mother, so I think we, we wear different hats but I try to give my patients the best

advice, the best care that I can, so I think yes, we, there are two different roles as a woman and as a nurse.

(Catherine 2:737-742)

One of the very significant issues to consider in the findings was the claim from the nurse participants that they generally placed others' needs before their own. This is very much evident in the biographies of the nurse participants in the previous chapter. Frances explained why she felt that nurses' personalities dictated that they had no time to care for themselves as they were often too busy caring for others and that the low priority she gave to herself resulted in the lack of control over her weight:

I think most of us...come from the same kind of grouping, if you like, and I think society is made up of groups, so you get your managers, you get your nurses, you get your doctors, you get your teachers and I think that the 'nursey' bit, if you look at their personality, most of them ...like to give don't they? They're very giving...people...they give all the time and they don't have any time for themselves, so sometimes I think that, unless you're really sort of: 'No, I'm definitely going to do it. I'm going to really prioritise...' - and there are some people that are really good at that, and make time for themselves... and they probably are the ones that do really well because they get themselves organised.

(Frances 1:274-283)

The nurses' understanding that they feel the need to place others' needs before their own often leads to feelings of guilt – and that the guilt can lead to unhealthier eating habits/ Catherine explained that guilt plays a major part in her working day:

... I feel guilty for taking that time because ...we are at the moment very busy and there has been staff sickness and staff shortage and everything else and I just feel that I couldn't take half an hour to sit down, but I know that I'd feel a lot better if I did. But it's, it's guilt, I think it's...my own guilt. I'm sure if you spoke to my manager she'd turn round and say to you 'Well take that half an hour.'... It shouldn't really have any impact on patient care because, if I don't eat healthily, I'm likely to go off sick and then there would be...another nurse short so that would impinge on the nursing care. So, in actual fact...we all ought to take half an hour, but we don't. It's, it's a known fact that we just don't take, we eat in the car or anywhere and ... rightly or wrongly, nine times out of ten, it's the wrong food, the wrong type of food...I, I'm out there giving patient care and they're my priority and I know it's wrong because at the end of the day, as I said, if I don't look after myself I won't be able to look after them, so, but you look and you think 'Oh no, I'll eat that on the way to Mrs so and so's you know, and then I'll go and

do her and yes, and oh and I can eat that later', and so we constantly put ourselves lower than them [in our priorities] and I know it's wrong ...and it is frustrating because I know that I'm not valuing myself and I know I'm not taking care of me, you know? The job, I put the job first I put the patient care first... I shouldn't be treating myself like this. I'm not respecting my body, so it's very difficult.

(Catherine 2:602-637)

The sense of being self-sacrificing, by making time for others before making time to look after yourself, is a common unity of understanding and featured in many of the conversations with the nurses in this study in both their home and working lives.

I haven't the time for me, to do it, really, and to think ... about chopping up the salad and chopping up the coleslaw, and you know... I'm very busy in the day...

(Frances 1: 141-2)

In the above quotation, Frances said that she has access to healthier foods but that time is short for her and prevents her from eating it and so she turns to faster and less healthier alternatives. Catherine also suggested that her working life interferes with her weight maintenance:

Well, as far as nursing's concerned...we're supposed to...give out all this education and information and advice and, in actual fact, the majority of the time we do not have time to eat healthily ourselves. We grab food on the hoof because we're busy, because we're short staffed and we don't eat healthily ourselves. We just think 'I'm hungry, I'll eat that bun. Yes, that will do, that will be fine.'

(Catherine 2:594-598)

Time management and the prioritisation of personal needs was an issue for Frances, particularly as it impacted on her own health and fitness:

I definitely know that I'm overweight and...the way I, sometimes...get out the car and I think, 'Gosh, my legs really hurt or my back really hurts.' And it is because I'm overweight so I know that I need to do something about it, but then there's so many pressures on, on me - but not just me, it's life pressures. Trying to sort the kids out, trying to have a full time job and it's just, it's, it's really hard and sometimes you have no time and I think if you're going to go on a diet you need to have time to plan it.

(Frances 1: 130-136)

This is echoed in a comment from Beatrice who feels that work pressures are additionally an issue in managing time and weight:

I think it is in a way...it's staffing levels, it's time management...It's all right them saying 'Well, if you manage your time properly, you'll have a lunch break.' But then you've got 13 patients to see that day, you know? Okay, well, I won't go and see two of them and I'll have my lunch. It doesn't happen...you go at the end of a long list... 'Sorry I can't see that patient with a surgical wound, which is leaking everywhere, because I need my lunch break.' You can't do it, you know? As nurses we can't say 'no'.

(Beatrice 2: 580–586)

Further to this, there are several accounts of how low self esteem affects their ability to care for themselves. In the previous chapter, it appears that some of the nurses recognised this as a factor in their own weight management:

I know that I'm not valuing myself and I know I'm not taking care of me. I put the job first; I put the patient care first but if I'm not well in myself, because I don't look after myself, then I won't be giving the patient care. I shouldn't be treating myself like this. I'm not respecting my body, so it's very difficult.

(Catherine 2:633-637)

Erin recognised that her weight management concerns are related to self esteem but continued to objectify her own body:

...It's all to do with self esteem, isn't it, and what the perfect ideal person is? I think a normal woman is quite curvy, should be anyway. I think I've got fat arms. I think I've got really big thighs and bum. I just see myself as a pair of thighs and bum, really, and quite chunky.

(Erin 2:697/733/741-744)

Aligned with low self esteem is sometimes the lack of assertiveness mentioned here by Frances:

...I'm not a selfish person really, but I give too much and I need to learn to say 'no'. Yeah, and I don't say 'no' because... it's not that you like to be liked, but, yeah, I never say 'no' and safeguard myself, I never have a safety net. So, yeah, so I need to do that and I'm learning. I'm nearly 46 but I'm learning! I think

that's it, yeah, and I, I think to actually go on a diet you have to say 'no', you can't have that piece of cake as well... (Frances 1:226-242)

Self esteem and valuing yourself seems to play a significant role in the working environment. This aspect of feeling guilty for addressing your own needs first was raised by Erin who also recognised that this will have an impact upon patient care:

It's just dreadful because you can go the whole day without eating and then you're absolutely hypoglycaemic and you need...I just find myself stopping off at the nearest garage and getting a bar of chocolate to keep me going because the food that they, the other food they have there, the sandwiches and everything are just rubbish anyway and yes, there's, you do feel almost in the NHS that you're some kind of martyr; you have to keep going and going and going for the sake of everybody else, and you feel almost guilty if you take a lunch break, like you're stealing time from them...I mean it's your time.

It's crazy, you don't get paid for it but you're so used to working unpaid overtime and that's what keeps the NHS going... women's weight is just completely tied up with their self esteem and how they feel and... the stress. I should imagine the stress that nurses are under just causes huge problems with their weight and their self esteem and no time to think about themselves and that will have a knock-on effect on clients and patients.

(Erin 2:621/833-837)

Geraldine claimed that her own experience of trying to manage her own weight has increased her knowledge from a variety of different sources:

...[I] know a lot about it, really, because I do know every single diet underneath the sun and every single slimming club there is in [name of place], and ...every single possible calorie of every food you've ever thought of and ... ways to lose it, exercise, you name it, I know a tremendous amount about it - so I think actually I'm quite a good resource because I do know so much about it.

(Geraldine 1:426-432)

In this example, Geraldine also claimed that, while she draws from her knowledge from theory, it becomes entangled with experiential knowledge:

...you draw on everything, don't you? And it's a mish-mash inside your head after a while...stuff you've drawn from text books and because I've had years now of sort of being overweight and...dealing with it myself and because I'm interested in

this as well....I've read lots and lots of research, so it does become all involved, doesn't it, after a while? And...a mish-mash of knowledge inside your head, and ... experience and maturity and age all have an effect on that, don't they?

(Geraldine 2:743-749)

Some nurses in this study seem to draw heavily from their own experiences when discussing weight with patients, in addition to using the evidence base. Frances referred to a colleague's theory:

My colleague has a theory that...if you constantly go on these diets, these crash diets, which lots of people tend to do, is that your body then kind of like loses...its own identify as a metabolism, so think, 'Oh Gosh, so she's starving herself again, so therefore let's lay down the fat more, because we don't know whether there's going to be another famine.' She says the ones that just keep to a normal diet; actually, they're the ones that don't have any breastfeeding problems. The ones that keep this sort of like fluctuating weight up and down, they're probably the ones that do have problems.

(Frances 1: 512-519)

Nurses in this study seemed to realise from their own experiences that losing weight and maintaining weight loss is not simple:

...You've got to be realistic about it. I know that you are not going to go away and lose three or four stones, you know? We all need to look at our lifestyle when we are diagnosed with something like that (diabetes) – but I know that's ... not reality...

(Alison 1:184-187)

...I've never known anybody lose weight and lose it forever.

(Catherine 2:1065-1066)

Some of the nurses felt that their health education messages about weight had varying outcomes:

I think they [work] because some of them have actually gone on then to lose weight and I've worked with it...and suggested that...I can come and weigh them monthly if they want it whilst they are so large and feel uncomfortable about going into the public arena to be weighed...and they've taken me up on the offer.

(Geraldine 1:208-212)

...if they're really motivated to lose [weight], they're going to do it...and so...you need to really want to do it – and that's what I'm saying is...the mindset – it's being 'Right, I'm going on that diet and I'm going to lose two stone. I'm going to do it come hell or high water...I'm going to have it planned and I'm going to do it then.
(Frances 2:628-633)

This applied as much to Hannah as to her patients:

I can read all the literature and I know all the evidence and it doesn't make an ha'penny difference really.
(Hannah 2:636-637)

Recognising practical ways of addressing weight management may derive from nurses' personal experience; Alison discussed how she talks to patients about taking steps to weight loss and management:

I talk about going to Weight Watchers and diet clubs and that sort of thing, saying it can help initially – but if you want to sustain your weight loss, you know it really has to become complete lifestyle change...I would talk a bit about how...they can achieve even just a few changes that might make a difference, not only about diet but about exercise as well.
(Alison 1:193-201)

Alison appeared to be learning from her own experience as she had explained to me very early on in our first interview:

I've gone on very strict diets and lost [weight] ... and I've always put it back on again... and now I still struggle with my weight. And I just feel that there's no point in going on [a diet] – I try not to talk about diets, because that's what women do, don't they? They always talk about diets...and I am trying at the moment to make small achievable changes...because that's the only way I think I can do it...to change my life. And I do the usual things like I'll start on Monday and try hard next week...
(Alison 1:61-69)

Frances seemed to understand the theory behind weight management and draws from her own lived experience of being overweight, but despite giving advice to her patients, does not act upon her own advice. The feeling of guilt often seemed to pervade their interactions and Frances talked about how the 'knowing' does not always lead to the 'doing':

I feel guilty if I'm talking about their weight and I'm already overweight, but that doesn't seem sensible, does it? ... 'cos I think what I said to you earlier is, before

we started the tape, is that...inside you is a little person trying to get out, so you ... think, 'Well, I know all of this; I know all about the healthy education stuff; I know all about health promotion; I know all about...what to eat, what not to eat, when to eat is the best time and to exercise and having time for yourself to do that...so, therefore I can impart the knowledge, and I think I'm quite a good speaker and I think...I get on well with my clients.

So, if they actually ask me - but then when you take a step back and you think, 'Well, I've just given them all of that information and I'm sitting here like this...I'm not a very good role model.

(Frances 1:260-270)

Some of the nurses reflected on the impact that being overweight may have on their own health;

... I know I'm overweight, I know it's affecting my health. I suffer with asthma in any case, but I'm more out of breath, my clothes don't feel right, I feel awful in this weather because it just...I think if you're overweight it makes you feel worse so... it's made me look and think about patients and myself and how they might perceive me. And although I know I shouldn't think...what they think about me, but I think it's a human trait. We're aware that we're overweight so, hopefully, yes, I am going to do something about my weight. I need to do something about my weight before I'm ill.

(Catherine 1:549-556)

In this section the nurses explain their understandings of how their lifestyles and eating habits impact upon their own weight management and how this extends to their patients:

... when I was slim I suppose I had very little tolerance of overweight, not tolerance, but I couldn't...wasn't as sympathetic as I am now and I just thought, 'oh it's so easy'. And also it was easier, it's easier when I was in my early twenties to maintain my weight, whereas metabolism changes, you know, your shape changes after you've had babies and it's just not as easy, so I was, yes definitely I thought why aren't you doing something to lose the weight. Whereas now, I definitely feel sympathy I just think I know how hard it is to make the time to exercise, to have the time even to plan a healthy meal and to cook for yourself when you are just rushing around.

(Erin 1:93-102)

I think that it's quite difficult for the people that I see who are overweight because there is the added pressure of having young children. I just think it's very, very

difficult when you've got young children... to have time - to have the money as well - and to be able to go to the gym. I know exercise can be free too and there's other ways of doing it. ...it's just difficult, I think my clients are in quite a difficult situation.

(Erin 1:288-294)

Alison considered it to be helpful having a personal understanding of how it feels to be overweight when interacting with her patients and that her own overweight status may further assist in developing a fusion of horizons with her overweight patient:

... We [overweight nurses] probably have more empathy with our patients than we think, really, and we use that to our advantage, really ...I don't know, it's hard to know whether they do take any more notice of people who have a similar sort of problem, or appear to have a similar sort of problem to them or, I mean, I think they do think that they go and see somebody who's skinny and...looking fit and... taking advice from them, I think that they feel they're being told to do something, they've got to go and do it and they [skinny nurses] have no understanding, you know? This person can't possibly have any understanding how difficult it is for them.

(Alison 2:1236-1244)

Some of the nurses in the study doubted the effectiveness of health education messages about weight and attempted to rationalise why this might be the case for their patients. In the first example from Erin, she explained:

Obesity is going up all the time, isn't it?... there's too much junk food, too much access, there's too much money, I suppose for people to buy these rubbishy things... I think possibly a lot of the advice I give, people don't follow.

(Erin 1:252-255)

Erin provided her reason for her own issues with weight management and her implicit understanding of how this might be for the mothers in her care:

Your shape changes when you've had babies and it's just not so easy...

(Erin 1:97-98)

Hannah also considered stress and time management to be important factors in effective weight control for her own patients:

There's all sorts of outside pressures as to why...lots of it is pressure at work. Then with some of the older patients, they are talking about it [stress] because

they are carers – and the stress of being carers to either partners of mothers or next door neighbours – all sorts of pressures in that respect – that they perhaps don't have time for themselves – or think they don't have time for themselves.

(Hannah 1:126-130)

Although the nurses might expect health implications to affect their patient's attitude to weight loss, in Hannah's case, health problems have not acted as a trigger for her own weight loss or management:

I don't think people are ignorant of it...just because people know...doesn't necessarily mean that it changes their behaviour in any way...it sometimes needs a trigger. Like being told they have heart disease and that is actually something that is life changing for them and they will take it on board – but obviously sometimes it's not...because it's all part of the bigger picture, isn't it?

(Hannah 1:113-118)

I've decided not to worry about it [weight] ...but that is a cop-out because I've always said "Well, while it doesn't impact on my health I won't worry about it..." – and I'm on anti-hypertensive therapy now and it hasn't made the slightest bit of difference.

(Hannah 1:193-197)

Summary

In this section the nurses talk of the dissonance, discomfort and the low self esteem they feel in being overweight, sometimes objectifying their own bodies, whilst simultaneously responsible for the health education of overweight patients. The nurses manage this by sometimes retreating into a professional persona and/or using their uniform as a tool to distance them from their patients. There is a sense of guilt as they feel that they are poor role models who are overtly not adhering to their own advice – advice that they are not sure is effective either for themselves or for their patients. There is also a tendency to draw from personal experience rather than theory as they interact with their patient. Furthermore, self sacrifice is offered as a rationale for ignorance of self care and the

nurses profess to be too busy caring for others to be able to eat healthily or to take exercise regularly.

The nurses often draw from their own experiences and relate them to their patients' situations to help them to empathise with them, understanding some of the difficulties they face if their patients are also caring for others and are too busy for self care. They also seem to understand that health problems are not a prerequisite for automatic weight loss and that even if there is an awareness of the potential impact of being overweight this does not necessarily assist in their own or their patients' weight management. A significant element of this section of the findings is that one of the nurses states that she feels that overweight nurses have more empathy with their overweight patients than nurses who have no experience of being overweight.

Acting on understandings: managing the interaction with an overweight patient

Managing personal prejudices

'Prejudice is the child of ignorance' Hazlitt (1778-1830)

In the previous section of this chapter, I offered some examples of the ways that nurses draw upon their own experiences during the interaction, Now, I turn to the strategies that nurses employ within the interaction itself, whilst simultaneously managing their own self and emotions, possibly recognising that some of their own experiences of weight may be similar to those of their patients. I offer examples here of how overweight nurses use their personal experiences of being overweight in the interaction with their overweight patient. I also offer examples of the complexities of being an overweight nurse in these circumstances, the movements in their positions and prejudices, and the objectification of their own and their patients' bodies.

There was an element of the findings that surprised me. There was often a movement from one emotion and opinion to another and the nurses' feelings did not remain static. Two of the nurses expressed sympathy towards their patients but also expressed feelings of exasperation or disgust, significantly followed by the rationalisation and understanding of the patients' situation based upon their own experiences. Here is a short extract from one of the transcripts as Beatrice and I discussed prejudices towards overweight people:

I think I have sympathy with them because I am overweight myself so I know what it's like, but also on the other hand, depending on what their problems are, you can sometimes feel cross with them because you know the weight isn't helping their problem. So it's very difficult because I do have that sympathy because, I know, I know what it's like, but you also want to say "look, for God's sake, this isn't helping you; you need to lose that weight" which is quite scary because if anything ever happened to me and I was told I needed to lose that weight I don't know how I would deal with that. Really don't know.

Researcher: Do you think that being overweight yourself affects the way you care for an overweight patient?

Not affects the way I care for them, no, but I have empathy for them. Really, I think that's... as I say, I know what it's like. I know how you can feel, how down you can feel about it and if you start feeling down about it, what's the first thing you do? You turn to another packet of biscuits. And then you eat that packet of biscuits and you think "I shouldn't have done that. I'll never do that again" until an hour or so later and you're feeling cheesed off again and you have some more.

(Beatrice 1:325-342)

Erin also offered her views about overweight patients but her stance fluctuated as she considered her prejudice and then set it aside to care for her patient. Here are three extracts from Erin's first transcript:

Well, it actually happened yesterday in clinic I saw a lady who was really quite overweight and it sounds really awful but I did think "how did you get so big?" because she really was very, very big.

(Erin 1:131-132)

In my normal life I would be far more scathing [about overweight people], I think, which is really strange ... than when I'm at work.

(Erin 1: 423-424)

I'm sympathetic because the group that I deal with are like me and I'm really, really sympathetic towards them.

(Erin 1: 445-446)

Self awareness played a significant part in how the nurses managed their prejudices in their encounter with the overweight patient:

I think you have to look at your own attitudes or prejudices or judgements or whatever... I think it is all about self awareness of how you feel about people who are big...
(Alison 2:608-610)

Alison also revealed her own prejudices towards patients who are overweight but recognises that people are complex individuals and have their own issues with weight:

I mean, you do think that, you do sit there and think sometimes, you know, 'How on earth did they get themselves in that state?' and you have to think, well I mean it's, I don't know ...you do... you have to stop and try and put yourself in their situation which you can't always do, but I think that's important because everybody's individuals and they're overweight for different reasons...and I think you need to remember that they're not...not everybody's the same.

(Alison 2:643-649)

Summary

The prejudice demonstrated by three of the overweight nurses towards their overweight patients surprised me. That this was not mentioned by other nurses in the study does not necessarily indicate that they did not discriminate against their overweight patients but perhaps these three nurses were more candid. The nurses who admitted to prejudice towards overweight patients did appear to examine their own prejudices, however, and were aware of the complexities involved in being overweight and the attitudes of themselves and others. A significant element was the movement between stances of being discriminatory to accepting and attempting to achieve an understanding of their overweight patient.

Managing sensitive conversations: developing embodied empathy

If prejudice is the child of ignorance (Hazlitt 1778-1830), then empathy is borne of understanding. In this section I offer examples of how these nurses approach the sensitive

topic of weight with their patients and the unique abilities they feel they have in the status of being an overweight nurse often sharing similar embodied experiences to their patients.

In chapter four, the nurses share their histories and understandings of being overweight and their narratives offer insights into how their weight might impact on their professionalism and their empathy for others. Nurses in the study often reflected on how they use, or try not to use, their own experience and understandings of weight to develop empathy and a fusion of their own horizons with that of the overweight patient. They understand the importance of developing an empathetic relationship and a sense of interconnectedness with the patient in order to manage the interaction and conversation about being overweight with sensitivity. Here Alison seems to contradict herself:

I try not to bring my personal experiences into my interactions with the patients.
(Alison 1:94)

In practice, however, Alison admitted that she does sometimes share her personal experiences with overweight patients:

...I do occasionally say... where I've got diabetics coming back and saying "I'm trying really hard and I've lost this much but now it's stopped." I do just occasionally... it passes through my mind... it just depends who the patient is that... "I do understand that, you know?" I do say that I do eat quite a healthy diet but I struggle and it's not always easy...I mean, I do think about it and it does affect, probably, the way that I talk to my patients.

(Alison 1:95-96)

This openness with patients also featured in conversations with Beatrice and Frances:

I know how difficult it is...and depending on the patient, and how well I know them, I have before commented 'Yeah, well, I know I've got a bit to go myself.'... Occasionally you'll get a quip 'Well, what are you doing about it then?' And then again...I can talk about nutrition and what they should and shouldn't be eating and...I'll admit 'Hey, my downfall's chocolate. Keep me away from the chocolate, I'm fine!' Show me the chocolate. I have big trouble! So I try and make it reasonably light hearted because I think, personally, I find that if it's too serious, too full-on I don't feel that I get the results that I could do.

(Beatrice 1:92-103)

I really need to go on a diet! I need to get slim... but I don't, I honestly don't have a problem. Like as I say, I've been into people's houses and they are big and they're smoking and stuff and I say 'Do you need some help with it?' I haven't got a problem about actually asking them and I could actually say 'Well, yes, I am a little bit big and I intend to do something about it, not quite yet, but I will do something about it in my own time.' ...

(Frances 2:770-775)

Being overweight as a nurse is used to promote the nurse-patient interconnectedness in the examples offered by Geraldine and Hannah:

...I so obviously hadn't followed my own advice so...when I'm talking to an individual adult, for example, I sort of almost feel 'Well, perhaps we could go together.' I mean, I would never say that but there's that feeling in, perhaps I can encourage them by showing that I'm losing weight too, or something like that...

(Geraldine 2:832-837)

... with some patients I feel that...I can smile about it and, in some ways, empathise with them because I can say... you only have to look at me to know I understand...what the problem is, sort of thing. And sometimes that can be helpful.

(Hannah 1:210-213)

In this example, Erin explained her reluctance to use her own experiences in her care of the overweight patient but also sometimes found it helpful:

... I do try to show some empathy and just, I don't want them to, I don't want to bring my own experiences into my work, but ... just I would say constructive sentences as if to say, 'I know what you're talking about because I've been there.'

(Erin 2:451-454)

In the first interview Geraldine stated her concerns about the health impact of being overweight herself:

...[weight] it's high [priority] at the moment; it's high because...I've gone through a period of being quite large and feeling very uncomfortable and not being able to sort of run up the stairs without getting out of breath and all that sort of thing and...also I don't want to have diabetes, heart disease and those sorts of things. I mean the heart disease is quite prevalent in my family, my father's side, and I don't want those things - I want to be healthy...because I've got two young children..., I mean they're four and

six, I've got to have energy to be able to run around with them and you know how it is when you're overweight; you've got no energy or anything. You're just exhausted the whole time, and I can't be like that. It's just too much to cope with.

(Geraldine 1:100-109)

This is significant because, in the second interview, Geraldine demonstrated how she would use her personal experience of being physically uncomfortable in her initiation of a weight-related conversation with an overweight patient:

...I think what would be going through my head is how [to] actually open a conversation into an honest upfront discussion about their weight and how I would do that is to perhaps at first is ask an open ended question like, 'How do you feel today?' and if they say 'I feel really tired and uncomfortable.' then you've immediately got an in-road, haven't you? Or if they were to come to the door sort of out of breath I might sort of say, 'Oh Gosh, ... you're out of breath when you came to the door. Are you feeling alright today?' ...that's how you approach it, isn't it, without making sort of a huge declaration about their weight?

(Geraldine 2:755-763)

Beatrice considered that honesty was helpful when talking about weight with patients and that self-disclosure might be beneficial to patient care. Beatrice also related the patient's weight to their health issue, whilst denying to the patient that being overweight is affecting her own health:

I think I would probably say 'Be honest with them', because I'm not afraid to say 'Yes, I know I'm overweight.' That really is my choice because I'm the one that does eat that food, but health wise, technically, at the moment, it's not affecting me, although it probably is on the inside, whereas with patients if it is a reason and it is hindering their healing or whatever then you have to be honest with them and say 'Look this really isn't helping you.' But, yes, you can, but yes, if you wish to bring yourself into that part of the conversation, say 'Well, you know, yeah, I know I'm overweight but I've not got a leg wound that needs healing.' - or whatever it happens to be. I think that's the way I would go, so...just be honest, yeah? Say 'Yes, I know I'm overweight.'

(Beatrice 1: 348-356)

An understanding of the sensitive nature of the dialogue about weight is manifested in many of the nurses' dialogues with patients. This was a significant factor that emerged

from the study's recruitment process that included over 30 nurses of all weights. As part of the process of inviting nurses to participate in my study I attended nurses' meetings. During the meeting nurses were asked to write anonymous comments about how they felt about initiating discussions of weight with an overweight patient and, demonstrating their discomfort. I omitted to ask the nurses if I could use these comments in my thesis so it would be unethical to do so but, although none of these comments can be held as representative of all nurses, I offer a summary of the content of these anecdotes:

Many of the nurses said that they would think of health implications and wonder if it is difficult talking to an overweight patient when they are also overweight. Several nurses worried that bringing up the subject would cause offence and recognised that it is a sensitive topic. Two of the slimmer nurses admitted that initiating the topic of being overweight made them feel very awkward and they felt judgemental or condescending.

Alison commented that: '*Skinny nurses have no understanding*' of how it feels to be overweight (Alison 2:1236-1244). Some of the other nurses in this study also argued that slimmer nurses may not have the necessary sensitivity that derives from embodied experience of being overweight:

...sensitive communication, although I said you can't teach it, I think if you're...with nurses who have never been overweight, it might be worth kind of trying to give them some pointers, really, on being sensitive because it is an incredibly sensitive topic.
(Erin 2:866-869)

Geraldine expanded on this argument, suggesting that it can be viewed as an advantage to be overweight in this situation:

Well, as I've said before, I always feel it's, for me, a slight advantage that I'm overweight because you can identify with it and perhaps more so than if one was very skinny because you've got something in common, haven't you? You can sort of play on that a little bit and...go where they are and sort of acknowledge that 'Yes...it's difficult for me to lose weight too.' And for them you understand how...you can comfort eat and eat for lots of different reasons rather than just pure hunger.
(Geraldine 2:793-799)

Approaching the topic of weight can be particularly challenging if the patient has not made a direct request to discuss this with the nurse:

Let's take the scenario of someone coming in for a smear...and we ...always weigh ...people that come in. Sometimes they get on the scales and ...they're obviously quite overweight and I say 'Is that what you expect to find on the scales?' I try to let them take the lead and they more often than not say 'I know I'm overweight.'... and I often say 'Is there anything you are doing to change that?' ...so the conversation usually comes about then, when you weigh ...people. I never sit and look at somebody and say 'Gosh, you look terribly overweight. Do you need some help?' or ...'I think you ought to do something about that' or ...'your health chances will be a lot better if you weren't so' ...you know? 'Do you understand ...the risks of being overweight?' etc., etc., so I am usually quite diplomatic about the way I approach it.

(Alison 1:111-123)

Frances explained that there are times when she feels that a conversation about being overweight may not be well received:

I've had obese clients say to me before that they've been to see the GP and – she was really big, this girl – she said "Blooming cheek. She tackled me on my weight." And I still see this lady and she is still quite rotund and I thought "Well, perhaps I don't need to mention it to you then. Maybe you're one that I wouldn't mention it to.

(Frances 1:86-90)

...I do remember I had a lady, who's delightful...and I saw her an awful lot... and she was huge and she actually brought up the subject of her weight, via her going to see the GP, and the GP had automatically [said] - she had gone in for something completely different - 'Well, you need to lose weight.' And it had got her so upset and I thought 'Are you telling me to back off then? Are you telling me that you don't want to go down this route?' ... so some people you get those sort of feelings, you know? You think 'Okay, I hear what you're saying and maybe we'll leave that.' And sometimes...you drop a sort of a bit of information - and then let them think about it - and then you go back and then you start and go from that point again and then it's starting to sink in.

(Frances 2:885-895)

Some nurses in this study appear to rely on their own instincts and experiences and their knowledge of the patient when initiating the topic of weight:

'Nobody's taught you, nobody teaches you how to do it...it's just not standardised. I mean, you have to do it how it feels right and use different approaches with different people, so it's not necessarily because I've done it in the past, it's just what feels right at the time – but nobody teaches you anything about how to bring up topics like that in a sensitive way.'

(Erin 2:509-516)

Nurses in this study have developed their own strategies for introducing the sensitive topic of weight.

... if the patient wants to take on board what you are saying, they will take it on board, they may ask for help, they may ask for advice or they may ask for referral to a dietician etc. but if somebody's quite happy being who they are, they're not going to change unless maybe something comes along that scares them into doing it...and that's where maybe you can bring the conversation round to the fact that, because you've had this issue, be it leg ulcers or a surgical wound or something that could be taking time to heal, your diet is important and you can then bring it round into the conversation that way.

(Beatrice 2:449-460)

Catherine talked about challenges of introducing the topic of weight in some depth, drawing on her own experiences of being overweight:

I don't think I could not broach the subject because I think I could, you know and I, you know, I could sort of like, you know, I can sympathise with them because I'm overweight myself but I think some of the patients as well, you know, how do you tell, you know, an 85 year old lady that she's overweight and she's not to have that bar of chocolate? Yes, I'm sure she's heard it all before, she shouldn't be eating it, you know, while ever she's got the excess weight, you know, she's not... she losing mobility, it puts excess weight on the joints and everything else, but it is very difficult, it's very difficult.

(Catherine 1:190-196)

Catherine sometimes relied on personal knowledge of the patient in making her decision on whether or not to introduce the topic:

... if I knew the patient it would depend on whether I could broach the subject and I, you know, I would obviously, you know, we always have to sort of like, it's like walking on eggshells, you'd have to be very careful what you said or how you said

it. Um, I think the advice would be that, you know, as nurses we need to promote health and I think that it's something that's not done [for] overweight and obesity.
(Catherine 1:260-265)

From there, Catherine brings the subject of weight into the conversation but is still seemingly mindful of the sensitivity required for this element of nursing:

...I ... broach the subject just by asking them: do they know how much they weigh? And, do they know how tall they are? Do they feel overweight? Are their clothes getting tighter? – or because I think some of the patients that I've seen actually will say, "oh dear, I know I've put weight on. I can't get this dress on anymore." So they do, some of them, do recognise it, I think may be that would be our inlet, but, as I said, it's not a comfortable..., it just does not sit very comfortably. I don't know why, because I think out of all the ... procedures and things that we carry out as nurses, I don't have a problem with any of those procedures. And as I wouldn't, I have in the past, you know, told patients to cut down their cigarettes, now I don't have a problem with that because I don't smoke. So, and like the alcohol intake, you know, I've known, you know, a patient [to] drink, you know, had a bottle of spirits by the side of his chair from getting up to going to bed and I've said maybe, you know, just cut down a little bit and I don't have a problem with that, but to actually say to somebody, ooh, you know, have you actually thought about not having that bar of chocolate when I know full well that I've got one in my car and I shall be having it later. (laughter) you know, and that's the bottom line I think, so it's being overweight is a very sensitive subject.

(Catherine 1:304-322)

Two of the participants explained how they used personal knowledge of the patient to consider introducing the topic of weight. Firstly, this is an a short extract from Erin's first interview transcript:

She had two children, that was the first thing that kind of went through my mind. I mean the consultation wasn't about her, it was more about the baby, and I didn't know her, so it is quite different to if you've built up a relationship with someone, which is what I do in my job, and then you feel that you can mention things more easily. At that time I couldn't. There was no opportunity. It wasn't about her and her weight. Her husband was also big, and the babies were big and solid. In that situation I would [be inclined to leave it], yep, but if I knew someone, if I'd build up a relationship, if I'd seen them antenatally, postnatally and followed them through and, you know, perhaps knew them at eight months, at the eight month check and things were coming up then, I think that's when I would say

something...how would I broach it? It's difficult isn't it? It depends on what kind of context...

Yeah, I mean how we work as Health Visitors it's all very chatty, very conversationalist, conversational. They don't know what we're trying to do by speaking to them, you know? They just think we are coming round to have a chat, so it's difficult because I've got no standard way of bringing up something like that, it would have to happen naturally in the conversation, or I would kind of gear the conversation towards weight and exercise. It's difficult, there's no standard question, or...

Researcher: So do you look for cues in the conversation?

Yes, yes, absolutely that's what most of our work is about picking up on things and open ended questions um, and trying to get conversation going.

(Erin 1:130-160)

Frances offered her experience of making the decision about whether or not to initiate the sensitive conversation about weight:

Yeah, and I can do that, yeah, I do that probably really well. I think if somebody was really obese then, I've had obese clients say to me before that they've been to see like the GP and she was really big this girl, she said "Blooming cheek, you know, she tackled me on my weight." And I still see this lady and she is still quite rotund and I thought "Well, perhaps I don't need to mention it to you then, maybe you're one that I wouldn't mention it to." But if somebody's put it on ...their Field of Words assessment ... they feel that they're overweight, then that's a really good cue: "Oh, do you think that you're overweight then? Would you like to do something?"... if they said to me that they've really got a bad back or their knees really hurt and it was because of their weight, then that's a good opportunity, that's another little opening there. "Well, have you actually considered, you know, maybe if we lost, if you lost a bit of weight then that might be helpful to you?" So that's another, so again you're still looking for the opening and they've actually come to you because they've got a problem so, and that's a solution to the problem, so you kind of like fix on that. But I suppose if they're really big and I had the, and I knew them well enough, I would say, "Well, have you considered doing something about your weight? Would you like to do something about... ? Tell me whether you would like to do something about your weight. And if they say, "Well, no." - then it closes, then maybe we capture that at another time.

(Frances 1:90-118)

In my second interview with her, Frances talks about the sense she has developed to help her to decide if there is a situation in which she should avoid the topic of weight at a particular time or with a particular patient:

I did run a weight loss group, as I said before in that last meeting, and those girls were ready to lose weight, so that was easy to broach because they're motivated to do something and people if they want to have some advice or ... they want your medical knowledge then they're going to ask for it, so they're going to be the really good ones, really receptive ones to do some work with.

(Frances 2:885-900)

Interviewer: But you say, when you say about the opportunity arising how do you know when that opportunity arises to look at the issue of overweight with a patient?

Um, I said before when we were talking in the previous interview, is about we have a Field of Words Assessment Tool and in the tool it says: 'Do you think you're overweight?' 'Do you think you're underweight?' 'Do you think you eat too little?' 'Do you eat too much?' and stuff - so that's a nice little, that's a good opportunity there, or um, it, sometimes it just comes up in conversation. I do talk a lot so, you know, if you're quite... if the person's engaging as well then sometimes you can say 'Well, you know, what, are you fit, well and healthy?' If they say to you 'Well, I could be a little bit slimmer.' then that's a great opportunity. Do you see what I mean?

(Frances 2:808-818)

Geraldine also recognised that there is a great need for sensitivity when initiating the topic of being overweight:

You know, people have said that they've been approached rather differently, but I don't think I would, I wouldn't do that you know, I would much rather sort of have lots of little in-roads into...because, even though weight needs to be addressed, you don't want to go at it like a bulldozer do you and sort of offend people and hurt them? And you don't want to make them feel belittled or inferior because that's not going to help them lose weight is it, really? You need a far different approach than that, so yes, you know, a very sort of subtle approach with some open ended questions and perhaps some observations about how they come over to me that they are out of breath or something like that.

(Geraldine 2:740-783)

Unlike the other nurses in this study, Hannah explained how she has only one appointment to discuss health promotion issues with a new patient after their diagnosis of heart disease and therefore only one opportunity to broach the topic of weight:

[I'm] a bit tongue-in-cheek to start with, I have to say, because it is a sensitive issue and so ...quite often we talk about cholesterol levels and things like that and it comes around to diet in a ...I'm not very direct at it, I have to say. I'm not very good at being direct, but you have to temper it to whatever...over an hour you realise what the patient's like and what they're willing to accept and what they're blocking...it's probably from cues... no two people are the same, are they? So you approach it differently, but somewhere along the line, through the conversation, you have to be sure that these topics are raised one way or another... [I raise the issue of weight] towards the end [of the appointment] really, when we've got some conclusions and they're usually more receptive to that discussion then.

(Hannah 1:61-103)

Some of the nurses in this study seem to want to construct personal knowledge of their overweight patients and develop their own strategies for communicating uniquely with each patient about their weight.

... everybody is such an individual and sometimes you have to actually sort of meet the person, don't you... before you can actually make the sort of decision about your reaction... I think you have to know the particular person before you can make an approach, actually meet them, because you can't decide beforehand what you are going to say to a person until you have the feedback from them...the body language...

(Geraldine 2:729-742)

I think I'd have to look at a patient individually, I think. I don't think you can categorise. I don't think you can put them under the same umbrella. I think you've got to look at that patient as I said, assess their eating habits, I think, and you can only do that on an individual basis. I don't think you can, I think some of the things you could you know, like, um, giving them advice... I think you could actually use certain, certain rules or things that you've done in the past, but I think, no, you have to look at a patient on an individual basis and, and you have to know them. I don't think you can, sort of like, go into the patient's house and blurt it all out.

(Catherine 2: 1297-1304)

Summary

The nurses claimed that it is important to develop an interconnectedness, a 'fusion of horizons' with their patient by gaining personal knowledge of that patient and using their own experiences of being overweight to help them to communicate with sensitivity. This experience and personal knowledge of the patient may influence the decision about whether to initiate a dialogue about weight management. There appears to be some tension around self disclosure for the nurses and their own problems with weight management although most of the nurses claim to be open and honest with their patients and consider that the seeming disadvantage of overtly not following your own advice on weight management can be used to their advantage; their patients may feel that they have a better understanding of the issues and problems they face with weight management, particularly if it might have a negative impact on health.

The nurses seem to rely on well developed strategies for initiating the sensitive topic of weight that include: relating the conversation to the patient's health issues or personal concerns; waiting for cues from the patient; using tools such as 'The Field of Words Assessment Tool'; and addressing each interaction as a unique experience and adapting the approach according to how they feel that the patient might react.

Summary of findings chapters

The first of these two findings chapters offered biographies, which are narratives that illuminate and inform us of how and why these nurses might interact with patients in the way they do. This aims to help to underpin our understanding of the second of the findings chapter that relates to the nurse in her working environment. Both of the findings chapters are instrumental in participating in the hermeneutic circle and facilitating the interpretations of the reader, participants and researcher to form a fusion of horizons.

In this chapter I have described the overarching themes drawn and interpreted from overweight nurses' experience and understanding of their interaction with overweight patients.

The nurses understand their self as being dissonant, which is managed by moving between feeling guilty and detaching from their patients to accepting and moving towards their patients. The nurses also acknowledge the role of self esteem in weight management and talk about the potential impact of their self sacrifice on patient care and their own health.

The nurses describe the different sources of knowledge from which they draw to help them to empathise and understand their patients; this is not confined to theoretical knowledge as the nurses also seem to rely on their own embodied experiences of living within an overweight body but also consider it important to develop a personal knowledge of each patient so that they can approach each patient in a unique and bespoke manner.

The nurses acknowledge and manage their personal prejudices by drawing on their own lived experiences of having their own overweight bodies objectified by society and other health professionals and set these prejudices aside as they interact with their patient.

Sensitive conversations are managed by openness and developing a nurse-patient interconnectedness as the nurses use their different sources of knowledge to increase embodied empathy. There are many complexities within the interaction and I would particularly draw the reader's attention to the interpretations that suggest that the nurses are inconsistent in their stances and that there is movement in their positions. The nurses do not appear to hold unconditional positive regard towards their overweight patients and they are not always consistently empathetic in their understandings or actions. Their prejudices towards overweight patients, however, seem to be mainly managed and set aside. They also seem to prefer to construct personal experience of the patient and to use their breadth of understandings developed through their own embodied experience of being overweight to help them in managing the interaction with their overweight patient,

rather than employing singular reliance on theoretical knowledge of weight management, of which they claim some cynicism regarding its effectiveness.

In the forthcoming chapters I discuss the meanings and implications of these themes and I discuss how these findings contribute to current research literature and I critically appraise how the current literature contributes to the findings of this study.

CHAPTER 6: 'GOING WHERE THEY ARE'

'We are all one light.' (Merleau-Ponty 1962:xiii)

Introduction

According to phenomenological thinking, our bodies are the vehicles for our being-in-the-world and the previously defined concept of phenomenological embodiment underpins this discussion chapter. The nature of the study also explores the interaction between nurses and patients who share similar appearances in terms of being overweight and have a need to interact. Therefore the additional concepts of empathy and intersubjectivity are also drawn upon to explore how the nurses and patients might relate to each other.

I now discuss my findings in the context of demonstrating how these may add further insights to other literature and studies and their implications for nursing knowledge and practice. My problem in practice was the reticence of the overweight nurses, with whom I worked, to initiate the topic of being overweight with overweight patients prior to their potential referral to a community weight management scheme. I now discuss my findings in the context of my research question which is:

What are overweight nurses' experiences of their interactions with overweight patients?

I will now contextualise the body in existential phenomenology and introduce the original concept of *embodied empathy-in-action* which is my interpretation of the overweight nurse experience of their interaction with their overweight patient.

The body in existential phenomenology

This thesis is underpinned by phenomenological and philosophical concepts, one of which is existentialism. Merleau-Ponty (1962) describes this as four elements that are fundamental to how humans experience the world: spatiality (space), corporeality (bodily

nature/embodiment), temporality (time) and relationality (intersubjectivity). In this thesis, all four of these elements have significance.

Embodiment in phenomenological terms sees the human being as being situated and embodied and that perception is our primary means of being-in-the-world (Merleau-Ponty 1962). This challenges the Cartesian view, so prevalent in the medical model of caring, that humans are primarily a soul or a mind that temporarily inhabits a contingent and dispensable body: 'the mind-body split' (Descartes, 1641 cited in Carel 2009: 215). In contrast to this, the phenomenological stance is that there is no separation between the two; Merleau-Ponty claims that he does not just *have* a body, he *is* his body (Merleau-Ponty 1962:501). Heidegger (1962) and Gadamer (1975/1989/2004)), see the human being as situated in time and space, proposing the '... objective body is not the true version of the phenomenal body, that is, the true version of the body that we live by'.

The nurses in this study occupy bodies that are sometimes objectified and judged, in common with those of their patients and yet, this is not the whole story. The nurses talk of their own bodies as needing to be controlled and they sometimes objectify their own bodies, but their understandings of being overweight are complex and they confuse and contradict themselves by moving back and forth between objectification, rationalisation and acceptance for both their own bodies in their public and private lives and those of their patients. Nonetheless, the nurses find it hard to reconcile their overweight bodies in a situation that seems to dictate that they should be a role model to overweight patients. Taylor describes embodiment as flowing from 'an understanding that is largely inarticulate...our understanding is itself embodied (Taylor 1991:308-309, cited in Benner 1994:xvi) Benner herself agrees that 'embodied knowing is an understanding that encompasses skilful demeanour and perceptual and emotional responses' (Benner 1994:104-105). These underpinning concepts are relevant as it is the experience of living with an overweight body that affects the nurses in my study as they interact with overweight patients. In order to try to articulate what is happening in the interaction between overweight nurse and patient I have dissected the interaction into four parts which frequently overlap as the margins blur quite naturally. Within the interaction there are (perhaps not considered consciously) understandings occurring of the nurses' own

relationship with their bodies and how their experiences might relate to those of their patients alongside their actions, which are immediate and simultaneous. In order to make sense of this I have developed a new and original concept of embodied empathy-in-action, the discussion of which forms the structure for this chapter.

Introducing the original concept of ‘embodied empathy-in-action’

One of the challenges - and an unexpected opportunity - for me as a researcher, actually derived from not having the foresight to develop a research question that could draw upon a single theoretical framework. Instead I chose an extremely interesting research question which has personal resonance and has captured my attention for several years, but it was unspecific and I found it difficult to compare my findings with, or situate my findings within, a single theory as the data are so rich and diverse.

I considered that there were significant aspects of the findings from this study that related to phenomenological concepts and theories, such as Merleau-Ponty’s (1962) ‘intersubjectivity’; Gadamer’s (1976) ‘fusion of horizons’; Gendlin’s (1992a) ‘felt sense and primacy of the body’; Galvin and Todres’ (2009b) ‘nursing openheartedness’; Todres’ (2008) ‘embodied relational understanding’; Finlay’s (2005) ‘embodied empathy’; and Benner’s (1984/2001) ‘thinking-in-action’.

However, there were also very noteworthy concepts that belonged to sociological and psychological perspectives. These included Hochschild’s (1983/2003), Smith’s (1992) and Theodosius’ (2008) ‘emotional labour’; Goffman’s (1959/1990) ‘impression management’; Festinger’s (1962) ‘cognitive dissonance’; and Rogers’ (1961) ‘therapeutic use of self’. The latter did not sit with any strong sense of congruence within the phenomenological scope of this study but I felt strongly that by drawing from all these diverse but influential concepts, it would help me to explain the complexity of how these overweight nurses experience their embodied interactions with their overweight patients. This is supported by Todres (2001:7) who explains that ‘compared to more specialist disciplines, nursing research often approaches phenomena that cannot easily be reduced to psychological, medical or sociological frameworks... instead viewing the holistic

approach as more relevant.’ The nurses’ experiences suggest that their interaction involves the nurses’ awareness of, and attendance to, their own feelings whilst being respectful of the patient’s feelings, but that it simultaneously entails use of their empathetic perceptions and actions in the interaction with their overweight patient.

Defining embodied empathy-in-action

In order to portray graphically my interpretation of the nurses’ experiences of their interactions with their overweight patients, I developed the concept of *embodied empathy-in-action* which brings together dimensions of all of their diverse experiences in a single diagram. Sometimes the nurses’ experiences are unique and at other times there are commonalities of understanding. On occasion there are also shifts in their emotions and embodied understandings and they fluctuate from one stance to another, which means that they do not always occupy all four of the quadrants. This concept is not static or fixed and the reader may have their own interpretations; understanding and interpretation is, as Gadamer (1975) says, ‘*always on the way*’. This section provides a summary of the concept and describes the range of variations within the concept as employed by the nurses.

There are four key aspects to embodied empathy-in-action:

1. Self understanding;
2. Other understanding;
3. Acknowledging-then-managing prejudice; and
4. Being-with: holistic interacting.

Embodied empathy-in-action is the fusion of: having a shared understanding of how it feels to inhabit an overweight body with all its complexities; and acting on those understandings to develop an interconnectedness between nurse and patient, a ‘fusion of horizons’, to promote sensitive communication. Swanson (1993, cited in Drew and Dahlberg 1995:336) describes this as ‘*being-with*’, a ‘seeking to discover and understand the other person rather than seeing the other person through a lens of assumptions.’

In order to explain this graphically I have developed a diagram (Figure 3) which shows how each of these inter-relates. These nurses, who work within the perspective of human science, appear to manage their interaction with the overweight patient by relying less on a scientific process, or one that is entirely underpinned by evidence based practice, and one that is more inclined to *combine* their own being-in-the-world and 'being-with' others holistically, rather than 'doing for' others, their personal experience and understanding of being overweight, their personal knowledge of the patient and their *embodied empathy-in-action*.

Drawing also from Figure 2 that describes the thematic structure of the data, I will discuss each of the themes in turn as I have interpreted them. In keeping with the concept of the hermeneutic circle, understanding how the particular relates to the whole provides both reader and researcher with a more holistic understanding of the nurses' experiences. Gadamer (1975) explains that to see a horizon requires looking beyond what is close, seeing the phenomenon in proportion and then viewing it within a larger whole.

Developing self understanding

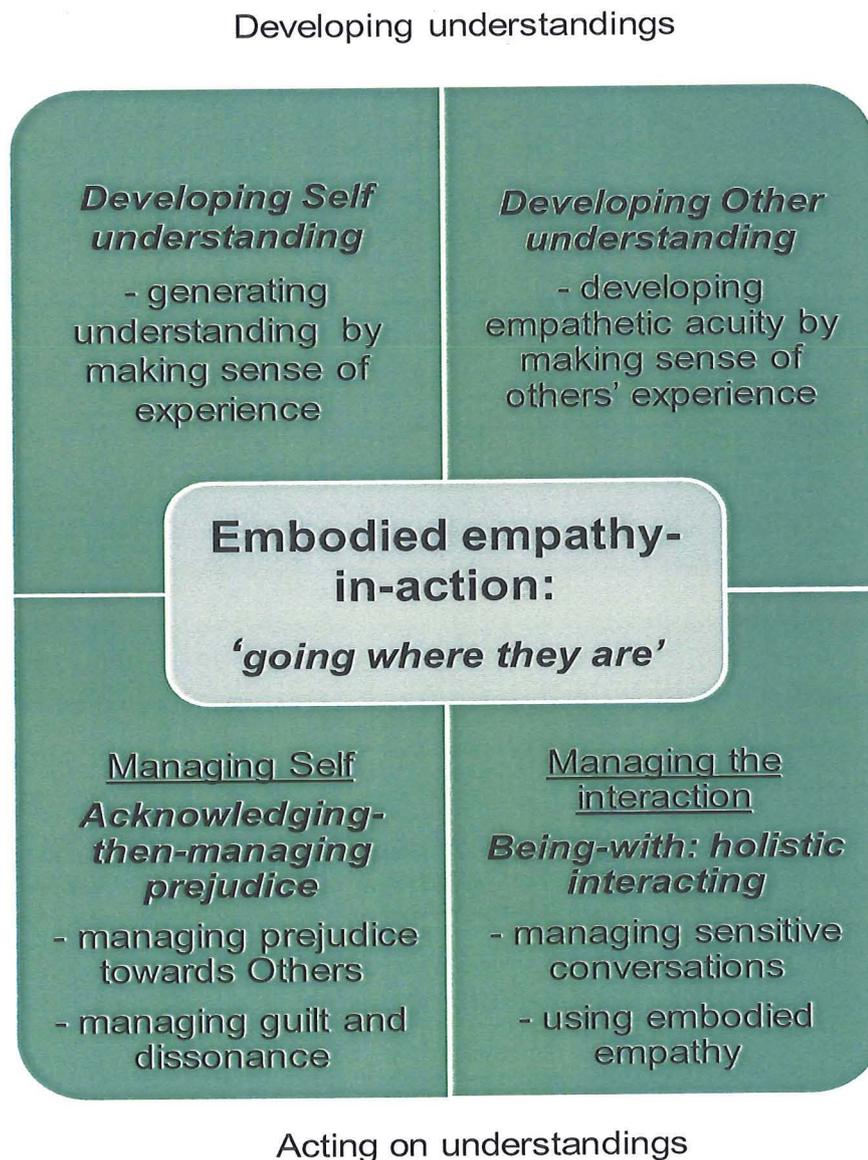
Gadamer (1975) tells us that the past allows us to understand the present and that experience leads to self understanding so it follows that the nurses develop their self understanding through personal experience, reflecting on their own histories of being overweight through dialogue. All of the nurses, with the exception of Hannah, talk profusely of their physical and emotional discomfort with their weight and say that they are concerned about their weight for a variety of reasons such as: feeling unfit; concerns about their future health; the sense of unfairness that others can remain slim whilst eating similar amounts of food; feeling ashamed that they are unable to manage their weight; feeling that they are regarded as lazy or stupid; being unable to find clothes in which they feel attractive; having a poor self image and low self esteem with associated worries about being objectified by others, particularly health professionals; and eating inappropriately, for example for emotional reasons rather than hunger. Hannah takes a slightly different and more pragmatic stance on being overweight and seems a little more

accepting of her body as she explains that: 'I do care about what other people think to a certain extent, obviously not from a professional perspective but ... I'm sort of happy with myself, I think' (Hannah 1: 386 – 388) and 'in real life people do have body image problems no matter what their body image is, don't they? So nobody thinks their [image] is right... no-one's happy.' (Hannah 2: 1059 – 1061) Yet, this is tempered by her statement that she 'avoided PE like the plague when I was a kid, because I was too big to take part. I ... didn't want to get undressed'. (Hannah 1: 373 – 376). This contradiction serves to demonstrate the complexity and messiness in human emotions, interactions and recollections and that the concept of embodied empathy-in-action cannot compartmentalise stances, experiences and emotions.

Developing Other understanding

Other understanding, in the context of Gadamer's argument, is that 'understanding is part of a dialogue, a fusion of horizons and that it is the accommodation of the Other' (Lawn 2006:70). In this quadrant of the concept of embodied empathy-in-action, the nurses strive to achieve an empathy with their patients, not necessarily deriving from shared actual personal experiences but from shared discomforts. This quadrant overlaps with the quadrant concerning the nurses' management of their overweight patient and the initiation of the sensitive dialogue about being overweight. A key element of this quadrant is the ability of the nurses to be reflexive and to understand the effect of their own embodied being-in-the-world on the patient. Although this thesis does not take a stance on whether it is an advantage to be overweight when communicating with overweight patients Geraldine talks of feeling that it is helpful that she shares a similar shape to her patients as 'you can play on that a little bit and go where they are.' (Geraldine 2: 793 – 799).

Figure 3. Embodied empathy-in-action



[Original in colour]

Some of the nurses refer to some of their own embodied experiences such as feeling out of breath (Catherine 1: 562) or having difficulty getting in and out of their car (Frances 1: 131 -132)) and relate this experience to those of their patients to build up empathy. This is resonant with the 'infinity of otherness where the nurse may not understand exactly how the other feels but allows herself to not know and act as the moment requires, alongside the embodied intertwining that offers the levelling power of shared vulnerability and a possible reversibility with others' (Galvin & Todres 2009:144). All the nurses claim empathy with their patients and some of the nurses state that they also consider the positive impact that their being overweight can have on their patients: Alison claims that 'overweight nurses probably have more empathy with their patients than we think' (Alison 2: 1236 – 1237). However there are negative impacts perceived by the nurses as they interact with their patients and all of the nurses, Hannah included, lay claim to feeling uncomfortable with dispensing advice about weight management when their embodied presence might indicate that they are not following their own advice.

Acting upon understandings – managing prejudice

Of the nurses who claim empathy with their patients, four of the nurses contradict this in opposing statements as the next quadrant of the concept is considered. These nurses claim to act a role as they admit that they internally criticise their patients. These nurses make statements such as: 'how did they get themselves into that state?' (Alison 2: 643 - 645); 'you can feel cross with them as you know the weight isn't helping their problem' (Beatrice 2: 328 – 329); 'I think they are not helping themselves, that they are making their ...situation worse' (Catherine 1: 304 -305); 'I had very little tolerance of overweight. I thought "why aren't you doing something to lose the weight" – whereas now I definitely feel sympathy.' (Erin 1: 8-94). The other nurses in the study do not specifically make any statements that criticise their overweight patients although it is impossible to tell whether they feel critical but do not admit it. There is, nonetheless, clearly movement in some of the nurses' stances as they move from empathy to criticism and back to empathy.

Acting upon understandings – managing the sensitive conversation

This section of the quadrant is based upon nurses' behaviours and strategies for initiating the sensitive dialogue of being overweight with patients by being openhearted and occasionally disclosing personal experiences. There is less movement within this quadrant than the other quadrants as all the nurses have strategies they employ with their patients although they do appear to rely on the combination of different forms of knowledge, mainly experiential and propositional, which are sometimes combined.

I propose that the concept of embodied empathy-in-action adds meaning to other existing important and significant concepts. Having provided a summary of the phenomenon and described the universal and range of variations that underpin the concept of embodied empathy-in-action, I now further define and debate this concept within the context of my findings by drawing on key authors and other concepts by exploring each of the headings within the quadrant in turn.

Self understanding

'I sort of went home from this interview with you and it really made me think about myself and my weight, me as an individual'

(Beatrice 2:410-411)

The first element of the concept 'embodied empathy-in-action' I describe is 'self understanding'. Gadamer (1976:302) describes understanding as being a product of dialogue and of the interplay of text, such as hearing narratives or participating in conversation. Some of the nurses in the study talked to me about how this had been the first time they had ever really been given the opportunity to discuss their weight with someone interested enough to listen to their story. The biographies in chapter four are narratives that do not offer 'truth' but they are reality for each of these nurses who constructed their stories according to their time and place and interpreted them accordingly. Holloway and Freshwater (2007:16) describe the narrative as being 'one of individual history and biography and helps people to come to terms with what happened

to them during the course of time.’ In other words, the nurses have constructed these histories of their weight to help them to understand and make sense of their experiences, which can be confusing, upsetting and downright uncomfortable both physically and emotionally. However, the researcher’s role is to do more than just retell a story; it was my role to interpret their stories and to make my own sense of their histories (Holloway and Freshwater 2007:107). In this section, I draw from their narratives and their talk of weight as I interpret what their stories might mean for nursing practice. There is a necessary overlap between this section that discusses self understanding and the section that explores the management of self, in particular the management of guilt and dissonance.

The nurses cope with dichotomous personal and professional identities; the feeling of being a poor role model, of feeling guilty, being hypocritical by overtly not following their own advice for weight management and not being ‘in control’ of their body contributed to the nurses’ feelings of dissonance and discomfort in their role of health educator. Although nursing is growing as a discipline in its own right, interdisciplinary research is still widely encouraged and nursing, therefore, benefits from drawing from other concepts and theories to assist in building its body of knowledge (LoBiondo & Wood 2002:20). It is for this reason that theories such as Festinger’s (1962) cognitive dissonance and Goffman’s (1959/1990) impression management were employed to help me to work through and discuss their experience and their self understandings in their interactions with overweight patients. Although considered to be theoretically situated in a sociological and ethnomethodological, rather than a phenomenological, context Goffman follows the first four steps of Husserl’s descriptive ‘eidetic’ phenomenology in his work: *‘Frame Analysis: an essay on the organisation of experience’* (Goffman 1974). Lanigan (1988) argues that Goffman cannot be considered to be a phenomenologist because Goffman prefers to view the person as a member of society rather than describing individual lived experience. Nevertheless, he does draw from narratives (Gubrium and Holstein 2009) and I argue that his findings and theories have considerable resonance for this study and help to illuminate the issues faced by the nurses.

Another significant element of the nurses' feelings about being overweight is the issue of self esteem. In chapter four, the nurses' biographies tell us how being overweight has impacted on their daily lives as they struggle with their bodies both physically and emotionally. The nurses objectify their own bodies and have their bodies objectified and ridiculed by others, leading to feelings of low self esteem. The loss of self worth often seems to manifest in behaviours such as overeating for comfort, which helps them to submerge their emotions that can shift from defiance to hopelessness to pragmatism, or by placing themselves low on the list of their own priorities.

This led me to investigate literature concerned with the concept of emotional labour, which can be defined as having three characteristics: 'face-to-face contact with public or patients; it requires workers to produce an emotional state in another person; and it allows employers to have a degree of control over workers' emotional activities, through training and supervision' (Smith & Lorentzon 2007; Smith 1992; Hoschild 1983 cited in Gray 2009:26).

In nursing clinical practice today, therapeutic relationships are an important element of nursing care in terms of listening to patients and caring for their mental and physical health, even if counselling is mostly now undertaken by professionally trained counsellors and psychotherapists (Theodosius 2008:145). Kwaitek et al (2005:30) additionally suggest that 'empathy is the cornerstone of therapeutic work'. Rogers (cited in Sahakian 1976) suggests that there are three qualities that are fundamental to therapeutic relationships: 'empathetic understanding and sensitivity towards others' feelings; genuineness and a willingness to be open with clients; and having unconditional respect for clients.' Watkins (1978:234) also talks of the therapeutic use of self as having resonance and 'that inner experience within the therapist during which he [sic] co-feels, (co-enjoys, co-suffers) and co-understands with his patient, though in mini-form.' It is claimed that the defining characteristics of empathy are the 'ability to see the world as others see it, being non-judgemental, understanding another's feelings and communicating that understanding' (Burnard 1988).

However, the therapeutic relationship may be more complex than these authors suggest as my study indicates that, within overweight nurse-patient interactions, some of the nurses

take multiple positions, moving back and forth from discriminatory to non-discriminatory perspectives. Although discrimination may not overtly manifest within the interaction itself, it may mean that sometimes clinically indicated conversations about weight may not actually occur, and the nurses also admit to having feelings that do not always resemble empathy for the patient, but instead require them to act out a role. Rogers is persuading us that everyone should sanitise their own prejudices (similar to Husserl's bracketing of prejudices: epoché) but this is inconsistent with the findings of this study which indicates that the human interaction is more complicated and his ideal of unjudgemental care is unachievable.

The congruence factor, which Rogers regards as the therapist being authentic and behaving and speaking as he feels, has implications for the findings of my study in which the nurses often feel dissonance and consider that they need to act a role in front of their patients. This element of dissonance is a concern as it may hinder effective therapeutic communication with patients. Furthermore, this seemingly natural instinct or innate ability, which is not as straightforward as it might appear, to develop a respectful and empathetic relationship with their patients may come at a personal cost to these nurses. Hochschild (1983/2003:35) reviewed the emotional labour conducted in her study of flight attendants and considers that these professionals acted in two ways: 'surface acting and deep acting'. She likens the surface acting to Goffman's impression management manifested in overt or deliberate body language 'the ability to deceive others about how we are really feeling without deceiving ourselves' (Hochschild 1983/2003:35).

However she defines deep acting as 'deceiving ourselves about our true emotions as much as we deceive others; the actor does not try to seem happy or sad but rather expresses spontaneously' (Hochschild 1983/2003:35). In response to Hochschild, McQueen (2000:729) claims that experience contributes to competence and that more experienced workers were more adept at deep acting which allowed them to separate out their personal and professional selves. This has significance and implications for clinical practice as, if the nurses in this study are frequently feeling dissonant and surface acting rather than deep acting, it will have an impact on their own health and their continued ability to empathise with their patients.

In a longitudinal study conducted by Allcock & Standen (2001), the authors describe their findings of 15 interviews with student nurses who care for patients in pain and suggest that there was little evidence that the students were offered any assistance to cope with emotional labour and they were also given little opportunity to discuss their feelings or try to make sense of their experiences. Although this study was conducted several years ago, there seems to be little change for nurses in terms of support for emotional labour, particularly in initiating or conducting sensitive conversations – or coping with their overt disregard for their own health education advice, as I discussed in the literature review in chapter two of this thesis.

There are implications for nursing in that, in order to promote good therapeutic relationships between nurses and patients, nurses should be supported in their practice if they are drawing on their spontaneous emotions and experiences in their drive to support their patient. There is a need to acknowledge formally that it is not unprofessional to draw from their own inner personal selves or experiences when interacting with patients at a deeper level and it could, in contrast, be considered to be good practice. Nonetheless, there are some concerns regarding deep acting in that it involves ‘evoking the nurse’s emotion memory and/or her imagination which can then become a distressing template by which she measures the degree of her feelings if she cannot give the same deep level of care given previously to patients’ (Theodosius 2008:20).

Smith (1992:139) suggests that the ‘emotional components of caring require formal and systematic training to manage feelings, grounded in a theoretical base.’ However, Smith has failed to consider that theoretical knowledge and evidence based nursing and training can be challenged and that diversity of opinion through the findings from qualitative research methods should also be acknowledged (Rolfe 2002:10). I do agree, nonetheless, that nurses should be supported in nursing practice, for instance, by offering nurses regular counselling, if they are drawing on deep emotions and feelings of their own in their interactions with their patients.

In the effort to understand themselves and their weight, the nurses often seemed to experience a state of inner conflict, caused by the dissonance of overtly not following their own health education advice about weight management. They appeared to strive to

maintain their professional and 'good role model' self by trying to control their weight and to distance their personal 'poor role model' self from their patients, not always succeeding, causing the nurses to feel discomfort and dissonance. Carlson & Warne (2007:511) argue that 'healthier nurses make better health educators' and there are many authors who consider that nurses who do not adopt healthy lifestyles are poor role models for their patients and that it could affect their professional credibility (Wells M, Lever D, & Austin EN 2006; Sarna & Percival 2002; Borchardt 2000; Veach & Cissell 1999; Clarke 1991).

Within the biographies of the nurses in chapter four, there are examples of nurses feeling very uncomfortable about their weight status. Alison describes her confidence at work but her shame about her weight with her colleagues and friends. This view is shared by other nurses such as Frances who says she 'feels like Mrs Blobby' when she goes swimming and worries what people think and yet is confident about her abilities as a health educator: 'I can impart the knowledge and I think I'm quite a good speaker' (Frances 1:262-269).

Goffman's (1959/1990) concept of impression management considers the relevance of theatrical performance, deriving from dramaturgical principles, to everyday life. His theory is that the individual presents their self in ordinary work situations by attempting to guide and control the impression formed of them and the activity they perform in front of an audience. Goffman claims that it is significant whether individuals actually believe the role they are playing as there is an implicit requirement for observers to take them seriously. He suggests that there are two extremes: 'an individual may be taken in by his own performance or be cynical about it' (1959/1990:30). The way nurses describe their conflicting emotions is consistent with Goffman's claim that 'professionals are usually keen to display professional competence in the workplace but often adopt a much more modest role in their lives outside of work' (Goffman 1959/1990:43).

Many of the nurses expressed their discomfort in the interaction with the overweight patients and are often concerned that patients will challenge them about their own weight status. Although this was the case for one of the nurses, this did not seem to be their general experience. This could, however, be due to the nurse seemingly having more power in the relationship between nurse and patient. There is another possibility, though,

as Goffman contends that patients may have 'sympathy for those who have but one fatal flaw' (1959/1990:67). Indeed, the nurses themselves consider that being overweight can help the relationship between the overweight nurse and patient, claiming that 'skinny nurses have no understanding' of how difficult it is for overweight patients to manage their weight (Alison 2:1236-1244).

The nurses in my study did strive to be good role models but this was something that they felt often seemed to elude them and this caused some stress for them as they had concerns regarding their credibility as health professionals. For example, Geraldine described her reluctance, and eventual perceived inability to apply for a post which would have meant working with overweight children. As I was unable to find similar studies that addressed overweight nurses and their dissonance with being overweight, whilst simultaneously providing weight management advice, I investigated comparative studies such as nurses who smoke but who also offer smoking cessation advice. In a research study undertaken by Clark et al (2003) a sample of 366 undergraduate self selected nursing students participated in a '*Smoking and Health Promotion Instrument*', with Festinger's (1957) theory of cognitive dissonance providing the theoretical framework for the findings.

The purpose of the study was to explore undergraduate nursing students' knowledge of, and attitudes about, smoking. Festinger's (1957) theory is similar to Goffman's (1959/1990) in that individuals need to feel coherence in their beliefs but he expands on this and also reasons that people have difficulty in adapting when they hold two conflicting beliefs. This has resonance with the findings of my study and the nurses often use the term 'struggle' in their fight to maintain what is perceived to be a normal weight whilst also acting as a good role model to their patients. The nurses do try to manage their own weight and to reduce the dissonance and chapter four outlines their lifelong battles with their weight so it might be expected that these nurses would try to reduce any dissonance by either avoiding the sensitive conversation about weight altogether, which was my original problem in practice, or by adopting strategies of distancing their personal self and feelings from their professional self and identity. However, the nurses in this study more frequently do the opposite, which is to acknowledge their own difficulties with weight to the patient when they feel it is appropriate and to share understandings.

Returning to Clark et al's quantitative study (2003:592) which cannot be generalised to other schools of nursing, the nursing students reported good general knowledge about smoking but those who had stopped smoking had higher specialised knowledge than those who continued to smoke. Clark et al suggest that the more specialised knowledge held by these student nurses, the higher the level of cognitive dissonance.

Evaluating the actual level of experiential or propositional knowledge held by the nurses was beyond the scope of my own study but some nurses claimed that they had good general knowledge about weight management:

'I know a lot about it really, because I do know every diet underneath the sun...and every single possible calorie of every food you've ever thought of...'

(Geraldine 1:426-432)

Geraldine claimed to combine experience with propositional knowledge but this does seem to lead to dissonance for her:

'I've read lots and lots of research, so it does become... a mish-mash of knowledge inside your head... and experience and maturity and age all have an effect on that, don't they? ... I always feel that I should not be sort of plump because I'm a nurse, oh, yeah, definitely.'

Geraldine 1:149-151).

In a quantitative study conducted by Benz Scott and Black² (1999:618) 233 randomly selected health education graduates were surveyed by questionnaire to assess perceptions of their professional responsibility to be role models of healthy behaviours. In this study, which is potentially limited by its nationwide (United States) sampling strategy and possible response bias, the authors suggest that it is essential for health educators to recognise how their professional identity as messengers of health information can affect message learning and subsequent health practices, particularly if their own behaviour is inconsistent with their own health behaviours.

² Lisa A Benz Scott and David R Black

Clarke states that 'communication theory and the view of the nurse as a credible source may add to these pressures' and suggests that 'nurses should consider relinquishing a 'controlling' role and focus instead on 'being real' to patients but adds that this will require a nurse to be self aware.' I agree with Clarke who argues that nurses should move 'towards experiential and self-focused learning and that making relationships with clients based on empathy, warmth, and respect seems to be a more effective method of helping people to make healthy choices' (Clarke 1991:1178).

The dissonance between the role that these nurses play, that is of professional care giver and advice provider, whilst being simultaneously considered to be ignoring their own weight management advice, is consistent with Goffman's theory that individuals can be 'cynical' and Hochschild's theory of 'surface acting'; the nurses are uncomfortable as their actions do not match their words. The audience is asked to believe that the character they see actually possesses the attributes they appear to possess, putting on a show for the benefit of other people, in this case, their patients. This dissonance often led to the nurses claiming to detach their personal self from the interaction with the patient. For example, Hannah (2:611-629) compared this situation with acting: 'it's acting in a way' and claimed to distance her personal self from her professional self by playing a role and pretending that 'you're not you', something echoed by Erin (2:941-958) who talks about separating herself from her and her job to deal with her feelings of hypocrisy: 'what I say to people and don't actually do myself'. In sharing their feelings of discomfort in the interaction, several nurses also disclose that they feel that they use the uniform or their professional persona as a shield (Hannah 2:611-629; Erin 2:941-958) which is consistent with Festinger's theory of individuals finding methods of reducing the dissonance where possible.

Goffman theorises that individuals are concerned with 'maintaining the impression that they are living up to the many standards by which they are judged' (Goffman 1959/1990:243) and he claims that people perform for an audience, subduing their inner thoughts and conflicted feelings in order to play a character but accepts that this can cause dissonance and upset if they do not believe the role they are playing. There are many authors who believe that nurses should be role models (Borchardt 2000; Sarna 2002:16)

and that this emphasises healthy behaviours to clients; the nurses in this study were aware of judgements made upon them by colleagues in addition to patients, and particularly when they were patients themselves.

In Festinger's seminal theory of cognitive dissonance, Festinger reasons that the existence of dissonance is psychologically uncomfortable so the individual will be motivated to attempt a reduction of dissonance by avoiding situations or information that increases the discomfort (Festinger 1962:3) and so dissonance is currently sometimes employed as a tool in contemporary psychotherapy to promote behaviour change (Cooper 2007:174). However, the dissonance caused by being an overweight nurse when advising overweight patients was a significant concern; it formed one of my initial problems in practice which then led to this research study and therefore was an issue worthy of exploring. In this study the nurses talk about their problems with feeling hypocritical and not being good role models. They cope with this dissonance by retreating into how they see their 'professional' self, by which I refer to their use of uniform as a shield or acting a performance so as to inspire trust from their patients (Mandy & Gard 2000:11). However this surface acting or cynical impression management is likely to cause emotional trauma for the nurse if she is unsupported.

This has implications for nursing practice as it is suggested in numerous studies that overweight patients do not always receive appropriate care and advice. In particular, if overweight nurses are struggling with dissonance, it may be possible to introduce support measures to decrease the level of dissonance which would potentially reduce the impact on patient care.

Some of the nurses in this study recognised that, in addition to feeling guilty and dissonant, low self esteem was a concern for them and most of the nurses in this study seemed to place themselves low on their own list of priorities. They often talk of their need to see patients over the need to eat properly or healthily and claim that nurses' are generally 'giving people' compared with other professions such as doctors, teachers or managers (Frances 1:274-285). They also talk of their loyalty to their colleagues and covering for staff illness or other shortages which would deny them the opportunity to take a break in which they could take exercise or eat healthily.

This is consistent with Hochschild's concept of emotional labour as being the work involved in other people's feelings and the induction or suppression of feelings in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place (Hochschild 1983/2003:7). In this study, one of the nurses is aware that she is not valuing herself or taking care of herself as she puts her job and the patient first (Catherine 2:633-637). Another nurse describes this action as being 'some kind of a martyr' and that she keeps going 'for the sake of everybody else' (Erin 2:625-846).

Smith (1992:136) also theorises that nurses need to work on themselves emotionally in order to appear to care, irrespective of how they feel about themselves, individual patients, their conditions and circumstances. This is pertinent to this study as some of the nurses recognise that self esteem is connected to their weight but that having no time to think about or look after their self will 'have a knock-on effect on clients and patients' (Erin 2: 837).

In particular, there is the concern for nursing practice that, if nurses do not have time to take care of their own health, then eventually this will have a negative impact on the care they can offer to patients. It also sets a questionable example to patients who might also be struggling to juggle a variety of demands. The unintentional message from the nurses may be that it is satisfactory to submerge your own health needs in order to satisfy those of others. It is suggested that support could be offered by employers in terms of helping nurses to manage better their time and workloads so that they are empowered to value their own health as much as the health of their patients.

Gadamer uses a phrase '*bildung*' to convey the ability to subsume personal needs and private interests (Uhrenfeldt & Hall 2007:389). Gadamer calls this 'sacrificing particularity for the sake of the universal ... [in] the restraint of desire ...man gains the sense of himself' (Gadamer 1976:11) which leads to self understanding. This study suggests that nurses have a tendency to place others' care before their own and that this will have implications for nursing practice. The nurses recognise that the unwillingness to put their own health needs first is often related to low self esteem, even though they offer many reasons such as being too busy to eat properly - and that this may also be a factor in the weight management for their patients.

Other understanding

This section focuses on the discussion of how overweight nurses generate their embodied understandings of the challenges faced by their overweight patients, the 'Other' understanding. It explores how the nurses' experiences, suggested by their narratives in chapter four and the findings in chapter five lead to a potential shared sense of connectedness, empathetic acuity and a fusion of horizons between nurse and patient. Moustakas (1994:57) describes intersubjective communication as being 'reciprocal understanding where each can experience and know the other, not exactly as one experiences and knows oneself but in the sense of empathy and copresence.' The nurses' personal experience of being overweight has a significant influence on their interaction with their overweight patient and this quotation led me to the title of this chapter:

'I always feel it's for me a slight advantage that I'm overweight because you can identify with it and perhaps more so than if one was very skinny because you've got something in common, haven't you? You can sort of play on that a little bit and go where they are.'

(Geraldine 2:793-799)

Geraldine's talk of 'going where they are' is resonant with the concepts of intersubjectivity and the embodied empathy that these overweight nurses employ to understand their overweight patient and the way they enter the space between the 'I and Thou' (Buber 1970). Merleau-Ponty describes perception as 'the background from which all acts stand out, and is presupposed by them ... truth does not inhabit only the inner man, or more accurately, there is no inner man, man is in the world, and only in the world does he know himself' (Merleau-Ponty 1962: xi-xii). There is another position on perception as Gendlin (1992a:341-353) argues with Merleau-Ponty, claiming that he 'exaggerates the importance of perception and that perception should not precede the bodily sense, asserting that the bodily sense of a situation is not just a perception, it is more of a felt sense'. He explains that it is understanding the world, 'not mainly through the five external senses, but more basically through the body's self-sensing, because the body is interacting with its environment' (Gendlin 1992b:450).

This has resonance for my findings as the nurses make choices about whether to initiate a conversation regarding weight with an overweight patient, not necessarily based on clinical reasoning, but instead upon how they feel about it and how they feel the patient will react. Frances explained how she chooses not to introduce the topic by using her own 'felt sense':

'Now, I do remember I had a lady... and she was huge and she actually brought up the subject of her weight, via her going to see the GP, and the GP had automatically, she had gone in for something completely different, [said] 'Well, you need to lose weight.' And it had got her so upset and I thought 'Are you telling me to back off then? Are you telling me that you don't want to go down this route?'... So [with] some people you get those sort of feelings, you know? You think 'okay, I hear what you're saying and maybe we'll leave that.'

(Frances 2:885-895)

This is echoed by other nurses in the study and Erin (2:513) describes it thus: 'You have do it how it feels right.' The nurses here may be using a combination of their senses, watching the patient's body language and listening, not just to what is being said but the way that it is said, but these senses on their own do not necessarily provide the basis of the nurse's decision to initiate the topic of weight. I argue that the nurses, in the immediacy of that situation, may be drawing from their past experiences, whether consciously or not, to make that decision through a 'gut' feeling.

Another significant element of the findings is that, when the nurses do decide to interact with an overweight patient about weight, they often do seem to use their own embodied experiences to ease the initiation of dialogue, or to have an honest dialogue with the patient and look for common ground. Merleau-Ponty argues that:

'In the experience of dialogue, there is constituted between the other person and myself a common ground: my thought and his are interwoven into a single fabric. Our perspectives merge into each other and we co-exist through a common world.'

(Merleau-Ponty 1962:413)

In the biographies in chapter four, the nurses often refer to their understanding of how difficult it is for their patients to manage their weight and refer to the many factors that

they, themselves, have identified as being issues for them, such as being breathless, exacerbating existing or provoking potential health conditions or having difficulties with mobility. They include their own experiences in their interactions with the overweight patients and refer to their own weaknesses and personal problems with weight management but also recognise that their patients often already have health problems with which the nurses (thankfully) cannot readily yet fully identify. It is not of paramount importance that the nurses understand fully all the differing experiences of their overweight patients in order to offer empathetic care, in the same way the nurses recognise that it is not necessary for a nurse to care empathetically for a patient with cancer, when they have not experienced this illness themselves. The nurses seem to have the ability to imagine being in their patient's situation without needing to have experienced exactly the same experiences and this demonstrates the complexity and skills required to manage this type of encounter and I argue that empathy is instead borne from *understanding*, of Other, rather than necessarily of direct experience. This is one reason that I consider this study has great significance for clinical practice; nurses who have never experienced being overweight may read this study, and the biographies in particular, and develop a deeper understanding of how it feels to be overweight and consequently develop greater empathy with their overweight patient. I agree with Galvin who states that the:

'empathic encounter between nurse and patient should not be simply based on commonality or sameness and the other person cannot be reduced to what one knows, defined by one's familiar ideas.'

(Galvin 2009:144)

Moreover, my study suggests that these nurses present practical examples of how they experience all three essential dimensions of openheartedness as articulated by Galvin & Todres' (2009b) theory: *'the infinity of otherness: keeping open the other's difference; embodiment: our shared vulnerable heritage; and practical responsiveness: embracing the value of the objectified gaze and technology.'* The findings suggest that the nurses generally respect both the similarities and the differences between themselves and their patient with regard to their weight management and, when they are empathetic, it is not based simply on commonality of experience; however empathy is not always immediately

present and sometimes the interaction with her patient requires the nurse to internalise her feelings before being outwardly caring. Conversely, whilst the nurses and patients inhabit their own overweight bodies, they may both experience objectification, and occasionally ridicule by others, which can lead to an 'embodied intertwining' and a shared sense of vulnerability. Lastly, the nurses in the study seem to be able to act with immediacy in their interactions and demonstrate practical responsiveness, particularly pertinent to the *being-with: holistic interacting* element of their interaction with the overweight patient which is discussed in a later section of this chapter.

The overweight nurse-patient interaction is complex to unravel. The nurses are subject to similar, or potentially worse, discrimination given their professional status, and so the fusion of horizons relies on more than knowing and understanding how each other feels about being overweight; I argue that, for the nurse in particular, it is the recognition and setting aside of their own prejudices, the messy and unexpected element of the interaction, that determines the level of sensitivity and empathy employed.

The nurses do work hard to gain an understanding of their patient and this is willingly undertaken by a conversation or a series of conversations as they get to know their patients, acknowledging their differences but recognising the similarities in experiences. This is in keeping with Gadamer who suggests that understanding is borne out of dialogue and that this leads to the fusion of horizons where 'to understand is to understand differently' (Gadamer 1976:302). The nurses spend time with their patients and feel that they need to know and understand them before making judgements about how to initiate dialogue about weight.

In a qualitative research study conducted by Ramos (1992) that explored nurse-patient relationships in a purposive sample of 15 nurses who were each interviewed twice, it was reported that the degree of intimacy between patient and nurse varied and that there were several types of levels of relationships. Most of the nurses reported a modified social relationship which required 'liking' each other as the stimulus for bonding but where the nurse retained 'control' and decided how much and what kind of information to share with patients. Some nurses sacrificed this 'control' to further the relationship with their patient but the nurses described this as less comfortable for the nurse and considered this

made them become 'too close and it was not in the best interest of their patients' (Ramos 1992:500-501). At this lower task-orientated level 'the instrumental level', the nurses claimed they felt 'hampered by their own emotional state, rather than experiencing a balance between cognitive and affective elements.' At the next level, 'the protective level with an emotional component', the nurses described balanced emotional and cognitive connection with the patient, manifested by an attempt by the nurses to understand the patient's position but were still nurse-dominated and unilateral in style (Ramos 1992: 502-503). Level three, entitled 'The reciprocal relationship with resolved control issues' is described by Ramos as moving beyond the other levels and where a mutual relationship emerged. Although not all the nurses in her study made the claim of moving to level three, the nurses who did described this as a process of evaluating the patient's situation from the patient's point of view and called this the 'very cornerstone of nursing care.' This study, which has a small sample size, does not examine the relationship between overweight nurse and patient specifically, but my study offers practical examples of nurse-patient relationships and the differing levels of intimacy as suggested by Ramos (1992).

The nurses additionally seem to set aside their concerns regarding their overt disregard of their own health education advice and their dissonance with being a poor role model and reach out towards the patient in a personal way. This is significant because the nurses in this study are very self conscious about their weight and feel judged by society both outside of work and by their colleagues in the workplace. They are in a position of potentially also having their own bodies judged by their patients, in particular their overweight patients with whom they are expected to raise the topic of being overweight. The experience of being a patient who is also a nurse offers these overweight nurses a unique opportunity to develop further empathetic Other understanding.

In order to further our understanding of how the nurses' experiences might relate to their patients, I compared the nurses' talk of their personal experiences of being overweight in chapter four, which is not confined to the clinical environment, to the literature that explores the experiences of those who are not necessarily in the role of a nurse but who are overweight.

Of particular interest was a qualitative study conducted by Williams (1997:18) in which a convenience sample of six nurses were interviewed about their experiences of being patients. The weight status of these nurses is not identified. One of the significant findings of this small study, which relates to my own study, is that these nurses also felt that their bodies were inferior and imperfect, 'viewing their own bodies with judgemental eyes'. This may suggest that the overweight nurse as a patient might suffer more discomfort than overweight patients who are not nurses as they may be regarded as poor role models and subject to the additional discrimination often faced by overweight patients. Williams claims that nurses, who had experienced being a patient, caused them to have increased levels of empathy with their own patients and a heightened sensitivity to the importance of patients' basic needs.

Other understanding derives in a phenomenological sense from intersubjectivity and Crossley (1996:32-33) posits that both Merleau-Ponty and Gadamer identify dialogue as a communication system which is *immediate* [my emphasis] and which both subsumes and is greater than the sum of the two speakers involved.' Merleau-Ponty, for example, claims that 'there is an intersubjective system that forms between body-subjects where they stand together in an I-Thou relation, their actions interlocking and engaging but without reflective awareness of either Self or Other' (Crossley 1996:32). It is therefore argued that Other understanding contributes to empathy. Rogers (1975:3 cited in Finlay 2005:273) describes empathy as 'entering the private world of the other ... being sensitive, moment to moment, to the changing felt meanings which flow in this other person'. In the biographies chapter four, I shared the nurses' stories and suggest that many elements may have resonance with their overweight patients and so the nurses may be better able to enter the private world of the Other, in this case, their patients.

In a qualitative study conducted by Thomas et al (2008:321) in-depth interviews were conducted with a purposive sample of 76 self-selected individuals, of whom 'most had struggled with their weight for most of their lives'. Almost all their participants had experienced stigma or discrimination in adulthood (n=72) and about half stated that they had been humiliated by health professionals because of their weight. Many of the participants had tried extreme dieting to lose weight and 80% said that they strongly

disliked the word *obesity* preferring to be called *fat* or *overweight*, which was in keeping with the findings of my study.

Also, in common with the participants in my own study, major lifestyle changes were suggested as significant triggers to weight gain and the authors identify in their study particular factors such as a transition to a more sedentary lifestyle, weight gain from pregnancy or ill health problems, particularly physical injury. Additionally factors such as access to convenience food, comfort eating, stress, poor dietary habits and hereditary disposition are mentioned as factors contributing to their being overweight.

The participants in Thomas et al's (2008:322) study also state that they have tried to lose weight on numerous occasions, had taken part in fad diets and in slimming clubs, with dieting having immense emotional effects on their lives. In particular, their participants had experienced comments from strangers on their weight, particularly when buying food or clothing and they felt that there was an emerging culture of blame directed towards obese people as professionals, not helped by policy makers' talk of the 'burden' of obesity.

Their participants developed a variety of strategies to deal with the discomfort of being overweight such as 'making fun of myself', 'switching off' or 'ignoring the discrimination'. Although not the direct focus of my study, this has significance for overweight nurses who are also patients, and developing strategies for dealing with the psychological discomfort of being physically exposed is very important. Williams (2001) agrees that nurses are very uncomfortable being patients who have to surrender to other health professionals and would prefer to avoid unnecessary scrutiny of their bodies. One of the nurses in my study admitted to subjecting herself to sunbed treatment in order to appear slimmer and to avoid the critical gaze of her surgeon. This affirms the findings of the studies conducted by Merrill & Grassley (2008:144) and Wright (1998) who also found that overweight women experienced inappropriate comments from their physicians about their weight, further diminishing their self esteem. Nonetheless, the overweight nurses in my study, who had experienced simultaneously being an overweight patient, felt that they had a good understanding of how it feels to be objectified, particularly on the operating table. This is particularly pertinent as overweight patients who feel objectified

and ridiculed will avoid seeking health care (Dobie 2005; Dunkley & Ward 2005; Yanovski 1998).

A study conducted by Carryer (2001:91) supports the findings of Thomas et al's study (2008). In Carryer's study (2001:91), over three years nine overweight women participated in five semi-structured interviews about their experiences of being overweight. They disclosed that they have been 'battling a body that would not stay small' and tried repeatedly dieting. They also 'avoided seeking health-related consultations for fear of criticism and had a strong sense of personal culpability for being overweight' (Carryer 2001:93). The theme of personal blame and shame is further found in Overgaard's (2002) study and is very common to the nurses in my own study. The nurses often talk of the shame of being overweight and irritation with themselves that they know what to do but do not take action to manage their weight, often using the term 'struggle' to convey their difficulties. The next element of the concept 'embodied empathy-in-action' to discuss is 'acknowledging-then-managing prejudice' as the nurses struggle with prejudicial feelings within the interaction with their overweight patient.

Acknowledging-then-managing prejudice

As Gadamer (1976) suggested I should be, I was genuinely surprised by some of my research findings. One of the most unexpected elements of this study was that some of the overweight nurses admitted how they did not always understand how patients could become overweight. Even though the nurses are also overweight there were some instances where they admitted to thinking about overweight patients in a potentially derogatory manner. In her second interview, Alison declared that she did think sometimes: 'How on earth did they get themselves in that state?' although this was tempered by her empathetic behaviour, demonstrated by the explanation of her need to 'try to put yourself in their situation ... everybody's individuals and they're overweight for different reasons.' Alison (2; 643-649). The nurses seemed to be very self aware of their own feelings and reactions to overweight patients. Galvin & Todres (2009a:314) suggest that 'researchers engaged in reflection of themes that communicate something of

the uniqueness of the individual's experiences, as well as the shared intersubjective horizons within which any unique experience occurs', can be assisted by 'poetic representation'. In this study, the term 'gentle hypocrisy' was employed to portray the embodied interpretation of the nurses' feelings; the nurses could occasionally be critical of overweight patients but simultaneously conscious that they could, themselves, be criticised in the same manner, possibly leading to a sense of interconnectedness and fusion of horizons which helped the nurses to resume the caring role. The nurses claimed to have resonance with the term 'gentle hypocrisy' as it helped to portray how they felt in the interaction with the overweight patient.

Goffman (1959/1990:168) discusses the 'treatment of the absent which is inconsistent with the face-to-face treatment provided to an audience'. Here he suggests that customers who are treated entirely respectfully during the performance are often ridiculed and criticised when performers are back stage. Dramaturgical loyalty (1959/1990:209) dictates that a team develops a sense of cohesion and a front before the audience to protect themselves. This is consistent with the findings of my own study and with studies such as Schwartz et al (2003) and Loomis (2001) appraised in chapter two, whose studies suggest that health professionals associate overweight people with stereotypes such as lazy, stupid and worthless.

It is vital to recognise that all nurses may be as subject to holding prejudices as those not in the profession, but nurses should also be aware that the Nursing and Midwifery Council's (NMC) standards of conduct, performance and ethics for nurses and midwives dictate that 'you must treat people as individuals and respect their dignity; you must not discriminate in any way against those in your care' (Nursing and Midwifery Council 2008:3). This has great implications for nursing practice as, in order to defeat prejudice and discrimination, there needs to be raised understanding of the issues faced by those who are overweight and who are fighting their own struggles with self esteem, health and/or appearance. My own study is significant in that it is an original study which offered overweight nurses an opportunity to voice their own experiences as a woman, as a nurse and sometimes also as a patient.

The nurses use reflexivity to help patients in the sense that they acknowledge their own experiences of difficulties in managing their weight and so have empathy with their overweight patients. Rungapadachy (2008:17) concurs that developing self awareness is important, as to understand others requires us to search within ourselves, the 'self', in this case, referring to all those descriptions that individuals ascribe to themselves.

Despite some holding prejudices towards overweight patients, the nurses in this study seemed to demonstrate self awareness and had considered their own feelings about patients who are overweight, also claiming to understand their overweight patients: 'It's just difficult – I think my clients are in quite a difficult situation' (Erin 1:293-4). Beatrice (1:92), also, for example, explains that she understands how difficult it is for overweight patients to manage their weight and Alison (2:608-610) talks about her need to examine 'your own attitudes or prejudices or judgements about people who are big'. They also understand the dilemma of needing, for health reasons, to manage their weight, but that reality does not always meet expectations and that there is a need 'to do something about it in my own time' (Frances 2:775). These perceptions of the challenges faced by both the nurses and their patients for weight management lead the nurses to a more holistic, and perhaps *self and Other-forgiving* approach in their interactions with their overweight patients.

Being-with: holistic interacting

In this section I discuss how empathetic acuity manifests in the sensitive communication strategies adopted by these nurses in their interactions and how they move towards their patients in an effort to merge their horizons, not necessarily based upon consensus, but to develop a sense of interconnectedness, intersubjectivity, and mutual trust. Gadamer's hermeneutics of empathy proposes that we understand 'through our effective history, with an aim to reach mutual understanding through a fusion of horizons' (Langdrige 2007:50).

I feel that it is sensible to revisit the phenomenological concept of intersubjectivity at this point of the thesis as the discussion of sensitive communication is underpinned by this concept. Intersubjectivity is described in the Oxford Dictionary of Philosophy as: ‘an intersubjective property is one on which the opinion of different subjects does or can coincide’ (Blackburn 1994:197). Holloway (2005:293) summarises intersubjectivity as ‘a process in which human beings share meanings and assumptions with each other and is a reciprocity of perspective between people.’ However, these definitions do not entirely explain the varying complexities of this concept for this thesis. There are several competing definitions of intersubjectivity, such as those proposed by Merleau-Ponty and Gadamer who identify intersubjectivity ‘as a communicative system which is immediate and which both subsumes and is greater than the sum of the two speakers involved’ (Crossley 1996:33). Merleau-Ponty (1962:406-407), for example, claims that two people stand together in an ‘I-Thou’ relation and their actions intertwine but without reflective awareness of either Self or Other. Gadamer (1976:387) generally describes intersubjectivity as a ‘fusion of horizons’ which is reached through dialogue and he describes conversation as:

‘coming to an understanding and that each person opens himself to the other, truly accepting his point of view as valid and transposing himself into the other to such an extent that he understands not the particular individual but what he says... (to be) at one with each other on the subject.’

I regard intersubjectivity as an intertwining of understandings (rather than consensus). It is further complicated as a concept when embodiment is also considered so I offer a brief explanation of my understanding of this concept in relation to my study.

This thesis is underpinned by existential concepts of embodiment which refers to ‘the phenomenological fact that we are always bodily in the world’ (Van Manen 1990:103). In other words, our bodies are our vehicle for being in the world. However, we are not alone in the world and in order to understand ourselves and others we interact using language which is situated in our historicity and temporality (Gadamer 1975) and by using our perceptions (Merleau-Ponty 1962) and/or our embodied ‘felt senses’ (Gendlin 1992; Finlay 2005/2006; Todres 2008; Galvin 2009).

Finlay (2005:271) describes embodied intersubjectivity as having three layers: 'connecting and tuning in with embodied reactions; acting into which focuses on empathy and intertwining; and merging with which is a reciprocal insertion and intertwining where self understanding and other-understanding unite.' Gendlin (1992:3) suggests that 'interaction... is the body's way of living its situation' and he further argues that humans have a 'felt sense', that is, [having] a very distinct feeling that has not yet opened to reveal what it contains (Gendlin 1996:19). Todres explains this as 'sense-making requiring a knowing with the body, as it is the lived body that connects language to the world of experience' (Todres 2008:1570).

In summary, my definition of embodied intersubjectivity is drawn from these authors and, for the purposes of this thesis, lies in the understanding and interconnectedness of our self and others, achieved through dialogic means, but which is inseparable from our felt bodily senses and empathetic perceptions.

Returning to my study, when the body is ill or does not conform to social norms it might affect the person's self esteem or sense of well-being. The nurses in this study understand some of the difficulties likely to be experienced by their overweight patients and they may well have experienced some similar situations and feelings. The nurses often feel judged both in their personal and professional lives and so have an understanding that their patients may also feel judged and sensitive to comments or suggestions about weight management, particularly if weight management was not the original purpose of the patient's visit.

The literature reviewed in the second chapter of this thesis contends that patients often feel discriminated against and that sometimes this will lead to health care avoidance. The nurses adopt strategies for non-judgemental, respectful, empathetic and sensitive communication, described by one of the nurses as 'walking on eggshells', in an attempt to reduce the discomfort felt by the patient. There are some common strategies mentioned by the nurses used to initiate the dialogue with their patient and to '*go where they are*'.

The nurses sometimes refer to their own weight, often in a self-deprecating humorous way to help to ease the tension of the conversation. They also indicate to the patient that

their own weight problems can help them to understand what they also experience: 'You only have to look at me to know I understand' (Hannah 1:211-2)

The nurses also seem to instinctively understand when a conversation may not be welcomed, particularly if their patients tell them of previous or recent insensitive approaches made by health professionals.

An important element of their empathetic nature was their ability to listen for cues and to hear if there is a way to initiate the topic of weight management that would cause least offence and then to act immediately upon this. If cues are not forthcoming then the nurses adopt a different approach and they refer to situations where they might retreat to the use of a formal universally used-questionnaire such as the 'Field of Words'. Another tactic, if cues are not forthcoming, was to introduce the topic by identifying a specific element of being overweight such as the patient being out of breath.

The timing of the conversation was also featured as an important element of the interaction; sometimes weight would not be mentioned at all on a single visit if it was felt to be unwelcome and saved for another day. It might also simply be left until later in the interaction when mutual trust had developed through other dialogue.

The sense of interconnectedness underpins the nurse-patient interaction and the dialogue itself is only one part of this complicated process. The knowledge base from which the nurses in this study draw is also complex and does not seem to be reliant on, or limited to, the use of theoretical knowledge and they seem to lean more towards the use of both experiential knowledge of being overweight and personal knowledge of the patient when initiating the topic of weight. The nurses also frequently talk about how being overweight actually provides an advantage in many situations as they consider that the patient might feel that they have a greater embodied understanding of their situation. This heightened level of understanding is suggested by other researchers, who have studied the lived experiences of overweight patients, as being of prime importance in these patients' care in order to avoid stigma and to promote excellence in nursing care (Merrill & Grassley 2008; Thomas et al 2008).

The nurses in this study do indeed seem to apply a complex blend of different types of knowledge to help them in their interactions with overweight patients and conform to Carper's theory that the nurse in therapeutic use of self 'rejects approaching the patient-client as an object and strives instead to actualize an authentic personal relationship between two persons' (Carper 1978:251). They often talk of the need to know the patient fairly well before approaching them and, when reflecting on specific interactions with specific patients, will reveal a depth of knowledge of their patients' personal circumstances, often relating it to their own circumstances or being sympathetic to the differences.

Carper (1978) proposes that there are four interrelated fundamental patterns of knowing in nursing practice: factual knowledge, experiential methods, personal knowledge or knowledge of self and ethical knowledge. However, the data suggest that these nurses are less inclined to use theoretical knowledge than experiential knowledge to help them in their interactions - or to use theoretical knowledge in conjunction with experiential knowledge, which seems to be the most frequently used basis for their conversations, even though there is sometimes a 'professional' reluctance to do this. Despite this, patients view 'empathy as a prerequisite of good nursing practice' (McCabe 2004:46) and 'professional socialisation encourages nurses to lose their individuality and results in task-centred communication, rather than patient-centred communication' (Gould 1990, cited in McCabe 2004).

The medical model generally relies on the evidence-based type of knowledge and task-centred communication that is intended to lead to behaviour change. Rolfe (2002:3) argues that 'evidence based practice is an illusion and that nursing is subject to competing discourses'. Within nursing, Rolfe (2002:3) suggests that 'the dominant discourse is based upon rigorous and systematic enquiry, such as the 'gold standard' randomised controlled trials, that lead to 'generalisable contributions to knowledge' (Department of Health 1999). Rolfe is concerned that the adoption of evidence based practice, considered to be the 'integration of nursing research evidence with clinical expertise, the resources available and the views of the patients (Thompson 1998 cited in Rolfe 2002:3) is

demeaning the use of small scale qualitative research studies', such as my own, and that 'evidence should be based on reflection rather than research' (Rolfe 1999:433).

Rolfe reasons:

'the shift in importance from research-based knowledge to experiential knowledge and praxis, is that the status of nursing practice ... and the clinical nurse is elevated in accordance with her new role as researcher and generator of theory. She no longer applies theories dictated by educationalists and researchers; she is an educationalist and researcher.' (Rolfe 1996:43)

Rolfe's argument may also have resonance for the nurses in this study who seem to have a strong inclination towards the use of their own experiences and personal knowledge of their patient in their interactions with the latter - rather than rely entirely on theoretical knowledge, based on evidence and causal relationships.

While Benner (1984:294) argues that 'experience is gained when theoretical knowledge is refined, challenged or disconfirmed by actual clinical evidence that enhances or runs counter to the theoretical understanding', Galvin & Todres (2009b:142) claim that the humanisation of caring is as important as scientifically-based care, reasoning 'nursing open-mindedness and open-heartedness', dominated by three factors that intertwine: 'being there for otherness, embodiment and practical responsiveness', are also important concepts to consider. Todres (2004:44) describes embodying as '*where being and knowing meet*' and proposes the concept of embodied relational understanding.

The concept of *embodied empathy-in-action* adds to these authors' concepts as it demonstrates how *being, understanding (of self and Others)* and *doing* can combine in nursing practice, and should particularly resonate with Todres (2008:1569) who has a quest for 'something larger than knowledge and evidence'. Galvin & Todres (2007:146) refer to 'Gendlin's consideration of the importance of a kind of understanding that brings together head, hands and heart (understanding, application and feeling), which is particularly relevant to the notion of practical wisdom (phronesis)'. Furthermore, Newman et al (1991) argue that nurses require an open heart to the 'unconditional acceptance of the whole'. I offer an example of praxis in this research study, that is,

where the nurse lives the theory in practice (Freshwater 2002:151) and I assert that embodied empathy-in-action brings together head, hands and heart.

The spontaneity of embodied empathy-in-action also proposes resonance with a '*thinking-in-action*' approach which encompasses feelings, emotions and senses' (Uhrenfeldt 2007:388) and is consistent with Merleau-Ponty and Gadamer who identify dialogue as a communication system which is *immediate*.

This pluralistic approach to nursing care is in opposition to models such as the 'nursing process' and other earlier models of nursing whereby 'the emphasis was on scientific processes that relied on a positivist perspective consistent with Cartesian duality in order to identify nursing priorities and interventions.' It is argued that 'only from a relativist stance is it possible to understand the notion of human connection' (Pierson 1998:294-295). Pierson (1998:300) also suggests that:

'active engagement does not require nurses to intertwine with clients so closely that autonomy of each is breached, rather that active engagement of participants within an intersubjective process honours the space between individuals by allowing leeway for all individuals in the relationship to express and feel their own experiences.'
(Pierson 1998:300)

The nurses in this study employ *embodied empathy-in-action* and this blended approach to the interaction with overweight patients may be unique to these nurses but it may also have meaning when investigating the interaction between, for example, a nurse who smokes but who offers smoking cessation advice. In short, embodied empathy-in-action *is* where 'experience, understanding and doing' meet.

Overweight patients are usually expected to subject themselves to diets and exercise programmes deriving from theoretical knowledge bases to lose weight but there may be a lack of understanding as to why the patient gained weight initially or why there is difficulty in managing their weight. A holistic nursing approach towards the patient may be far more effective as the usual public health approaches do not seem to be effective (Renchal et al 2008). The nurses in this study seem to understand that diets do not work: 'I've never known anybody lose weight and lose it forever' (Catherine 2:1065-1066), and that this applies to their patients equally as it does for themselves. In keeping with

Gendlin's (1992a:341-353) theory, these nurses use their own bodies, feelings, experiences and emotions to interact, empathise and connect with their patients in their interactions, whether consciously or otherwise. This study offers examples of embodied empathy-in-action.

Summary

In this chapter I have discussed how nurses manage their inner feelings as they interact with their overweight patients. The nurses experience dissonance, feelings of guilt and hypocrisy as they struggle to be a good role model to their overweight patients. Nonetheless, their empathy for patients who also struggle to manage their weight seems to outweigh their need for dissonance reduction or for discriminating against overweight patients. In addition to the phenomenological life-world's requirements for spatiality, temporality and embodiment is the need for intersubjectivity, that is, the relationship between people. These nurses, despite any dissonance they experience, rarely avoid the sensitive conversation with patients about their weight and draw on different types of knowledge along with their own experiences in their interactions. Furthermore, the nurses use their own embodied experiences to enhance their interaction with their overweight patient and intertwine their own experiences and understandings of being overweight with those of the patient forming a nurse-patient sense of interconnectedness.

This chapter has also explored and described how overweight nurses in this study manage their interactions with their overweight patients and, finally, it has offered insights from this study to other nurses and health professionals, whether overweight or not, into these nurses' experiences of being overweight. I have offered original contributions to both nursing practice and knowledge by offering new insights into overweight nurses' experiences and I have proposed a new concept that describes their interactions with overweight patients: *embodied-empathy-in-action*.

In the next chapter I reflect on the process of undertaking the study, writing the thesis and I also consider researcher reflexivity, my influences on the research study both as having experience of being an overweight woman and as a researching health professional.

CHAPTER 7: RESEARCHER REFLECTIONS AND REFLEXIVITY

Introduction

'...knowledge does not end with moments of connectedness, understanding and meaning. Such journeys open vistas to new journeys for uncovering meaning, truth and essence – journeys within journeys, within journeys... this is the beauty of knowledge and discovery. It keeps us forever awake, alive, and connected with what is and with what matters in life.'

(Moustakas 1994:65)

In this chapter I reflect on the process of undertaking this study and the impact and influences that this study has imposed on my participants and myself. Undertaking the Professional Doctorate in Nursing has been a challenging and sometimes frustrating experience but this has been offset by the highest sense of personal achievement and self-actualisation, simply for completing this study.

This chapter also discusses issues of researcher reflexivity and embodiment. Reflexivity is described as being 'examining and uncovering the researcher's place in the research process' (Holloway 2005:295). There are ways that the researcher can affect the research study, some are more overt than others. In this chapter I specifically explore some of the ways that I could have impacted on the study, perhaps because of my professional role or because of my own body shape and size. My body shape was very similar to most of the participants, although they may have noticed from afar that I had gained a considerable amount of weight over the previous year, which I consider to be caused by my overeating as a response to the stress of organisational change and uncertainty about my career.

Effect of researcher on the participants

At the time of the second round of interviews my post of Health Promotion Manager had been made redundant and I had just moved to a new role of Public Health Programme Manager, responsible for population based screening. However, I was still known to the participants in a professional capacity as a Health Promotion Manager as that had been my role for several years and was the role I inhabited when I recruited to the study. The

awareness of my long history of my role in health promotion, which did overtly affect at least one of the participants, Hannah, who was only one of two participants known to me professionally prior to the study:

Hannah: ... *I felt uncomfortable discussing my thoughts on health promotion afterwards because of you, because of your role.*

Researcher: Interesting... oh, okay. Which it isn't now, I'm now 'screening'.

Hannah: *I know, but I know you know. So I did write down afterwards... actually that made me feel quite uncomfortable, sort of felt slightly defensive because I know you know, so I couldn't, you know, um...*

Researcher: So did you feel defensive in the interview enough to not say everything you really wanted so say?

Hannah: *No, I think I kept it very flippant. Well, I know I did, having read the transaction - transcript, rather, that I didn't, um, no, not on a personal nature, but just on a professional nature, I felt quite defensive because I felt like I was being put on the spot a bit, a bit, not... in the nicest possible way, but I just thought I would write that down so you would know that I felt that.*

Researcher: No, I understand, and you understand that I'm not judging you in any way, this is purely for this [research study] and it won't obviously... it's all confidential.

Hannah: *Um, what else did I put? Oh that I didn't, having read the [transcript], you know, I felt I should have been more professional because we did have a laugh etc. It was very informal, um and then just about having read the transcript, an incoherent ramble, which is what I wrote. (laughter)*

Researcher: I think most people that read their transcripts... [feel like that].

In Engelsrud's study (2005:274-5) a similar situation arose when the researcher handed her participant, Edith, her transcript to read and she handed it back almost immediately, in tears, saying 'This is not what I want, there are all kinds of mistakes here, I sound like...like...' The researcher describes her bodily response as feeling ashamed and this is something that I can identify with in this situation. In my field notes from the second interview with Hannah I noted:

Participant quieter and more reflective; her notes talk about defensiveness in her previous discussion of weight. I felt uncomfortable when she said she felt defensive of her health education/practice (because of my role) in our previous discussions.
(McGreevy 2007a)

Similarly to Engelsrud, I was concerned that I had also ‘subjected the informant (sic) to an emotional pressure whereby they feel compromised’ (Engelsrud 2005:275-6). I was relieved when Hannah did not react in a way with which I felt I could not cope as a researcher but it taught me a lesson in that, whilst I was busy gathering my data, it was easy to forget that I could be simultaneously affecting my participants on an emotional level. Most participants are not familiar with seeing their words as transcripts or converted into academic text, so they may be left feeling very uncomfortable at feeling seemingly inarticulate (Forbat & Henderson 2005; Engelsrud 2005).

This was not the only effect of the research study, or of me, in my role of researcher on the participants in this study. In the following examples of extracts from the transcripts, some participants admit that the study and my involvement would have affected them in differing ways:

Erin: Well, since I've spoken to you I've just realised that um, actually my weight is probably affecting me more than I thought, um, because it was interesting just having some time to focus on you and, you know, your issues, which you don't really get. So um, yes, it's affected me, I've dropped down my hours at work and I started to exercise and um, started to eat a bit more healthily, not all the time, but just, you know, making an effort now really, so yes, it has affected me.

Researcher: That's interesting. So do you think it's quite 'a positive'?

Erin: Mmm, definitely.

Researcher: Sorry, that was a very leading question. (Erin 2:560-571)

In this situation, I was initially startled when Erin told me that I had made her think about how her weight affected her now more than before the research study began. It was only later when I read Finlay (2002b) that I was reassured, as a researcher, that the ‘phenomenological task’ was to ‘capture a more holistic sense of her unreflective lived existence’ and that I had actually probably achieved this. By Erin's admission that she

had only thought about her weight in this depth since the first interview suggests that, initially at least, I was exploring her experience of her life-world as she lived it.

However, my reaction to her in this interview was inappropriate as a researcher and I immediately wanted her to reassure me that the outcomes were positive – and then almost as instantaneously realised that I should not have led her to give me the response I desired that would make me feel more emotionally comfortable. I have considered since that I could have discussed with her further the effect of the research on her own feelings and experiences and reiterated my offer of further support, perhaps by way of referral to counselling, if she felt this was appropriate and welcome.

My feelings of discomfort were compounded by the fact that the first interview with Erin had already left me feeling very troubled. In this extract from my research field notes I explain how badly I felt that the first interview had gone:

This interview was a challenge for me as I had just heard that I had been unsuccessful in my application for an internal post in the PCT reconfiguration – one step closer to being possibly made redundant. This weighed heavily on my mind and I was really not in the mood to conduct this interview. I think this is reflected in the interview and I feel very guilty that I did not feel I did my best in it to ask the questions I perhaps should have. It was a much shorter interview than previous ones and I asked her if she would be happy to be re-interviewed. Happily for me, she was very agreeable to this idea and she seemed also very keen on the notebook idea, saying that she would use this as a diary, sharing with me her thoughts next time. She had come to me to be interviewed in her annual leave, which compounded my sense of guilt.

I feel it was unprofessional of me and this will be borne out in the transcript. I asked leading questions; I didn't follow up on questions enough and I forgot to ask some altogether. The interview was 'clunky' and I am almost ashamed of it. It is not what a professional who is researching should do and it really confirms for me the sense that you cannot separate the personal from the professional at times no matter how hard you try. It doesn't help the sense of guilt though.

The participant was the first of the participants so far to mention the fact that she had suffered an eating disorder – another factor that compounds my guilt. I understand that this is not a therapeutic interview but I feel that I did very little to reciprocate her efforts to help me. She looked a little tearful at times. I did not explore this in the interview as it felt inappropriate and abusive and when the

recorder was turned off she told me what was troubling her. For reasons of confidentiality I will take what she told me to the grave but I feel humbled and blessed to be trusted by this brave woman.

Selfishly I am also thankful that what she told me would have little resonance for my research or I would have felt that possibly I should have asked for it to be included in the data – thankfully this was not an issue and if it happens again I would still put the needs of the participant ahead of my research data. I am still trying to work out how I ‘knew’ that something was bothering her which was not necessarily to do with the research subject. There is something I sometimes recognise about someone who has battled with similar issues to me that does not need to be overtly stated. I cannot put my finger on what it is.

She did talk more readily also, however, about issues concerning her overweight once the recorder was switched off and I wondered if it was because we had talked honestly after the interview had ended, sharing some of our life history. This seemed to begin to develop a rapport that was not there at first as we had never met before the interview. She had come to me through word of mouth and contacted me by phone so I spent some time prior to the interview discussing the consent aspects and the participant information sheet. This really placed me in the position of ‘researcher’ rather than ‘colleague/friend’ and so the interview content may have been guarded until I had shared with her personal aspects of my own life...

(McGreevy 2007b)

After my second interview with Erin I noted that I was “very much more comfortable and I did connect [with her]. I felt quite maternal towards her [and] sad that I won’t see her again but have agreed to stay in touch re findings.”

(McGreevy 2007c)

This was not the only time that my study seemed to affect participants. In these extracts from the transcripts Alison explains how it affected her:

Alison: It has me think about when I’m dealing with people talking to them about losing weight um, perhaps um, do understand more about how they feel really. I don’t think it’s really changed me as a woman. I’m still fed up that I’m overweight, fed up that I think about it all the time and really I’m sure that there’s other things that I should be thinking about. (laughter)

Researcher: Has it changed your practice at all?

Alison: *Um, no, made me think, hasn't changed that much, made me think about it more.*

Researcher: Yes, in what way?

Alison: *I suppose it has, um, it just makes, it's just made me think about how they must perceive how I am may be more what they're thinking more of, but I'm sure they don't take that much notice of me, you know, who is the very overweight people just, they see themselves as huge and they probably see me as slim. They probably, that's how they see themselves.*

(Alison 2:892-909)

Reflections on writing

It seems to me that there several challenges when writing about the context of your research when you are a Professional Doctorate student. As a student, I am required to reflect upon a problem in practice, converting it into a viable research question. One of the challenges presented by writing about context lies with its temporality, particularly at a time of monumental change in the NHS. The dynamic nature of the health service environment in which I work means that whatever I write today will probably be obsolete by the time of reading, or at least unrepresentative of the situation as it was at the time of writing.

Another challenge is about 'writing myself' (Rolfe 1997). Having previously written three assignments that explore the context and nature of the problem in practice, it would seem, on a superficial level, to be undemanding to revisit what has been previously rewritten, rework it and present it as part of the final thesis. However, I find it hard to recognise my own words on the pages. This, apparently, is not a phenomenon peculiar to myself as Rolfe (1997:443) describes the act of writing as 'a meteorite falling', that is, 'once a text is written, it travels far from the body', and he refers to Virginia Woolf (1978) who said that 'the self who writes is different from the self who later reads what is written.'

The act of physically writing such a huge tome is less daunting than the one of exposing my thoughts and deliberations to the reader, who might read what I write now, long into the future. I sometimes find it difficult to organise my thoughts and

find Rolfe's words comforting when he refers to Van Manen's reflective cognitive stance where 'to write is to measure our thoughtfulness...writing teaches us what we know, and in what way we know what we know.' (Van Manen 1990:127).

With deference to T S Eliot (1945), I acknowledge that sometimes '*what we call the beginning is often the end and to make an end is to make a beginning. The end is where we start from.*' So, I am writing what I 'know' today, aware that the next time this document is read, I, and the world, will probably have moved on. My thinking and perspectives constantly evolved during the research process (and continue to do so) as Gadamer suggested they would, particularly in terms of context and historicity. I came across this quotation from a philosopher from ancient Greece and his words had much resonance for this dynamic world view:

You could not step twice into the same river; for other waters are ever flowing on to you'

Heraclitus, Greek Philosopher (c.535BC-475BC)

Integrating new literature in the discussion chapter

I was troubled about the structure of the thesis and in, particular, where to introduce new literature in the discussion section. For a phenomenological study it is regarded as 'reasonable to define the study in a preliminary literature review which does not presuppose the outcome' (Streubert & Carpenter 1995). This type of study does not ground itself in the literature prior to the research and instead remains theoretically naive, limiting the initial literature searches to establishing the importance of a study (Creswell 2003:29-30). This presents its own challenges when writing the discussion chapter as it is important to foreground your own literature (Murray 2006) whilst also being mindful that firstly, the theoretical frameworks, in which the discussion of the study might be contextualised, have not yet been introduced and secondly, that the literature and other studies with which the study's findings might be compared, have not yet been critically appraised or introduced to the reader. Consequently, in an endeavour to assist the

flow of reading, I decided to reflect on the process of choosing the frameworks in which I situated my findings, within the discussion chapter itself.

Embodied co-understandings

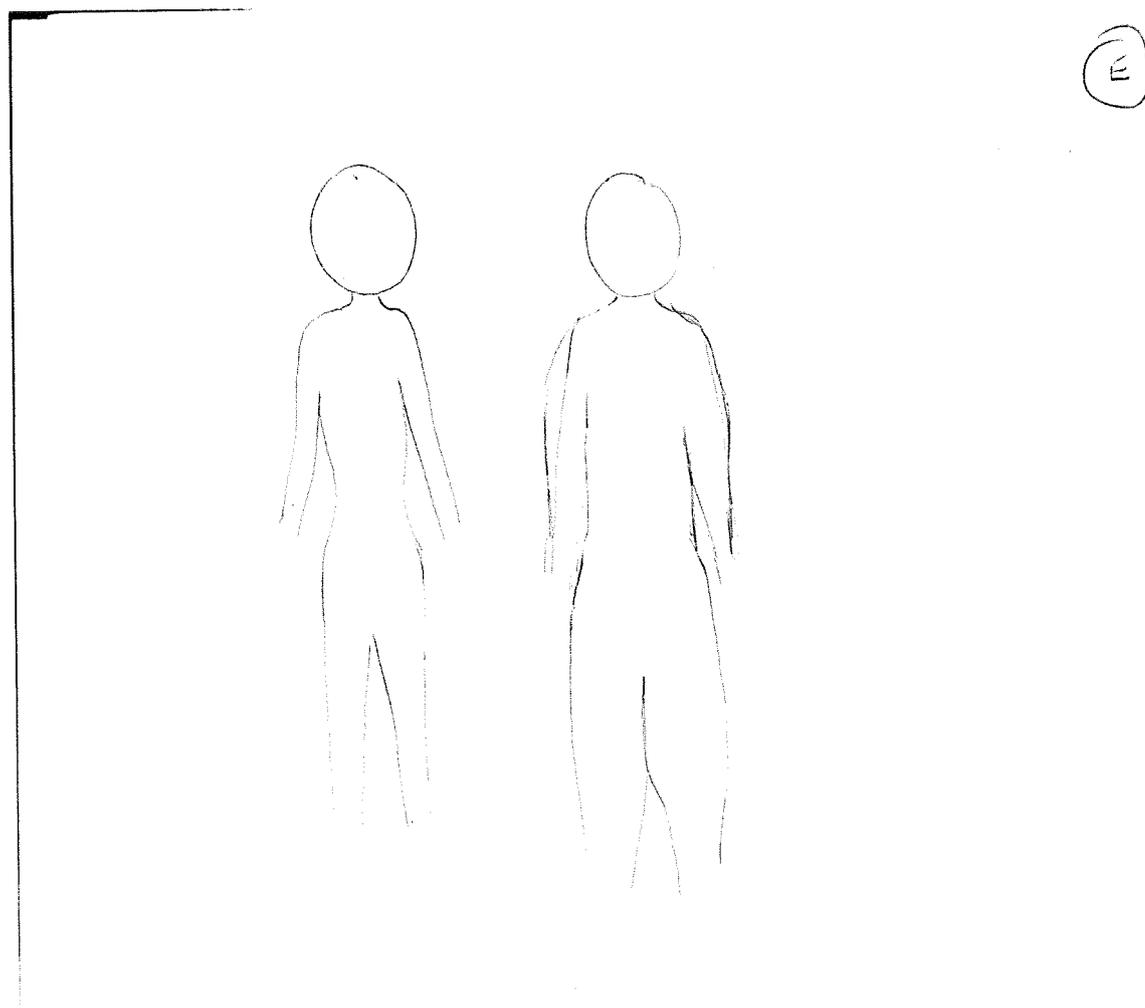
The topic of this phenomenological research study is that of 'being overweight' and it was appropriate, therefore, to consider embodiment and how the nurses viewed their bodies as part of the research process. During the interviews, I asked the participants about their thoughts on their own bodies and asked them to draw themselves and how they saw people of 'normal' weight in comparison. Although the drawings are not included as part of the data (and some participants claimed to be unable to draw) it offered me an opportunity to explore their thoughts on their own bodies, perhaps in a less self-conscious way as they were in the act of drawing. Their spoken thoughts, as they are drawing, are included in the biography chapter (Figure 4). This representation of herself in comparison with someone of normal weight is very similar to the others' drawings from the study.

Embodied empathy was a significant feature when I offered participants an opportunity to ask me questions in a relatively naive attempt to balance the researcher-participant power base. Earlier I had discussed with Frances the 'mouth feel' of food (Frances 2: 935-959)

Researcher: Interesting[ly] some nurses if they were presented with choices they would still choose the less healthy food, what do you think about that?

Frances: *Oh, it's so much yummier, isn't it though? (laughter) If you really think about it, it's like when you go on a diet don't you, don't you feel that you really want to eat something that you can put in your mouth and just chew...and it's not the same as fruit, is it? (laughter)*

Figure 4. Erin's drawing of herself (on right) and someone she sees of 'normal weight' (on left)



Researcher: Do you know I had this conversation with someone the other day and it is exactly that, it's when you've been dieting for a while you miss the kind of the mouth feel of carbohydrates, cakes and biscuits because you don't get that and yet, after about a year, I ate a biscuit, I hadn't eaten one for about a year, and all I could taste was salt and fat.

Frances: *I can appreciate that. I can totally appreciate that.*

Researcher: So dominating, the flavour, but it is that sort of munchiness because you're right, fruit and veg just don't cut it, do they really? I eat masses of them but I long for doughnuts.

Frances: *Yes, it's that, it's that bite isn't it?*

Researcher: I wonder what it is, do you think it's comfort or pleasure or...?

Frances: *Um, it's definitely pleasurable...*

This extract is taken from the second interview with Frances and comes quite late in the conversation when it seemed even more relaxed:

Researcher: Is there anything you would like to ask me about my own experiences of weight and being an overweight nurse? You don't have to, but it's just I want to give people the opportunity to ask me the really difficult questions (laughter), I feel I've been there and asked you that!

Frances: *No, you don't have to, no that's fine, no, that's absolutely fine. How do you feel about being overweight then and doing this [study]? Sorry you might not feel that you are!*

Researcher: No, I am. I've put on three stone since Christmas. Actually what's really interesting was when I thought about doing this I'd actually lost an awful lot of weight and, I don't know, I could actually play the psychology card and say 'of course I couldn't do this research unless I had empathy with my participants, therefore the only reason I've put all this weight on is so that I can do this research', which, of course, is absolute nonsense, but actually I do wonder how comfortable I would have felt, because I hadn't met a lot of my participants ever before, if I'd have sat here being 9 ½ - 10 stone, whether I would have had the same responses from...

Frances: *Mmm. That's a good point.*

Researcher: Because I think I'm the same age as most of my participants and I'm a similar weight to most of my participants

Frances: *The thing is, I can sort of talk to you because you are the same as me. You understand about the 'crunch pangs!'* (Frances 2:1466-1467)

It was at this point that we laughed in unison as we mimicked eating crunchy food and I felt that my own bodily experiences were merging with those of Frances, what Finlay refers to as 'entangled selves' (Finlay 2009:17), assisting the research process. Finlay describes reflexivity in research terms as being:

...thoughtful, self aware analysis of the intersubjective dynamics between researcher and researched. Reflexivity requires critical self reflection of the ways in which researchers' social background, assumptions, positioning and behaviour impact on the research process. (Finlay & Gough 2003:ix)

Finlay also discusses 'the body's disclosure in phenomenological research' and describes this as being '*bodily empathy*' that is to be especially attentive to participants' expressive bodily gestures; '*embodied self awareness*' that is to 'reflect on how we [researchers] are being affected at a bodily level by the research; and '*embodied intersubjectivity*' that is a 'reciprocal intentionality that inhabits both the participant's body and that of the researcher' (Finlay 2006:19-30). Finlay (2002b:5) describes this as being 'intertwined with my participant [so much that] I can no longer separate the pieces.'

Finlay (2006:26) refers to Merleau-Ponty (1945/1962:215) who argues that:

'The communication or comprehension of gestures comes about through the reciprocity of my intentions and gestures of others, of my gestures and intentions discernable in the conduct of other people. It is as if the other person's intention inhabited my body and mine his.'

There is an example of this in my own study as the term '*gentle hypocrisy*' arose when the nurses and I discussed the dissonance they felt as they inhabited bodies that were overtly not adhering to the same advice they were providing to overweight patients. I cannot find the term in the first set of transcripts of the nurses although it may have arisen as a conversation either side of the recorded interview. I cannot remember who said it first and Finlay (2002b) recognises this as a feature of phenomenological intersubjectivity where data is co-created. I used the term in the second interviews to underpin part of the

discussion of the nurses' feelings of being overweight in a situation where they might be regarded as a role model. The nurses seemed to find resonance with the term as it offered increased understanding of how they felt. In the methodology chapter I discussed the potential problems of going beyond the data and quoted Dreyfus (1991, cited in Benner 1994: xviii) who claims that the researcher interpretation is authentic if participants say 'you have put into words what I have always known, but did not have the words to express.' In this study, I felt the term 'gentle hypocrisy' was a helpful term that summarised the caring nature of the nurses but also conveyed the dissonance:

'Mmm... It is a 'gentle hypocrisy' and that's what causes that tension about you know, and it, it... That's a lovely way of putting it because it is, it is, you know? How could I possibly give you advice if I'm big?' (Frances 2:800-804)

Whereas Finlay (2006) focuses her attention on the intersubjectivity between researcher and participant, Todres (2008:1566) further proposes the concept '*embodied relational understanding*' that refers to 'a more intimate relationship between the findings of qualitative research and the practice of care in health-related contexts'. The link for me as a researcher between these authors is the concept of intersubjectivity, both between researcher and the participant but I have adapted these concepts to explore the space between the overweight nurse and their overweight patient through the experiences of the nurse. If I were to conduct the study again, I would consider also researching the lived experiences of the overweight patient in their interactions with overweight nurses, not for reasons of validation, but for enriching the data and deepening our understanding of patients' feelings and what happens in the 'intertwining' (Merleau-Ponty 1945/1962) between patient and nurse.

Reflections on the research methods

“Faith is taking the first step even when you don't see the whole staircase.”

Martin Luther King (1929-1968)

I felt that, initially, I needed to investigate my epistemological stance in view of the research question. Mason (2002:16) outlines a framework for exploring what can be regarded as knowledge and how this knowledge can be demonstrated. I soon came to the realisation, though, that, although I held an epistemological position, I could not readily articulate either that or my ontological stance until I had investigated the methods I wanted to use for my research and align them with the theory that is proposed by many different authors regarding the phenomenological approach. This became a problem as many of the authors argue with each other and, again, I had to come to terms with the fact that there is no absolute truth; looking for *solutions* in theoretical texts was largely unhelpful. To learn as much as possible meant skimming the surface of the works of a large numbers of authors; this was an iterative process and I had to revisit many texts more thoroughly to help me understand better their meaning, having read other texts in the meantime. After some time I realised that I needed to make a brave personal decision about what best fitted my research question and settled on the methodology and methods previously outlined in the thesis.

There was another matter that troubled me which was that of sensitivity, for two main reasons: the topic matter which can be contentious (Brannen 1988) and that, when writing up about a small number of participants, there is a need to acknowledge that they may recognise themselves in the final thesis and experience some discomfort at this (Hoskins & Stolz 2005). This, I felt was largely counteracted by involvement by the participants in the early interpretive and analytical stages, when they were offered two opportunities to remark upon their transcripts and ethical procedures were followed by requesting consent at each stage of the research process.

Summary

In this chapter I have reflected on conducting the study and writing the thesis. I have also described some of the possible influences I imposed upon my participants and the findings of my study, in my role as a researcher. In the next and the final chapter, I affirm how I have met the aims and objectives of the study, offering a summary of the significant elements and findings of my study. I also discuss my previous and proposed methods of dissemination of my findings. Finally, I make explicit how this study makes an original contribution to nursing knowledge relating to practice.

CHAPTER 8: CONCLUSIONS

Introduction

In this final chapter, I reflect upon and confirm how I have met the aim and objectives of the study, offering summaries of the findings and the implications of my study for nursing knowledge and practice. I also make suggestions for further research and discuss my previous and proposed methods of dissemination of my findings. Finally, I make explicit throughout this chapter how this study makes an original contribution to nursing knowledge relating to practice.

Achieving the aims and objectives of the study

I set out in this study to use a hermeneutical approach to gain a deeper understanding of overweight nurses' experiences of their interaction with overweight patients.

My research objectives were:

1. To explore and describe how overweight nurses in this study manage their self in the interaction with the overweight patient;
2. To explore and describe how overweight nurses in this study manage the interaction with overweight patients; and
3. To offer insights from this study to other nurses and other health professionals, whether overweight or not, into these nurses' experiences of being overweight.

In the next section I summarise how I have met the objectives of this study.

Conclusions

The findings of this study cannot be generalised but they aim to deepen our understanding of how overweight nurses manage their self in their interactions with the overweight patient and also how they manage the interaction itself.

The government is concerned with what it calls 'the rising epidemic of obesity' (DH 2004) but protocols and policies do not take into account the interpersonal relationships between overweight nurses and their patients or make any suggestions how to initiate a sensitive dialogue that is underpinned by complex emotions, experiences and prejudices. Furthermore, despite the lack of literature offering strategies specifically for sensitive communication with overweight patients, the literature suggests that there is widespread discrimination in health care towards overweight patients, which might lead to healthcare avoidance (Dobie 2005; Dunkley & Ward 2005; Yanovski 1998).

My initial problem in practice, the reluctance of nurses to initiate sensitive conversations about managing weight, was echoed in the literature (Michie 2007; Miller et al 2008; Cook 2009) and led me to undertake a phenomenological hermeneutical study of overweight nurses' interactions with their overweight patients using two semi-structured interviews with each of seven nurses of varying disciplines, some of whom also maintained a note-book as part of the data gathering process.

To describe the findings of this study, I have proposed a new and original concept of embodied empathy-in-action which describes the different elements that combine in the overweight nurse-patient interaction. The concept consists of a quadrant made up of four overlapping features. The upper two segments of the quadrant portray the nurses' understandings, divided into *Self understanding* and *Other understanding*. The remaining two segments are concerned with how the nurses manage the interaction and are divided into: *Acknowledging-then-managing prejudice*; and *Being-with: holistic interacting*. I have summarised the findings and discussion of each of the segments to help to demonstrate how I have met the objectives of the study.

How overweight nurses manage their self in the interaction with the overweight patient

In describing how each nurse in the study experienced her interaction with her overweight patient, I explored her understandings of being overweight for both herself and her patient.

By *Self understanding* I firstly refer to the development from personal experience of the nurses' personal understandings and feelings about being overweight, drawing from their narratives in chapter four. The nurses talk of the impact of being overweight on their daily lives, the objectification of their body by both themselves and others, how it is a constant struggle to maintain what is considered to be a normal weight and the toll this takes on them emotionally both personally and professionally.

Nurses in this study seem to sacrifice their own feelings and time in order to care for others both at home and their patients, and are reluctant to take the time to look after themselves, placing themselves lower on their own priorities. Within the interaction they are empathetic and pragmatic, often open and honest with their patients, offering holistic care and using sensitive communication to initiate, or sometimes avoid, dialogue with their patient about weight management. The self sacrifice and use of personal experience within their interactions is portrayed by the nurses in this study and the findings add to the body of knowledge derived from studies such as those conducted by Smith (1992), Hochschild (1983/2003) and Theodosius (2008).

This use of nurses' personal experiences is significant as patients may benefit from these and support should be offered to overweight nurses to assist patients, not just with health education, but also by equipping them with skills of assertiveness and communicating with sensitivity. Furthermore, if these overweight nurses are not confident enough to draw spontaneously on their own emotions and experiences during their interactions with their overweight patients, what Smith (1992) calls 'deeper acting', they should be offered opportunities for sense-making and reflecting on their experiences when not in practice. Eventually lack of support, particularly if the nurses have stressful and high workloads, will have an impact on patient care and the nurses' ability to empathise (Baillie 1996). My study indicates that the qualities required for the therapeutic use of self as proposed

by Rogers (1976) are idealistic i.e. empathetic understanding and sensitivity towards others' feelings; genuineness and a willingness to be open with clients; and having unconditional respect for clients; the nurses' understandings of the interaction with their overweight patient are complex and the nurses admit to having feelings towards the patient that do not always resemble empathy. Despite this, these nurses should be reassured that to aspire to the use of the therapeutic self is not unprofessional practice and is likely to be an effective method of enhancing the nurse-patient relationship.

It should be recognised that mental health and self esteem are as important as physical health and the effect of good self esteem is often manifested in the maintenance of a healthier lifestyle. Some of the nurses in this study recognised that, in addition to feeling guilty and dissonant, low self esteem was a concern for them. This leads to a concern for nursing practice that, if nurses do not have time to take care of their own health, then eventually this will have a negative impact on the care they can offer to patients. It also sets a questionable example to patients who might also be struggling to juggle a variety of demands. The unintentional message from the nurses may be that it is satisfactory to submerge your own health needs in order to satisfy those of others. It is suggested that support could be offered by employers in terms of helping nurses to manage better their time and workloads so that they are empowered to value their own health as much as the health of their patients. Clarke (1991) also suggests that specific support should be provided for nurses to move towards more experiential and self-focused learning, and that their relationships with clients should be more holistic and based on empathy and respect.

Other understanding refers to the empathetic acuity and the fusion of horizons between nurses and patients as the nurses relate their own experiences and struggles with managing their weight to those of their overweight patients. Nurses are subject to the same kinds of discrimination and prejudice as their patients. However, I reason that, although it can and often does, nursing empathy does not *necessarily* derive from having similar embodied experiences as their patients; I argue that there is a skill in the overweight nurse management of the interaction with their overweight patient as the nurses do not approach their overweight patient by making the assumption that they automatically should understand each other. Rather, each interaction with a patient is

approached with sensitivity and the patient is regarded as an individual – there is no automatic approach, or one that is based upon theory. The nurses use their personal experience to develop self understanding and then use this to develop Other understanding and empathy to support their management of the interaction even though this can cause them discomfort and a conflict in feelings about their self and their patients. I consider that this study is relevant to developing new understandings for all nurses about their interactions with overweight patients and demonstrates practical applications of Gadamer’s ‘fusion of horizons.’ I argue that nurses who have never experienced being overweight may, through developing understandings from the experiences and narratives of others, develop enhanced empathy for their overweight patient.

How overweight nurses manage the interaction with overweight patients

In this section I summarise how the nurses managed the interaction with her overweight patient, firstly by *Acknowledging-and-then-managing prejudice* and finally, by *Being-with: holistic interacting*.

By *Acknowledging-then-managing prejudice*, I refer to the complexities that underpin the interactions between overweight nurses and their patients. The nurses’ acknowledge their prejudices toward their overweight patients and the self awareness of the ‘gentle hypocrisy’ attached to this. This was the biggest surprise to me in the research as I did not expect that overweight nurses would subject overweight patients to derogatory thoughts. The findings of this study are in agreement with Goffman’s (1959/1990) theory of dramaturgical loyalty. However, the nurses who admitted these thoughts also claimed that they would not deliberately act in a discriminatory manner towards their overweight patient, but would instead set aside their prejudices and retreat to their empathetic self, who understands the challenges that weight management causes.

This study suggests that overweight patients frequently experience inappropriate comments from their physicians about their weight, which can affect and diminish self esteem (Merrill & Grassley 2008) and can lead to health care avoidance (Dobie 2005;

Dunkley & Ward 2005; Yanovski 1998). Two of the overweight nurses in my study, who had experienced simultaneously being an overweight patient, felt that they had a good understanding of how it feels to be objectified and this deeper understanding of potential discriminatory practice towards overweight patients may help to inform nursing knowledge and practice and promote less prejudicial care.

It is vital to recognise that nurses may be as subject to holding prejudices as those not in the profession, but nurses should also be aware that the Nursing and Midwifery Council's (NMC) standards of conduct, performance and ethics for nurses and midwives dictate that 'you must treat people as individuals and respect their dignity; you must not discriminate in any way against those in your care' (Nursing and Midwifery Council 2008:3). This has great implications for nursing practice as, in order to defeat prejudice and discrimination, it is recommended that there is a raised understanding of the issues faced by those who are overweight and who are fighting their own struggles with self esteem, health and/or appearance. My own study is significant in that it is an original study which offered overweight nurses an opportunity to voice their own experiences as a woman, as a nurse and sometimes also as a patient.

There is another dimension to the management of self for the nurses in their interactions; guilt and dissonance can manifest in their roles of health educators as they are overtly disregarding their own advice. The frequent resultant loss of self worth manifests in behaviours such as overeating for comfort or in placing themselves low on the list of their own priorities and suffering feelings of guilt, dissonance and hypocrisy. The nurses feel that they are poor role models and their self esteem is affected by their weight both at home and in the clinical environment. This study suggests that overweight nurses have conflicting emotions; these nurses are often in a state of inner conflict and feel guilty that they do not practise what they preach in terms of weight management. They manage this by retreating into their professional self and 'acting' their role, often using their uniform or status as a nurse to act as a barrier between the nurse and the patient. The conflict arises as they are not being 'true' to their own feelings and innate sense of empathy in which they want to connect with their patient. Although they talk of not bringing their personal experiences into their interactions with the overweight patient, this is a common

occurrence which causes further dissonance as the nurse struggles to feel 'professional'. The findings of this study support the earlier works of Goffman (1959/1990), who theorises about impression management, and Festinger's cognitive dissonance (1962). The findings offer practical examples of how impression management and dissonance affects, and are managed by, overweight nurses in their interaction with their overweight patient.

The interaction between overweight nurse and overweight patient is complex. For overweight nurses, developing strategies for dealing with the psychological discomfort of being in overt disregard of their own weight management advice is vitally important to their own self esteem and for the benefit of the nurse-patient relationship. Serious consideration should be given to the provision of individualised measures of support to nurses such as counselling and any training identified by the nurses. The nurses often talk about feeling hypocritical and consider that they are not good role models to their overweight patients. Consequently they sometimes cope with their feelings of dissonance by retreating into how they see their 'professional' self, by which I refer to acting out a performance or their use of uniform as a shield, which they may hope will convey trustworthiness (Mandy & Gard 2000:11).

This is a concern as nurses may be reluctant to interact with their patients in a way that is 'less reductionist but which requires the nurse to be confident in combining theoretical knowledge with personal experiences, employing their felt sense and openheartedness which leads to the being-with the patient rather than the doing-to or doing-for the patient' (Galvin & Todres 2009b). My study helps to generate a new understanding of this and offers practical examples of the three essential dimensions proposed by Galvin & Todres' (2009b:142) theory in nursing experience: the infinity of otherness: keeping open the other's difference; embodiment: our shared vulnerable heritage; and practical responsiveness: embracing the value of the objectified gaze and technology.

Lastly, these nurses use embodied empathy in their interaction with their overweight patient and *Being-with: holistic interacting* refers to this intersubjectivity and intertwining, that is, the relationship between people as they communicate through dialogue or body language. These nurses, despite any dissonance they experience, rarely

avoid the sensitive conversation with patients about their weight and draw on different types of knowledge and their own experience in their interactions. Furthermore, the nurses use their own embodied experiences and felt sense to have an honest dialogue with their patient and to understand when an approach may or may not be welcomed; this enhances their interaction with their overweight patient, and the nurse regards them as a whole person rather than a patient who simply needs to lose weight, and the nurses intertwine their own experiences of being overweight with those of the patient forming a nurse-patient sense of interconnectedness, a fusion of horizons. This study consequently adds to the body of knowledge regarding intersubjectivity, particularly for authors such as Gadamer, Merleau-Ponty, Galvin, Todres and Finlay.

Despite several government policies indicating the need for nurses to be the front line care providers and health educators for overweight patients, there is no formal training offered in initiating sensitive conversations with overweight patients and the relevant literature is sparse. Further research should be conducted with both patients and health professionals such as nurses and general practitioners to identify and promote sensitive and good practice in interacting and supporting both overweight patients and the health professionals who are caring for them. Although the focus of this research study was not that of public health policy, I reviewed recent policy in chapter two of this thesis and it was evident that, whilst the government is keen to address the 'rising epidemic of obesity' it is not so clear on how this might be conducted within the nurse-patient relationship. There was advice given about holding conversations with patients but no further advice was forthcoming about sensitive communication or, indeed, how to cope if the nurse was also overweight and was concerned about introducing the sensitive topic of weight. I recommend that the employers should consider the provision of 'communicating with sensitivity' training to all staff who are tasked with caring for all patients and overweight patients, in particular.

Dissemination of findings

In this section I describe how I intend to meet my third objective of the study i.e. to offer insights from this study to other nurses and other health professionals, whether overweight or not, into these nurses' experiences of being overweight.

Presentations

The following are presentations that I have delivered within approximately the last year:

1. *How do overweight nurses perceive their interactions with overweight patients?*
Presentation given at the 9th Annual Interdisciplinary Research Conference 5-7th November 2008, School of Nursing & Midwifery, Trinity College Dublin
2. *Overweight nurses' experiences of their interactions with overweight patients*
Presentation given at PhD and Professional Doctorate Annual Work in Progress Presentations 14th July 2009 University of Brighton

I intend to submit or have submitted an abstract of the completed research study to:

1. The 11th Annual Interdisciplinary Research Conference 2010 at the School of Nursing & Midwifery, Trinity College Dublin, November 2010;
2. The Annual Professional Doctorates Conference 2010 organised under the auspices of the Southern Universities Alliance for Doctoral Education; and
3. Delivering Better Health Services: The 2010 Joint Health Service Research Network and National Institute for Health Research Service Delivery and Organisation Programme Conference. June 2010, Manchester, UK
4. British Sociological Society Food Study Group Conference 2010: Food, Society and Public Health, July 2010

Potential book and journal publications

1. No time for chopping coleslaw: overweight nurses' experiences of the effects of emotional labour on personal weight management.
Proposed journal: *Journal of Professional Nursing*
2. Going round in hermeneutic circles: the trials and tribulations of data analysis when using a Gadamerian-underpinned hermeneutical methodology.
Proposed journal: *Nursing Inquiry*
3. Walking on eggshells: how overweight nurses initiate discussions of weight with overweight patients.
Proposed journal: *Journal of Holistic Nursing*

4. The gentle hypocrisy: overweight nurse perceptions of being a role model
Proposed journal: *Health Education and Behaviour*
5. Going where they are: embodied empathy of overweight nurses who nurse overweight patients
Proposed journal: *Journal of Advanced Nursing*

Dr Linda Finlay has also offered me an opportunity to include examples of some of my research study in a forthcoming publication entitled: '*Phenomenology for Therapists*'.

What would I do differently if I did the study again?

If I were to conduct this type of research again, I would like to conduct further interviews once I had analysed the data more fully. Because I had formulated a very broad research question I generated very rich data that spanned various concepts and I would have liked to have focused on one or two areas in more depth. I do not believe that this thesis suffers academically for the lack of further interviews as further research could be conducted on specific elements and this study has generated very rich data that will inform nursing knowledge and practice.

Additionally, if I were to conduct the study again, I would consider also researching the lived experiences of the overweight patient in their interactions with overweight nurses, not for reasons of validation, but for enriching the data and deepening our understanding of patients' feelings and what happens in the 'intertwining' (Merleau-Ponty 1945/1962) between patient and nurse.

Finally, although I attended to matters of researcher reflexivity throughout the study, I would explore further my personal *specific embodied experiences* as a researcher during the co-constructing data generation phase and record my own *felt senses*.

I began this process during the data generation phase of this study on reading the works of authors such as Finlay, Galvin, Todres and Gendlin, who suggested increasing researcher reflexivity by the use of 'felt sense'. This would add a deeper dimension to a

phenomenological study that would allow me to expand my understanding of how the researcher impacts upon and influences the research process.

Suggestions for further research

One of the key factors to emerge from this study that warrants further research is that of communicating with sensitivity. A larger scale study, such as one based upon grounded theory, could build upon elements of my study and develop theory on initiating sensitive topics with overweight patients as we learn from experienced nurses.

There is very limited research concerning overweight nurses and their interactions with overweight patients, particularly in the area of support for reducing the lack of congruence and dissonance. I suggest that this is an area worthy of further exploration as I consider that support measures for nurses may decrease the level of dissonance which would potentially reduce the impact on patient care. This type of research would also translate into other areas of dissonance such as nurses who smoke but who offer smoking cessation advice.

Carlson & Warne (2007:511) claim that 'healthier nurses make better health educators' and there are many authors who consider that nurses who do not adopt healthy lifestyles are poor role models for their patients (Sarna & Percival 2002; Borchardt 2000; Veach & Cissell 1999; Clarke 1991). The issue of effectiveness is a positivist critique, not in keeping with the ontological stance of this study and beyond its scope.

However, whilst overweight nurses may not conform to the body image so revered by these authors, I argue that there is little evidence to suggest that overweight nurses are less effective health educators but this highlights the need for further research on the effectiveness of nurses of all weights in their interactions with overweight patients to explore factors which impact upon the patient's health outcomes, mental or physical. There is little evidence to show that existing public health approaches are having any significant impact on the 'obesity epidemic' (Renehal et al 2008).

Finally, the nurses in this study employ embodied empathy-in-action in their interaction with overweight patients - and this may be unique to these nurses - but further research may be useful to explore whether my findings might also be consistent with the experiences of other overweight nurses who interact with overweight patients.

Original contribution to nursing knowledge and practice:

This study makes an original contribution to nursing knowledge and practice by increasing awareness and generating new understandings of ways that overweight nurses experience and manage the interaction with their overweight patients. In particular, I have further described how these nurses approach the sensitive topic of weight management. Furthermore, I have developed a new and original concept of *embodied empathy-in-action* to convey graphically the nurses' experiences of their interactions with their overweight patient.

This study builds upon the gaps in nursing knowledge and extends the studies conducted by other researchers. I have presented my own interpretations of rich qualitative data, not previously available, with which the reader can make their own interpretations and decisions, taking action as they feel appropriate.

The last word? ...

One of the greatest challenges I faced when writing up this research study was to know when to stop. The circles of writing and studying are engrossing and could continue indefinitely, so I found myself turning to Gadamer for his wisdom one last time:

But I will stop here. The ongoing dialogue permits no final conclusion. It would be a poor hermeneuticist who thought he could have, or had to have, the last word.

(Gadamer 1975/2004:581)

REFERENCES

- Allcock N & Standen P (2001) Student Nurses' experiences of caring for patients in pain. *International Journal of Nursing Studies* **38** 287-295
- Annells M (1996) Hermeneutic phenomenology: philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing* 1996 **23** 705-713
- Annells M (2006) Triangulation of qualitative approaches: hermeneutic phenomenology and grounded theory. *Journal of Advanced Nursing*. **56** (1) 55-61
- Aranda K (2005) *Community nurses' talk of equality and the discursive constitution of selves*. *Journal of Advanced Nursing* **51**(2) 131-139
- Baillie L (1996) A phenomenological study on the nature of empathy. *Journal of Advanced Nursing* **24**:1300-1308
- Bartlett S J (2003) Motivating patients towards weight loss – practical strategies for addressing overweight and obesity. *The Physician & Sports Medicine*. Minneapolis November **31**(11) 29
- Bauermeister R F (1998) *The Self* in Gilbert, DT, Fiske ST and Lindzey G (eds) *Handbook of Social Psychology* 4th edition pp 680-740. New York. McGraw-Hill
- Bauermeister R F (1999) *The Self in Social Psychology*. Philadelphia, Psychology Press
- Beck C T (1994) Reliability and Validity Issues in Phenomenological Research. *Western Journal of Nursing Research* **16** (3) 254-267
- Beech I (1999) Bracketing in phenomenological research. *Nurse Researcher* **6** (3) 35-51
- Benner P (1984/2001) *From Novice to Expert: excellence and power in clinical nursing practice*. (Commemorative edition) Menlo Park, California Prentice Hall, Health
- Benner P (1994) *Interpretive Phenomenology, embodiment, caring and ethics in health and illness*, London. Sage Publications Ltd

- Benz Scott LA & Black DR (1999) Health Communication and Professional Preparation: Health educator credibility, message learning, and behaviour change. *Health education and behaviour* October 1999 26 **5** 609-620
- Blackburn S (1994) *Oxford Dictionary of Philosophy* Oxford, Oxford University Press
- Blaikie N (1993) *Approaches to Social Enquiry*. Cambridge. Polity Press
- Blaikie N (2000) *Designing Social Research*. Cambridge. Polity Press
- Borchardt GL (2000) Role Models for Health Promotion. *Nursing Forum* Jul-Sep **35** (3) 29-32
- Brannen J (1988) The Study of Sensitive Subjects. *Sociological Review* **36** 552-63 in Lee RL (1993) *Doing Research on Sensitive Topics*, London, Sage Publications Ltd
- Braun V & Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* **3**:77-101
- Brown I (2006) Nurses' attitudes towards adult patients who are obese: literature review. *Journal of Advanced Nursing* **53**(2) 221- 232
- Brown (2006a) Primary care support for tackling obesity: a qualitative study of the perceptions of obese patients. *British Journal of General Practice*. Sep 2006 666-672
- Brown I, Stride S, Psarou A, Brewins L & Thompson J (2007) Management of obesity in primary care: nurses' practices, beliefs and attitudes. *Journal of Advanced Nursing* **59**(4) 329-341
- Buber M (1970) *I and Thou* (W.Kaufman,Trans.) New York. Scribner
- Burnard P (1998) *Empathy: the key to understanding*. *The Professional Nurse*. July 1988. **3**(10) 388-391
- Carel H (2009) A reply to 'Towards an understanding of nursing as a response to human vulnerability' by Derek Sellman: vulnerability and illness. *Nursing Philosophy* **10** 214-219

- Carlson GD & Warne T (2007) Do healthier nurses make better health promoters? A review of the literature. *Nurse Education Today* **27** 506-513
- Carper B A (1978) Fundamental Patterns of Knowing in Nursing. *Advances in Nursing Science* October 1978 **1** (1) 13-23
- Carter SM & Little M (2007) Justifying Knowledge, Justifying Method, Taking Action: epistemologies, methodologies and methods. *Qualitative Research*. **17**(10) 1316-1328
- Carryer J (2001) Embodied largeness: a significant women's health issue. *Nursing Inquiry* 2001 June **8** (2) 90-97
- Clark E, McCann TV, Rowe K & Lazenbatt A (2004) Cognitive dissonance and undergraduate nursing students' knowledge of, and attitudes about, smoking. *Journal of Advanced Nursing* **46**(6) 586-594
- Clarke AC (1991) Nurses as role models and health educators. *Journal of Advanced Nursing* **16** 1178-1184
- Colaizzi P F (1978) *Psychological Research as the Phenomenologist views it* in Valle R S & King M *Existential Phenomenological Alternatives for Psychology*, Oxford, Oxford University Press 48-72
- Cohen MZ, Kahn DL & Steeves RH (2000) *Hermeneutical Phenomenological Research – a practical guide for nurse researchers*. London. Sage Publications Ltd
- Cook D (2009) Adult obesity: tackling the causes of the obesity epidemic and assessing patients. *Nursing Times* 17 November 2009 **45** 10-12
- Coombes R (2002) Trouble at Large *Nursing Times* Nov 12-18, **98** (46) 22-26
- Cooper J (2007) *Cognitive Dissonance: fifty years of a classic theory*. London. Sage Publications Ltd
- Cossrow NHF., Jeffery RW., McGuire MT (2001) Understanding weight stigmatization: a focus group study *Journal of Nutrition Education* Jul-Aug **33** (4) 208-214

- Cresswell JW (1998) *Qualitative Inquiry and Research Design: Choosing among Five Traditions*. London. Sage Publications
- Cresswell JW (2003) *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. London. Sage Publications Ltd
- Crossley N (1996) *Intersubjectivity: the fabric of social becoming*. London Sage Publications Ltd
- Crotty M (2003) *The Foundations of Social Research – meaning and perspective in the research process*, London, Sage Publications Ltd
- Culbertson M., Smolen D (1999) Attitudes of RN students towards obese adult patients *Journal of Nursing Education* 1999 Feb, **38**(2) 84-87
- Darwin C (1859) *The Origin of the Species by means of natural selection*. London. Charles Murray, Albermarle Street.
- De Witt L & Ploeg J (2006) Critical Appraisal of rigour in interpreting phenomenological nursing research *Journal of Advanced Nursing* **55**(2) 215-229
- Denscombe M (2002) *Ground Rules for Good Research*. Philadelphia USA, Open University Press
- Denzin NK & Lincoln YS (Eds) (2000) *Handbook of Qualitative Research*. London. Sage Publications Ltd
- Department of Health (1999) *Making a difference* London. Department of Health
- Department of Health (2004) *Choosing Health: making healthy choices easier*, London, Department of Health.
- Department of Health (2006) *Care pathway for the management of overweight and obesity*, London, Department of Health

Department of Health (2007) *Lightening the load: tackling obesity and overweight: a toolkit for developing local strategies to tackle overweight and obesity in children and adults*. London. Department of Health

Department of Health (2008) *Healthy Weight, Healthy Lives: a cross-government strategy for England* London. Cross-Government Obesity Unit. London.

Department of Health (2009) *Healthy Weight, Healthy Lives: one year on*. London. Cross-Government Obesity Unit

Descartes R (1641) *Meditations on First Philosophy*. Hackett. London

Dillow C (2009) Growing Up: a journey toward theoretical understanding. *Qualitative Inquiry Online First*, 28 July 2009: doi: 10.1177/1077800409339581

Dobie M (2005) Obese patients suffering bias and discrimination. *Public Health News* **22** August 2005:5

Doordan AM (1998) *Research Survival Guide*. Philadelphia. Lippincott

Downey M (2003) The importance of being earnest. *The Lancet*. December 2003, **362** S42-3

Draper P (1991) The ideal and the real: some thoughts on theoretical developments in British Nursing. *Nurse Education Today* **11** 292-294 in Annells M (1996). Hermeneutic phenomenology: philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing* 1996 (23) 705-713

Drew D & Dahlberg K (1995) Challenging a reductionist paradigm as a foundation for nursing. *Journal of Holistic Nursing* **13**(4) December 1995 332-345

Dreyfus HL (1991) *Being-in-the-world: a commentary on "Being and Time"* Division I:283-340 Cambridge MIT Press cited in Benner P (1994) *Interpretive Phenomenology, embodiment, caring and ethics in health and illness*, London. Sage Publications Ltd

Drury C., Aramburu A., Louis M (2002) Exploring the association between body weight, stigma of obesity, and health care avoidance *Journal of the American Academy of Nurse Practitioners* Dec, **14** (12) 554-561

Dumont JP (1978) *The Headman and I* Austin, University of Texas, Austin Press in Cohen et al (2000)

Dunkley S & Ward M (2005) Should nurses be role models for health? *Nursing Times* 22 February 2005 **101** (8) 21

Edwards D, Ashmore M & Potter J (1995) Death and furniture: the rhetoric, politics and theology of bottom-line arguments against relativism. *History of the Human Sciences* **8**(2):25-49 cited in Nightingale DJ & Cromby J (1999) *Social Constructionist Psychology*, Buckingham OU Press

Engelsrud G (2005) The lived body as experience and perspective: methodological challenges. *Qualitative Research*. **5**(3) 267-284

Erickson F (1990) *Qualitative Methods in Research in Teaching and Learning* Vol 2 New York. Macmillan in Radnor H (2002) *Researching your professional practice*, Buckingham, Open University Press

Festinger L (1962 2nd ed) *Theory of Cognitive Dissonance*. London. Tavistock Publications

Finlay L (2002a) Outing the researcher: the provenance, process and practice of reflexivity. *Qualitative Health Research* **12**(4) April 2002 531-545

Finlay L (2002b) *The problem and the hope of phenomenology*. Paper presented at the BPS Social Psychology conference. Symposium on applying phenomenology, Huddersfield 2002

Finlay L & Gough B (2003) *Reflexivity – a practical guide for researchers in health and social sciences*. Oxford, Blackwell Publishing

- Finlay L (2005) "Reflexive Embodied Empathy": A Phenomenology of Participant-Researcher Intersubjectivity. *The Humanist Psychologist* **33**(4) 271-292
- Finlay L (2006) The body's disclosure in phenomenological research. *Qualitative Research in Psychology* **3** 19-30
- Finlay L & Evans K (2009) *Relational-centred Research for Psychotherapists: exploring meanings and experience*. Chichester. John Wiley & Sons Ltd
- Finlay L (2009) Ambiguous encounters: a relational approach to phenomenological research. *Indo-Pacific Journal of Phenomenology* **9**(1) May 2009 1-17 downloaded from www.ipjp.org
- Fleming V, Gaidys U & Robb Y (2003) Hermeneutic research in nursing: developing a Gadamerian-based research method. *Nursing Inquiry*. **10** 113-120
- Flynn TR (2006) *Existentialism: a very short introduction*. Oxford. Oxford University Press
- Foresight (2007) *Tackling Obesities: Future Choices – project report*. London. Foresight
- Foster GD., Wadden-Thomas A., Makris AP et al (2003) Primary Care Physicians' attitudes about obesity and its treatment *Obesity Research* Oct **11**(10) pp 1168-1177
- Forbat L & Henderson J (2005) Theoretical and practical reflections on sharing transcripts with participants. *Qualitative Health Research* **15** (8) October pp1114-1128
- Freeman M (2007) Performing the event of understanding in Hermeneutical Conversations with narrative text. *Qualitative Inquiry* **13**(7) October 925-944
- Freshwater D (2002) *Therapeutic Nursing*. London. Sage Publications Ltd
- Freud S (1923), *Das Ich und das Es*, Internationaler Psycho-analytischer Verlag, Leipzig, Vienna, and Zurich. English translation, *The Ego and the Id*, [Joan Riviere](#) (trans.), Hogarth Press and Institute of Psycho-analysis, London, UK, (1927).
- Gadamer H G (1975/1989/2004) 3rd revised edition *Truth and Method*. Translation revised by Weinsheimer J & Marshall DG. London. Continuum Publishing Group

Gadamer H G (1976) *Philosophical Hermeneutics*. Edited and translated by David E Linge. London. University of California Press

Galvin KT & Todres L (2007) The creativity of “unspecialisation”: A contemplative direction for integrative scholarly practice. *Phenomenology and Practice* 1(1) 31-46

Galvin KT & Todres L (2009a) *Poetic Inquiry & Phenomenological Research: the practice of ‘Embodied Interpretation’*, Chapter 25 in Prendergast M, Leggo C, Sameshima P (Eds) *Poetic Inquiry: Vibrant Voices in the Social Sciences* (pp307-316) Rotterdam, Sense Publishers

Galvin KT & Todres L (2009b) Embodying Nursing Openheartedness. *Journal of Holistic Nursing* June 2009 27 (2) 141-149

Gendlin ET (1992a) The primacy of the body, not the primacy of perception: how the body knows the situation and philosophy. Excerpt from *Man and World* 25 (3-4) 341-353

Gendlin ET (1992b) Celebrations and Problems of Humanistic Psychology. *The Humanist Psychologist*. 20 (2-3) 447-460

Gendlin (1996) *Focusing-oriented Psychotherapy: a Manual of the Experiential Method*. New York. The Guildford Press

Gergen K (1991) *The Saturated Self*. New York. Basic Books

Gergen K (1999) *An invitation to Social Construction*. London. Sage Publications Ltd

Giorgi A (1985) *Phenomenology and Psychological Research*, PA Pittsburgh, Duquesne University Press

Goffman E (1959/1990) *The Presentation of Self in Everyday Life*. London. Penguin Books

Goffman E (1974) *Frame Analysis: an essay on the organisation of experience*. Cambridge. Harvard University Press

- Gould D (1990) Empathy: a review of the literature with suggestions for an alternative research strategy. *Journal of Advanced Nursing* **15** 1157-1174, cited in McCabe C (2004) Nurse-patient communication: an exploration of patients' experiences. *Journal of Clinical Nursing* **13** 41-49
- Gray B (2009) The emotional labour of nursing: exploring the concept. *Nursing Times* **105** (8) 26-29
- Gray B (2009a) The emotional labour of nursing: analysing the barriers. *Nursing Times* **105** (9) 24-26
- Gubrium JF & Holstein JA (2009) *Analyzing narrative reality*. London Sage Publications Ltd
- Hahler B (2002) Morbid obesity: a nursing care challenge. *Dermatology Nursing* August 2002 **14**(4) 249-256
- Haslam D (2008) Managing the overweight/obese patient. *Practice Nurse* 2008 28 Mar. **35**(6) 26-29
- Hazlitt, W (1778-1830) <http://thinkexist.com/common/print.asp?id=10986"e=...>
- Haynes S (2004) Raising the issue of obesity with patients who need to lose weight. *British Journal of Primary Care Nursing* 3 Sep 2004 137-139
- Heidegger M (1962) *Being and Time* Oxford, Blackwell Publishing
- Heidegger M (1975) *The Thinker as Poet, Poetry, Language and Thought* trans. Albert Hofstadter, New York: Harper and Row page 4
- Heraclitus, Greek Philosopher (c.535BC-475BC)
- Hicks M, McDermott LL, Rouhana N, Schmidt M, Wood Seymour M & Sullivan T (2008) Nurses' body size and public confidence in ability to provide health education. *Journal of Nursing Scholarship* 2008 **40**(4) 349-354
- Holloway I (2005) *Qualitative Research in Health Care* Maidenhead OU Press

- Holloway I & Freshwater D (2007) *Narrative Research in Nursing*. Oxford. Blackwell Publishing
- Hoppe R & Ogden J (1997) Practice Nurses' beliefs about obesity and weight related interventions in primary care. *International Journal of Obesity and Related Metabolic Disorders* 1997 Feb **21** (2) 141-146
- Hochschild AR (1983/2003) 2nd edition *The Managed Heart: commercialization of human feeling*. London. University of California Press
- Hoskins M & Stolz J (2005) Fear of offending: disclosing researcher discomfort when engaging in analysis. *Qualitative Research*. **5**(1) 95-111
- Koch T (1994) Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing* **19** 976-986
- Kvale S (1996) *InterViews: An Introduction to Qualitative Research Interviewing*. London. Sage
- Kwaitek E, McKenize K, Loads D (2005) *Self awareness and reflection: exploring the 'therapeutic use of self'*. *Learning Disability in Practice* **8**(3) April 27-31
- Janesick V J (1994) *The Dance of Qualitative Research Design: metaphor, methodolatry and meaning* in Denzin N.K & Lincoln Y.S (eds) *Handbook of Qualitative Research*, London. Sage Publications Ltd
- Jebb S & Sritharan N (2005) The nurse's role in promoting weight loss and encouraging healthier lifestyles. *Professional Nurse* March 2005 **20** (7)25-29
- Lanigan RL (1988) Is Erving Goffman a Phenomenologist? *Critical Studies in Mass Communication* **5** 335-345
- Langdrige D (2007) *Phenomenological Psychology: theory, research and method*. Harlow. Pearson Education Ltd
- Lawn C (2006) *Gadamer: a guide for the perplexed*. London Continuum Publishing

- Leach K (2006) *The Overweight Patient: a psychological approach to understanding and working with obesity*. London. Jessica Kingsley Publishers
- Lee RL (1993) *Doing Research on Sensitive Topics*, London, Sage Publications Ltd
- Lees L (2009) Auditing the nursing standard for weighing patients on an acute medical unit. *Nursing Times* 14 July 2009 **105** (27) 12-13
- Letherby G (2003) *Feminist Research in Theory and Practice*. Buckingham, OU Press
- Lincoln YS & Guba EG (1985) *Naturalistic Inquiry*. Sage. Beverly Hills, CA
- LoBiondo-Wood G & Haber J (2002) *Nursing Research, Methods, Critical Appraisal and Utilization*, St.Louis, Missouri, USA. Mosby Inc.
- Loomis GA., Connolly KP., Clinch CR., Djuric DA (2001) Attitudes and practices of military family physicians regarding obesity *Military Medicine* Feb **166** (2) 121-115
- Madjar I & Walton JA (1999) *Nursing and the experience of illness – phenomenology in practice*, London, Routledge
- Mandy A & Gard P (2000) Communication Skills. Chapter in *A Behavioural Approach to Pharmacy Practice*. Oxford. Blackwell Science
- Mason J (2002), *Qualitative Researching* (2nd edition), London, Sage Publications Ltd
- Mateo MA & Kirchhoff KT (2009) *Research for the Advanced Practice Nurse*. New York. Springer Publishing LLC
- Mead G H (1934) *Mind, self and society: from the standpoint of a social behaviourist*. University of Chicago Press
- McCabe C (2004) Nurse-patient communication: an exploration of patients' experiences. *Journal of Clinical Nursing* **13** 41-49
- McGreevy D (1994) 'Learning to Survive' *Children's knowledge and perceptions of safety in the kitchen: the implications for accident prevention and health education* Unpublished MSc thesis. South Bank University

- McGreevy D. (2006) *Researcher Journal 2004 - 2010*, Professional Doctorate in Nursing
- McGreevy D (2007a) Field Notes: Hannah 30.5.07
- McGreevy D (2007b) Field notes: Erin: 1.3.07
- McGreevy D (2007c) Field Notes: Erin: 30.5.07
- McQueen A (2000) Nurse-patient relationships and partnership in hospital care. *Journal of Clinical Nursing* 2000 **9** 723-731
- Mercer SW & Tessler S (2001) A qualitative study of general practitioners' and practice nurses' attitudes to obesity management in primary care. *Health Bulletin* **59**(4) July 2001 248-253
- Merleau-Ponty (1945/1962) *Phenomenology of Perception*. London, Routledge
- Merrill E & Grassley J (2008) Women's stories of their experiences as overweight patients. *Journal of Advanced Nursing* **64**(2) 139-146
- Michie S (2007) Talking to primary care patients about weight: a study of GPs and practice nurses in the UK. *Psychology, Health & Medicine* October 2007 **12**(5) 521-525
- Miller SK, Alpert PT & Cross CL (2008) Overweight and obesity in nurses, advanced practice nurses, and nurse educators. *The Journal of the American Academy of Nurse Practitioners* **20** (2008) 259-265
- Moran D (2000) *Introduction to Phenomenology*, London, Routledge
- Morse JM (1994) *Critical Issues in Qualitative Research*, London, Sage Publications
- Moustakas C (1994) *Phenomenological Research Methods*, London, Sage Publications Ltd
- Munhall PL & Oiler CJ (1986) *Nursing Research – a qualitative perspective*, London, Prentice Hall International (UK) Ltd
- Murray R (2006) *How to write a thesis*. Maidenhead. Open University Press

- National Institute for Health and Clinical Excellence (2006) *Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children*. London. National Institute for Health and Clinical Excellence
- Nettleton S (2006) *Sociology of Health and Illness*. Cambridge. Polity Press
- Newman M, Sime A & Corcoran-Perry S (1991) The focus of the discipline of nursing. *Advances in Nursing Science*, 14(1) 1-14
- Nightingale DJ & Cromby J (1999) *Social Constructionist Psychology*, Buckingham OU Press
- Nursing and Midwifery Council (2008) *Standards of Conduct, performance and ethics*. London. Nursing & Midwifery Council
- Ogden J., Hoppe R (1998) Changing practice nurses' management of obesity...Proceedings from the ASO and BDA symposium held on 25 November 1997 at St. Bartholomew's Hospital, London *Journal of Human Nutrition and Dietetics* June 11 (3) 249-256
- Olsen DP (1997) When the patient causes the problem: the effect of patient responsibility on the nurse-patient relationship. *Journal of Advanced Nursing* 26 515-522
- Overgaard D (2002) Being obese is Paradoxical Living – an exploratory study of five persons lived experiences of being overweight. *Theoria: Journal of Nursing Theory* 11(2) 3-12
- Payne G & Payne J (2004) *Key Concepts in Social Research*. London. Sage Publications Ltd
- Peternelji-Taylor CA (1998) The effects of patient weight and sex on nurses' perceptions: a proposed model of nurse withdrawal *Journal of Advanced Nursing* Sep 14 (9) 744-754
- Pierson W (1999) Considering the nature of intersubjectivity within the nursing profession. *Journal of Advanced Nursing* 30 (2) 294-302

- Porter M (1994) *Second Hand ethnography – some problems in analysing a feminist project* in Bryman A & Burgess R *Analysing Qualitative Data*, London, Routledge
- Porter S (2007) Validity, trustworthiness and rigour: reasserting realism in qualitative research. *Journal of Advanced Nursing* **60** (1)79-86
- Puhl R & Brownell KD (2001) Bias, discrimination and obesity. *Obesity Research* December 2001 **9** (12) 788-805
- Radnor H (2002) *Researching your professional practice*, Buckingham, Open University Press
- Ramos MC (1992) The nurse-patient relationship: theme and variation. *Journal of Advanced Nursing* **17** (4) 496-506
- Ray M A (1994) *The richness of phenomenology: philosophic, theoretic and methodologic concerns* in Morse J M (1994) *Critical Issues in Qualitative Research*. London. Sage Publications Ltd
- Renahal AG; Roberts DL & Dive C (2008) Obesity and cancer: pathophysiological mechanisms. *Archives of Physiology and Biochemistry*. February 1008 **114**(1) 71-83
- Reto CS (2003) Psychological aspects of delivering nursing care to the bariatric patient *Critical Care Nursing Quarterly* Apr-Jun **26** (2) 139-149
- Richardson & Fowers (1997) in *Critical Psychology* edited by Dennis Fox & Isaac Prilleltensky, London, Sage 282-3
- Ricoeur P (1981) *Hermeneutics and the Human Sciences* (edited and translated by J.B.Thompson) Cambridge. Cambridge University Press.
- Rogers CR (1961) *On becoming a person: a client's view of psychotherapy*. Boston. Houghton-Mifflin cited in Watkins JG (1978:85) *The Therapeutic Self: developing resonance – key to effective relationships*. London. Human Sciences Press

- Rogers CR (1975) Empathic: an unappreciated way of being. *Counselling Psychologist* **5**: 2-10 cited in Finlay L (2005) "Reflexive Embodied Empathy": A Phenomenology of Participant-Researcher Intersubjectivity. *The Humanist Psychologist* **33**(4) pp271-292
- Rogers CR (1976) *Non-directive counselling: client-centred therapy*. cited in *Psychology and Counselling* (ed.Sahakian W. 2nd ed). Chicago. Rand McNally
- Rolfe G (1996) *Closing the theory-practice gap: a new paradigm for nursing*. Oxford. Butterworth Heinemann
- Rolfe G (1997) Writing ourselves: creating knowledge in a postmodern world *Nurse Education Today* **17**:442-448
- Rolfe G (1999) Insufficient evidence: the problems of evidence based nursing. *Nurse Education Today*. **19** 433-442
- Rolfe G (2002) Faking a difference: evidence-based nursing and the illusion of diversity. *Nurse Education Today* (2002) **22** 3-12
- Rolfe G (2006a) Judgements without rules: towards a postmodern ironist concept of research validity. *Nursing Inquiry* **1**:7-15
- Rolfe G (2006b) Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing* **53**(3) 304-310
- Ruesch J (1961) *Therapeutic communication*, New York. Norton
- Rungapadiachy DM (2008) *Self awareness in healthcare*. Basingstoke. Palgrave MacMillan
- Sahakian W (1976) 2nd edition *Psychology and Counselling* Chicago. Rand McNally
- Sanders C (2003) Application of Colaizzi's method: Interpretation of an auditable decision trail by a novice researcher. *Contemporary Nurse* **134**:292-302
- Saporta I & Halpern JJ (2002) Being different can hurt: effects of deviation from physical norms on lawyers' salaries. *Industrial Relations*. July **41**(3) 442-466

- Sarna L & Percival J (2002) Should we expect nurses to be role models? *Nursing Times* October 1 **98** (40) 16
- Schon DA (1983) *The reflective practitioner: how professionals think in action*. London. Temple Smith.
- Schwandt TA (2000:189-213) *Three Epistemological Stances for Qualitative Inquiry* in Denzin NK & Lincoln *Handbook of Qualitative Research*. London. Sage Publications Ltd
- Schwartz MB et al. (2003) Weight bias among health professionals specializing in obesity. *Obesity Research* **11** 9 September p1033-1039
- Silverman D (2001) *Interpreting Qualitative Data: methods for analysing talk, text and interaction*. London, Sage Publications Ltd
- Smith P (1992) *The emotional labour of nursing: how nurses care*. London. Macmillan Press
- Smith P & Lorentzon M (2005) The emotional labour of nursing in Spouse J et al (eds) *Common Foundation Studies in Nursing*. Edinburgh. Elsevier **cited in** Gray B (2009) The emotional labour of nursing: exploring the concept. *Nursing Times* **105** (8) 26-29
- Smyth T (1996) Reinstating the person in the professional: reflections on empathy and aesthetic experience. *Journal of Advanced Nursing* **24**(5) 932-937
- Sokolowski R (2000) *Introduction to Phenomenology* Cambridge. Cambridge University Press
- Speers SA (2005) *Gender Talk* Hove. Routledge
- Steeffel L (2002) From the desk of...Health at any size *Nursing Spectrum* Greater Chicago NE Illinois NW Indiana Edition Aug 26 **15** (17) 3
- Stevens R (1998) *Understanding the Self*. London. Sage Publications Ltd
- Streubert H & Carpenter D (1995) *Qualitative Research in Nursing: advancing the*

Swanson K (1993) Nursing as informed caring for the well-being of others. *Image* **25**(4) 352-357

Taylor B (1995) Interpreting phenomenology for nursing research. *Nurse Researcher* **3** (2) 66-79

Taylor C (1991) *The ethics of authenticity*. Boston. Harvard University Press cited in Benner P (1994) *Interpretive Phenomenology, embodiment, caring and ethics in health and illness*, London. Sage Publications Ltd

Teller E (2009) Quotations. [ThinkExist.com Quotations Online](http://thinkexist.com/quotations/when_you_get_to_the_end_of_all_the_light_you_know/155513.html). 9 Oct. 2009
http://thinkexist.com/quotations/when_you_get_to_the_end_of_all_the_light_you_know/155513.html

Theodosius C (2008) *Emotional Labour in Health Care: the unmanaged heart of nursing*. Abingdon. Routledge

Thomas S L, Hyde J, Karunaratne A, Herbert D & Komesaroff P (2008) Being 'fat' in today's world: a qualitative study of the lived experience of people with obesity in Australia. *Health Expectations*. **11** 321-330

Thompson D (1998) *Why evidence based nursing?* *Nursing Standard* **13**(9) 58-59

Throsby K (2007) "How could you let yourself get like that?": stories of the origins of obesity in accounts of weight loss surgery. *Social Science and Medicine* **65**(8) October 2007 1561-1571

Todres L & Wheeler S (2001) The complementarity of phenomenology, hermeneutics and existentialism as a philosophical perspective for nursing research. *International Journal of Nursing Studies* **38**(2001)1-8

Todres L (2004) The meaning of open understanding and the open body. *Existential Analysis* **15** (1) 38-54

- Todres L & Galvin K (2005) Pursuing both breadth and depth in qualitative research: illustrated by a study of the experience of intimate caring for a loved one with Alzheimer's Disease. *International Journal of Qualitative Methods* 4(2) 1-11 June 2005
- Todres L (2008) Being with that: the relevance of embodied understanding for practice. *Qualitative Health Research* 18(11) 1566-1573
- Todres L & K T Galvin (2008) Embodied Interpretation: a novel way of evocatively representing meanings in phenomenological research. *Qualitative Research* 8 568-583
- Uhrenfeldt L & Hall EOC (2007) Clinical wisdom among proficient nurses. *Nursing Ethics*. London. Sage Publications Ltd
- Vacek L (2007) Sensitivity training for nurses caring for morbidly obese patients. *Bariatric Nursing and Surgical Patient Care* 2(4) 251-253
- Valle R S & King M (1978) *Existential Phenomenological Alternatives for Psychology*, Oxford, Oxford University Press
- Van Manen M (1990) *Researching Lived Experience – human science for an action-sensitive pedagogy*. New York, State University of New York Press
- Veach CC & Cissell WB (1999) Role Modelling: a dilemma for the health education specialist. *Health education and behaviour*. 26(5) 621-622
- Wallis L (2004) Overweight patients face prejudice in health care, *Nursing Standard* June 2 18 (38):6
- Walsh K (1996) Philosophical hermeneutics and the project of Hans Georg Gadamer: implications for nursing research. *Nursing Enquiry* 3:231-237
- Warner J (1993) Size and Moans...why are nurses prejudiced against 'heavy' patients? *Nursing Standard* July 14-20 7 (43) 51
- Watkins JG (1978) *The Therapeutic Self: developing resonance – key to effective relationships*. London. Human Sciences Press

Wellington J, Bathmaker A, Hunt C, McCulloch G & Sikes P (2005) *Succeeding with your Doctorate* London, Sage Publications Ltd

Wells M, Lever D, & Austin EN (2006) The effect of the nurse's body size on client confidence in the nurse's ability to provide health education on diet and exercise. *Unpublished manuscript*, State University of New York, Binghamton

Wells M, Lever D & Austin EN (2006) *The effect of the nurse's body size on client confidence in the nurse's ability to provide health education on diet and exercise*. Unpublished manuscript. State University of New York, Binghamton, cited in Hicks M, McDermott LL, Rouhana N, Schmidt M, Wood Seymour M & Sullivan T (2008) Nurses' body size and public confidence in ability to provide health education. *Journal of Nursing Scholarship* 2008 40(4) 349-354

Willig C (2001) *Introducing Qualitative Research in Psychology*. Maidenhead, Open University Press

Williams A (1997) The body of the nurse as patient. *Australian Journal of Advanced Nursing* 15(1) 12-19

Woolcott H F (2001) *Writing up qualitative research*. London. Sage Publications Ltd

Woolf V (1978) *A writer's diary*. Triad Granada, Bungay cited in Rolfe G (1997) Writing ourselves: creating knowledge in a postmodern world *Nurse Education Today* 17:442-448

World Health Organisation (2000) *Obesity: preventing and managing the world epidemic: report of a World Health Organisation consultation*. Geneva. World Health Organisation technical report series 894

Wright J (1998) Female nurses' perceptions of an acceptable female body size: an exploratory study. *Journal of Clinical Nursing* 7 307-315

Yanovski SZ (1998) Large Patients and Lack of Preventive Health Care, *Arch Family*



Brighton and Mid Sussex Research Ethics Committee

Brighton & Hove City Teaching PCT
1st Floor, Prestamex House
171-173 Preston Road
Brighton
East Sussex
BN1 6AG

Telephone: 01273 545373
Facsimile: 01273 545372

04 August 2006

Mrs Deborah McGreevy
Health Promotion Manager

Dear Mrs McGreevy

Full title of study: How does the nurse experience of being overweight influence their interactions with the overweight patient?
REC reference number: 06/Q1907/76

The Research Ethics Committee reviewed the above application at the meeting held on 27 July 2006.

Ethical opinion

Thank you for attending the REC meeting along with your research supervisor to discuss the above study. Members noted that the study was a resubmission and they were happy to note that you had responded to most of the questions raised by the Committee on the previous occasion.

- 1 Members wondered what would happen if a participant wanted to enter the study but did not fit the selection criteria. At the meeting you explained to the Committee that you would use the gold standard to determine this and members were satisfied with your response.
- 2 It was noted that you would be storing research data on a home computer, but members were of the view that it would be preferable to store the research data in University or NHS premises rather than at home and it was noted that you were agreeable to this.

As all your responses were to the satisfaction of the Committee, members agreed that a favourable opinion could be given.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to complete Part C of the application form or to inform Local Research Ethics Committees (LRECs) about the research. The favourable opinion for the study applies to all sites involved in the research.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application		01 July 2006
Investigator CV	Appendix 3	
Protocol	1	01 July 2006
Covering Letter		01 July 2006
Letter from Sponsor		27 April 2006
Compensation Arrangements		02 November 2005
Interview Schedules/Topic Guides	2	01 July 2006
Letter of invitation to participant	2 (appendix 6)	01 July 2006
Participant Information Sheet	2 (appendix 4)	01 July 2006
Participant Consent Form	2 (appendix 5)	01 July 2006
Supervisor's CV		
Flow Chart	2 (appendix 8)	01 July 2006
Letter of Invitation - Follow up interview	2 (appendix 6C)	01 July 2006
Transcript Authenticity Check	2 (appendix 6B)	01 July 2006
Letter of interview confirmation	2 (appendix 6A)	01 July 2006

Research governance approval

You should arrange for the R&D Department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research at a NHS site must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q1907/76

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



CS
Mr Christopher Snowling
Chair

Email: nischinth.cherodian@bhcpct.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments
Standard approval conditions

Copy to: K.F.Aranda,
Centre for Nursing and Midwifery Research
University of Brighton
Westlain House
Falmer
Brighton, East Sussex

R&D Department for Mid Sussex PCT

Appendix 2: Participant information sheet

Working title: How does the nurse experience of being overweight influence their interactions with the overweight patient?

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- Part 1 tells you the purpose of this study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Part 1 – about the research study

Researcher background

I am a part-time post graduate student at the University of Brighton, studying for a Professional Doctorate in Nursing. This research study will form part of a Professional Doctorate Thesis.

What is the purpose of the study?

The main aim of the study is to address the research question:

How does the nurse experience of being overweight influence their interactions with the overweight patient?

The objectives of the study include exploring and describing the nurse experience of being overweight and assessing the effect this may have on self body image and the nurse's perception of being a role model; the study also intends to investigate how being an overweight nurse might affect clinical decision-making when caring for an overweight patient.

It is hoped the findings of the study may suggest methods of supporting overweight nurses as they interact with their overweight patients and that, ultimately, this may help to improve future patient care.

Why have I been chosen?

You have been asked to consider participating as you meet the inclusion criteria for this research study. In particular, you have indicated that you:

- have experience of being overweight i.e. a Body Mass Index of over 25 and a waist measurement of over 32" (female) or over 38" (male) and have simultaneously cared for overweight patients;
- are employed as a primary care nurse by the PCT and do not work directly with or for the researcher; and
- have expressed a willingness to talk about your experiences.

There will be a maximum of ten nurses participating in this study.

Do I have to take part?

Absolutely not – it is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and you will be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not cause any repercussions.

What happens if I take part?

You will be interviewed by me and asked to share some of your thoughts and experiences about being a nurse who has experience of being overweight and also about how this makes you feel about caring for overweight patients. Each interview will last approximately one hour but you should allow up to one and a half hours and the interview will be tape-recorded. You will also be provided with a notebook in which to record any thoughts that occur to you about the interview content after the first interview has taken place. The researcher will include your notes as part of the data. There is, however, no obligation to make any notes and they will be excluded from the data if you wish.

You are likely to be interviewed on one or two occasions: the first interview at the earliest possible time convenient to us both after September 2006 and, if a second interview is requested, as soon

as possible before September 2008. It is, however, likely to be a much shorter time span than this for the second interview. The interviews will be arranged at times and venues convenient to you.

The recorded interviews will be transcribed and anonymised. A transcript of the data recorded during the interview will be provided for you to ensure that it provides an as genuine as possible representation of your experience. You will be able to make comments, changes, remove or clarify any part of the transcript.

What are the possible benefits and disadvantages?

The research aims to provide a greater insight into understanding the issues faced by nurses who are overweight whilst caring for overweight patients. Findings will be used to find ways to support nurses in their role and to help to improve patient care, particularly when discussing weight, which can be regarded as a sensitive issue.

You may find that talking about issues of weight is a cathartic experience and that it helps you personally to provide an insight into your own thoughts and beliefs.

Sometimes, however, talking about an experience that may have been painful or affecting your daily life and work can be emotional and uncomfortable. The interview needs only to be about things that you feel comfortable to discuss – there will be no pressure on you to discuss anything if it makes you feel uncomfortable at any time.

If you do feel that you would like support following the interview please do feel free to use the XXX service. This service is provided free of charge 24 hours per day to all XXXXX Primary Care Trust employees and you can call for confidential counselling, information and advice. There is no limit to the number of times that you can call. The telephone number for XX is: XXX

Please continue to read if you are interested in participating in this research study.

Part 2 – additional information

Will it be confidential?

All the notes, tape recordings and transcripts will be protected under the Data Protection Act and will be kept in locked storage. Only I, in the role of the researcher, will have access to this material and will be the only person who knows your identity. Transcribing the audiotapes will be

undertaken by me or by an administrator who will not be aware of your identity and who will maintain confidentiality. Your contribution(s) will become anonymous from the interview stage and no identifying information will be used in transcripts.

The audiotapes and any notes you make for the research will be destroyed after the required length of time. Although information given by you will be kept anonymous, quotations may be used within papers, presentations, conferences, training sessions and the final thesis. No quotations will ever be attributed to an individual or any detail provided that could link the quotation with an individual.

Research Funding

There is no specific funding for this research and no payment will be made to the researcher or to you as a participant. Normal Whitley scale rates for your mileage and parking costs whilst attending for an interview will be met by the PCT as part of its commitment to sponsoring the research study.

Publication and dissemination of the findings

The findings of this research study will be used in part fulfilment of my Professional Doctorate thesis. It is intended that the research findings will be disseminated in a variety of ways. The findings will be submitted for publication in academic and/or professional literature and for presentations at professional conferences. It is possible that they will be used in future nurse training programmes.

If you would like a summary of the findings on completion of the study (this will be in approximately late 2008 or early 2009) I will keep your personal contact details in a secure NHS storage facility and will provide you with this summary as soon as it becomes available. Please let me know if you would like this summary.

Research approval

This research study is being carried out under the supervision and research governance approval of the Sussex NHS Research Consortium and the University of Brighton with the approval of XXX Primary Care Trust. This study has been approved by Brighton and Mid Sussex Research Ethics Committee.

Thank you very much for taking the time to read this information sheet. If you need any further information, have any concerns or complaints, please contact:

- Researcher: Debbie McGreevy, (deleted information to protect anonymity of participants)
- Research Supervisor: Dr Kay Aranda, University of Brighton, Westlain House, Falmer, Brighton, East Sussex BN1 9PH (01273 644022)

Appendix 3: Participant consent form

Title of Project:

How does the nurse experience of being overweight influence their interactions with the overweight patient?

Name of Researcher: Deborah McGreevy

Please initial box

1. I confirm that I have read and understand the information sheet dated 1.7.06 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

3. I understand that I am required to take part in one or two interviews which will be audio recorded. I understand that I will also have the opportunity to make notes to submit as part of the data if I wish. I have been informed that the research study may be published and that quotations taken from my interview may be used but I am aware that every effort will be taken to preserve the anonymity of my identity.

4. I agree to take part in the above study.

Participant

Signature _____

Date _____

Researcher _____

Date _____

Signature

When completed: 1 copy to participant; 1 copy to researcher for records

Appendix 4: Letter of invitation to participant for first interview

Dear Nurse

I am undertaking a research study as part of my
Professional Doctorate in Nursing at the University of Brighton.

The topic I am researching is:

'How does the nurse experience being overweight influence their interactions with the overweight patient?'

I would be delighted if you would consider taking part in my research. I have enclosed an information leaflet that will help you to make a choice about taking part.

I would be most grateful if you could find some time to read the information enclosed and consider taking part. If you require any further information before deciding you can contact me via the address, telephone number or email address provided. Alternatively, you are welcome to contact my supervisor, Dr Kay Aranda, and her contact details are also provided in the leaflet accompanying this letter.

I look forward to hearing from you and hope that you will consider taking part. If you would like to take part, please return the reply slip to me in a sealed envelope within 14 days. I have enclosed a pre-paid envelope for your convenience.

I would like to thank you for taking the time to read this letter and the accompanying information.

With kindest regards

Debbie McGreevy

Please complete and return this slip to: Debbie McGreevy, XXX Primary Care Trust, XXX

.....

Name:

Address:

Tel no:

Best time to contact by phone:

Email:

Signed:

Date:

I am willing to be interviewed for the research study: *How does nurses' experience of being overweight influence interactions with overweight patients?*

Appendix 5: Follow-up letter to interview

[name and address of participant]

[date]

Dear [name],

Thank you very much for agreeing to participate in my research study '*How does the nurse experience of being overweight influence their interactions with the overweight patient?*' by attending one or possibly two interviews. I am writing to confirm the details of our first interview:

Time:

Date:

Venue:

I expect the interview to last no more than 60-90 minutes.

If you have any problems with attending for this interview I would be very grateful if you would let me know immediately on XXX so that we can reschedule at a mutually convenient time.

If you have any questions at all please do not hesitate to contact me at any time on the above address or via email: XXX or by telephone on XXX

I look forward to seeing you.

Kindest regards

Debbie McGreevy

Appendix 6: Transcript authenticity form

Dear [name]

Research study interview – transcript checking

I am writing to thank you for taking the time to talk to me in confidence about your personal experiences of weight-related issues and how these might influence interactions with overweight patients. As you are aware, the interview was tape-recorded and I have attached the transcript of our interview.

I would be very grateful if you would read the transcript and confirm whether it is a genuine reflection of your thoughts and of our discussion. Please make any alterations, comments or deletions that you feel are warranted. Your further thoughts are highly valued and I thank you for taking the time to do this, although you do not need to make any alterations if you are content with the transcript in its current form.

I would be grateful if you would return the transcript to me as soon as is convenient to you, along with the attached form, and a pre-paid envelope is enclosed for your convenience. If the transcript has not been returned within four weeks I shall assume that the transcript is acceptable to you and will include it in the data to be analysed for the research study.

I reiterate that you may withdraw from this study at any time, without consequence and if you would prefer that your transcript is not included in this study please indicate this on the form attached and return it to me within four weeks of the date of this letter.

If you are happy for me to retain your contact details, when the research study is completed, I will forward to you a summary of the research findings but I would like to take this opportunity of reassuring you that any identifying information will be removed from the data, the consequent reports and the final thesis.

Please accept my grateful thanks for your help with this study – it is very much appreciated.

Kindest regards,

Debbie McGreevy

Appendix 7: Letter of invitation to participant for second interview

[name and address]

[date]

Dear [name],

Thank you for taking part in my research study that is exploring this research question:

How does the nurse experience of being overweight influence their interactions with overweight patients?

Interview: **[date, time and venue]**

(please ask for me at reception)

I would be most grateful if you would consider permitting me to interview you again; I anticipate that this interview would take approximately 60 minutes.

If you have made any notes in the notebook that I left with you at the time of the first interview please bring it with you to the second interview if you are happy for me to use it as part of my data; if you would prefer to just use the notes as a prompt, but do not wish me to retain them as part of the data, that is also perfectly acceptable.

Please note that you do not need to make any notes or feel that you have to share them with me if you do not wish to do so. In this case, please feel free to keep the notebook.

If you require any further information, you can contact me on XXX. Alternatively, you are welcome to contact my supervisor, Dr Kay Aranda, and her contact details are provided in the participant information leaflet sent earlier.

I would like to remind you that you may withdraw from the study at any time without consequence. In the meantime, however, please accept my grateful thanks for all your assistance so far. It is very much appreciated.

With kindest regards

Debbie McGreevy

Appendix 8: Semi-structured interview schedule outline – first interview

Welcome participant

Outline of session

Discuss and obtain consent

Reiterate rights of participants

Setting the scene

Can you give me a brief outline of your work as a nurse?

What does the term ‘overweight mean to you?’

Sense of personal identity

Can you describe the history of your own weight?

Sense of self as a nurse

Can you describe how weight affects you in your role as a nurse?

How do you judge if a patient is overweight?

How much would you identify with the patient and their overweight? In what ways?

Could you describe your experiences of working with overweight patients?

What is your experience of actually approaching an overweight patient about their weight?

What strategies do you use to support, advise and/or care for the overweight patient?

What are the health education/promotion messages you give to overweight patient?

What are your feelings about the health education/promotion messages you give?
How effective are these messages in your experience?
What do you think would increase effectiveness in supporting overweight patients?
What would you suggest as an alternative approach?
How do you see yourself in terms of a role model for overweight patients?
What are your own difficulties with weight? How do you manage your own weight?
What do you think are the main reasons for your overweight?
How do you think your weight influences you when you are interacting with overweight patients?

Attitudes towards the overweight patient

How do you feel about overweight patients?
How does their weight affect the way you care for them?
On the basis of your experience, what advice would you give to another nurse for this situation now?
Are there any other issues related to your own perceptions of weight and nursing overweight patients that we have not covered in this interview that you would like to tell me about?

Close interview

Provide participant with explanation of process of research and possible follow-up interview along with participant checking transcript for authenticity.

Appendix 9: Researcher Journal (edited extracts 20.8.07 – 24.2.08)

20 August 2007

I emailed my supervisors for reassurance. I have not read of anyone else approaching analysis entirely in the way I am adopting— I know I need to be more confident but I am sure this confidence will develop once I have a firm direction. This is how I currently plan to analyse my data:

Read and re-read whole text whilst listening to the recording of the interviews to gain a general understanding.

Clean up the participant's text to exclude fill-in sounds and phrases. They take up word count and do not, in my opinion, add or detract from the transcript's meaning.

Make notes on general themes emerging & make notes of personal thinking at the time (identifying my pre-understandings) about the transcripts. I am doing this electronically.

Investigate every sentence or section to expose its meaning for understanding of the subject matter.

List all the emerging themes.

Every sentence or section is then related to the meaning of the whole text.

Summarise the themes that are emerging and my pre-understandings. Use participant letter and line numbers to refer back to themes for audit purposes.

Move between initial themes, the transcript and the whole to refine the themes.

Complete this process with all transcripts.

Look for common and unique themes in all the transcripts.

Identify passages that seem to be representative of the shared understandings 'commonalities' between researcher and participant (including those not necessarily shared between participants e.g. any understandings unique to one participant and the researcher).

One of my supervisors has affirmed that my approach is clear and she understands that I am at the stage of investigating every sentence or section to expose its meaning for understanding of the subject matter; I am also documenting my pre-understandings and noting preliminary themes. I have made a start at locating these initial themes with findings from the broader literature. I know that I will need to repeat this process.

Further to another comment made by my supervisor about the meanings being initially located at an individual subjective level - and suggestions about analysing these meanings for their contingency upon a given social and cultural context additionally – I realise I have not added other stages to my analytical method.

This is a potential weakness of following Fleming's framework without considering in depth the issue of hermeneutics and the fusion of horizons. Fleming discusses the 'gaining of understanding through dialogue with the participants' in terms of indefinite dialogues between the researcher and the 'text' – which, in Gadamerian terms refers to both the participant and the transcript.

Fleming does not mention in her paper (Fleming et al 2003) the engagement with a wider social and cultural context. It is my intention to follow the suggestions of Geertz (1973:69) in Cohen et al (2000:72-73) who describes the focus of attention alternatively 'between the most local of local detail and the most global [of theoretical] structure in such a way as to bring them into simultaneous view.'

Cohen et al describe this process in terms of seeing a 'stand-alone' statement having meaning - but when taken in a larger context it could have a different or greater meaning. This could be regarded as going 'beyond the data' (Cohen et al 2000:97) but adds the historic, temporal and contextual elements of which, I believe, Gadamer would have approved.

Some of my own participants refer to 'size zero' in their discussions with me. On face value this could be taken to mean someone at a size much less than to which it actually refers, albeit that it is still referring to someone with an extremely low body mass index. In context, the size zero refers to an American dress size that equates to UK size 4. However, it is the high profile media debate regarding size that may be affecting the nurses' self image and their discussions with me regarding their own weight. Unless I, as a researcher, understand this social context and add its understanding to the hermeneutical circular process, I would not feel that I was interpreting the data in a way that takes all contexts into consideration.

Dumont in Cohen et al (2000:69) also points out that, 'while the researcher is going about the work of understanding what is meaningful for the participants, the participants are doing the same regarding the researcher's horizon.' I am not deeply enough immersed into my analysis yet to uncover elements of this type of engagement by my participants but will now look out for it as I continue.

On reflection, then, I will add further elements to stages 4-6 of my analytical method so that the wider context is considered when scrutinising the text for descriptive and literal meanings:

4. Investigate every sentence or section to expose its meaning for understanding of the subject matter, *taking into account the social and cultural context of statements and meanings.*

6. Every sentence or section is then related to the meaning of the whole text, *taking into account the social and cultural context of statements and meanings.*

References:

Cohen MZ, Kahn DL, Steeves RH (2000) *Hermeneutic Phenomenological Research*, London Sage Publications Ltd

Dumont JP (1978) *The Headman and I* Austin, University of Texas, Austin Press in Cohen et al (2000)

Fleming V, Gaidys U & Robb Y (2003) Hermeneutic Research in Nursing: developing a Gadamerian-based research method *Nursing Inquiry* 2003 Vol:10 113-120

Geertz C (1973) *The interpretation of culture*. New York, Basic Books in Cohen et al (2000)

31 August 2007

Editing the transcripts

I have decided to remove most of the 'ums' and 'you knows' and so on because I did not feel that they added value to the findings and they added unnecessarily to the word count. If there was a long hesitation, sigh or laughter I do mention it as it might influence the way it is read, if the reading is not accompanied by listening to the transcript simultaneously. This is my researcher interpretation of the text. Transcripts and tapes are, in any case, being retained for audit trail purposes.

I have also taken the decision to remove extraneous conversational matter for the same reason but I have added the line numbers of the extracts taken from the transcripts so that it is easy to track their original context for audit purposes and for transparency. In Cohen et al's (2000:76) *Hermeneutical Phenomenological Research*, this is a recommended action as long as this action does not change the unique character of the text.

Emerging themes

I have found that when I am analysing the transcripts at different times I am inconsistent with my remarks or emerging themes. I have decided not to worry about phrasing things differently for two main reasons; firstly I might come up with something better as I work through the transcripts and do not want to get stuck in a rut of semantics. Secondly, it should not prove too difficult to look at each theme and organise them even if they are worded differently. I can come up with better or different phrases at the next stage of the analysis.

I have also decided just to add my pre-understandings and comments as I feel them - and then I will merge them together at the end. I can also then state whether on what I am remarking was a revelation to me - or whether it was something I had already thought and/or had feelings about previously.

Sometimes a phrase or sentence seems to be saying more than one thing in my interpretative mode. In this case, I may use the phrase in more than one category – although it is doubtful that I would offer the same phrase more than once in the thesis as it might make it repetitive. I find it difficult to unravel whole paragraphs but sometimes, when you are analysing a paragraph sentence by sentence, it seems to lose its meaning so I feel I need to follow the hermeneutic circle to follow its interpreted meaning.

20 September 2007

I am not yet halfway through my second transcript for the first analysis and I have seemingly 79 themes emerging from the data although some may be repeated or very similar. This is clearly not sustainable as I cannot trawl through them for each sentence or section of every transcript to see if it is on the list already and I do not want to add further duplicates – and possibly miss adding new themes.

I am going to sift through the themes that have already emerged (given that there may be many more to emerge yet!) and try to sort them into categories now so that the continuing process of analysis does not become a threatening and unwieldy beast. However, this process will not pre-empt any of the other stages of my analysis and I will keep to hand all the original emerging themes for transparency. I list these below and remembering my original research question: *How does the nurse experience of being overweight influence their interactions with the overweight patient?*

The 79 emerging themes so far are:

Nurse's understanding/empathy for overweight patients

Nurse's professional detachment when caring for patients

Nurse's sensitivity in communication with overweight patients

Nurse's pragmatic health education advice to overweight patient

Nurse's understanding/empathy for patients who smoke

Nurse's perception of possible conflicting patients' views of her being overweight

Nurse's perception of people's views of her being overweight

Nurse's prioritisation of care for different types of overweight patient

Nurse's perception of other health professionals' prejudgement of overweight patients

Other professionals' judgement of overweight patients

Professional detachment when caring for patients

Understanding/empathy for patients/nurses who are overweight

Nurse's perception of possible conflicting patients' views of her being overweight

Nurse's perception of patients' and other professionals' views of professionals being overweight

Nurse's perception of patients' views of professionals being overweight

Nurse concerns about health effects of weight; nurse's perception of people's views of overweight

Motivating factors for nurse's weight management

Nurse/health professional not acting on own health behaviour or belief/understanding of issues for overweight patient/ineffectiveness of health education

Nurse struggling with acceptance of her weight

Nurse concerns about health and self image associated with overweight

nurse taking responsibility for own weight

Explaining self-awareness of attitude of overweight nurse towards overweight patients

Explaining self-awareness and possible hypocrisy of overweight nurse who cares for overweight patients

Explaining self-awareness of attitude of overweight nurse towards overweight patients

Explaining self-awareness of attitude of overweight nurse towards overweight patients/empathy with overweight patients

Explaining self-awareness of overweight nurse towards her poor eating patterns

Nurse analysing the factors that affect her own weight management/trying to follow her own advice

Nurse analysing the factors that affect her own weight management at home/work

Nurse analysing the factors that affect her own weight management at work

Nurse expressing shame and frustration for being overweight at work and home

Nurse expressing empathy with overweight patient and frustration with her own weight

nurse's perception of patients' views of themselves and professionals being overweight/
Effect of research process on participant

Effect of research process on participant

Pragmatic approach of nurse towards her own weight management and that of overweight patients

Approach of nurse towards her own weight management

Nurse perception of health effects of overweight

Nurse perception of the effectiveness of health education

Nurse perception of the barriers to weight management in society

Nurse discomfort in role as overweight patient

Nurse expressing frustration with her own weight

Nurse expressing a contradictory opinion about her self image and her overweight

Nurse expressing empathy for overweight patients and their relationship with health professionals who are 'skinny'.

Nurse expressing empathy for overweight patients regarding health behaviour

nurse's pragmatic approach to overweight patients

Nurse describing her reflections on her role

Nurse describing her experience of caring for the overweight patient

Nurse describing her emotions and her experience of weight whilst caring for the overweight patient

Nurse describing her own experience of weight and eating when stressed

Nurse describing her views on the lack of service specifically provided for overweight patients

Nurse describing her perceptions of being a role model/discomfort of being regarded as overweight by a patient

Nurse describing her discomfort of being regarded as overweight by a patient

Nurse explaining the reasons for her feelings of guilt

Nurse describing her present attitude towards addressing her weight issues

Nurse describing the barriers to her own weight management

Nurse describing the barriers to her own weight management and to putting patients first

Nurse understanding/empathy for overweight patients/expressing discomfort with discussing weight with patients/confidence in talking to overweight patients/conflict

Nurse confirming that she has not broached the subject of weight with a patient in recent times

Nurse explaining why she did not initiate conversation with overweight patient.

Nurse describing the problems of nursing an overweight patient

Nurse describing the barriers to initiating the topic of weight with an overweight patient

Nurse explaining her perceptions of how the media influence her attitudes towards weight

Nurse describing the difficulties in initiating the topic of weight with an overweight patient

Nurse describing the difficulties in initiating the topic of weight with an overweight patient and the lack of organisational and professional support in this

Nurse's perception of organisational support for nurses who need to manage their own weight/ Nurse describing the barriers to her own weight management and to putting patients first

Nurse concerns about health effects of overweight

Nurse's experience of initiating topic of weight with an overweight patient/nurse's feelings of hypocrisy when offering advice on weight to an overweight patient/nurse's perceptions of patient views of an overweight nurse who does not follow her own advice or is a poor role model.

Nurse's expression of desire for a tool with which to help care for overweight patients.

Nurse's perception of what it means to be an overweight or obese patient

Nurse's perception of how to judge if someone is overweight

Nurse perception of social and media pressures regarding weight and women

Nurse perception of social and media pressures regarding weight for men and women

Nurse's pragmatic advice to an overweight person

Nurse's perception of factors that affect weight

Nurse's self awareness of her weight issues

Nurse describing the problem of supporting overweight patients

Nurse describing self-awareness and her perception of the patient's views on her providing health education advice on weight whilst being overweight herself.

Nurse describing a tool she has devised to provide health education advice on weight for overweight patients

Nurse describing how she feels physically when she is overweight

Nurse describing her health education approach to overweight patients

11 December 2007

Having read the paper by Brown I & Thompson J (2007) JAN 60(5),535-543, I consider that my research overlaps in some areas but that I can address more thoroughly some of the issues he raises and either does or cannot answer from his own study. However, my research study is methodologically different as it is a phenomenological approach and does not make any claims on generalisability. None-the-less, I consider that the nurse participants in my study have stories to tell and I note that Brown and Thompson do not return to their participants and involve them in the analysis, whereas my participants were re-interviewed and early analytical themes (which have since evolved but not changed fundamentally) are negotiated.

So, looking at Brown's paper, possible questions to ask of my own data follow. I consider that my research study will add value to his own study and add to clinical knowledge and practice as it does offer more depth to the debate of the effect of high BMI in nurses on the interaction with patients.

Interestingly, my own findings regarding Brown's stated *'tendency in those with a high BMI to be more critical and judgemental about obese people, possibly because these participants were critical of themselves and also more open about discussing obesity.'* [p540] do not really concur. However, my sample is small and so that leaves me open to criticism if I challenge his findings on this issue.

The following questions, taken from Brown's study might be useful when attempting to interpret my findings:

Sensitivity issues

How does nurses' own body size affect efforts to tackle the issue of negative attitudes towards obesity with patients?

How do nurses establish a rapport with overweight patients?

Does the context of the discussion bear any relation to the degree of discomfort experienced by nurses in initiating the topic of weight?

Does having a protocol assist in initiating the discussion?

Do nurses think that the advice will achieve change and help the patient?

How do nurses approach the topic of weight?

Complexity of obesity issue

What factors affect weight?

To what degree does personal responsibility affect weight management?

Does motivation change over time?

Is there a sense of frustration from the nurse about patient overweight?

Effects of own body size - General

Are nurses concerned with or conscious of their weight? Is this more marked in interactions with overweight patients?

Effects of own body size - Low BMI (I would need to refer to my 'recruitment' data and do not feel that I could address this issue from my own study)

What strategies are employed by low BMI nurses in caring for overweight patients?

Effects of own body size - High BMI

Are overweight nurses self-conscious about their weight?

Do nurses express feelings of guilt?

Do overweight nurses make a virtue of their size in relation to rapport with patient and quality of service?

Do nurses make assumptions that the patient's experiences match their own?

Is advice given on personal hunches rather than the research evidence?

Are overweight nurses more critical and judgemental about obese patients than low BMI nurses?

General

What are the 'impression management' strategies of nurses in interactions with overweight patients? (similar to my own thoughts on cognitive dissonance?)

How can high BMI nurses manage raising the sensitive topic of weight with overweight patients?

Emerging themes 24 February 2008

I have broken down the themes into three sections but I am still not comfortable with these as the nurses move from one position to another and I am struggling with separating out the different elements of their being, their 'self', and there are so many overlaps between their personal and professional self that I need to reconsider this.

Being a professional (includes...)

- Being a role model
- Being detached
- Being comfortable
- Being confident
- Being pragmatic

Being a person (includes...)

- Being empathetic
- Being sympathetic
- Being sensitive
- Being understanding
- Being a good communicator
- Being caring
- Being self aware and 'other aware'
- Being self-sacrificing

Being in a state of conflict (paradoxical) (includes...)

Being all or some of the above AND

Being hypocritical

Being judgemental

Being victim-blaming

Being judged

Being ashamed

Being embarrassed

Being guilty

Appendix 10: Sample transcript (Erin)

Thank you very much for coming to see me. Would you like to first of all tell me a little bit about your role, what do you do as a nurse?

Okay, I'm a Health Visitor, I work primarily with um, families with children under the age of 5 years, or under school age.

Yes.

Um, I work full time and um, I visit, I do home visits, I do child health screening, um, what else do I do? Basically search out health needs, any needs that they have, do a bit of health promotion, um, do a lot of liaison work with school nurses, GPs, playgroups, that kind of thing.

So you'd say health promotion forms quite a bit of your role?

Yes it does, yes.

In what sort of forms would you use health promotion?

Um, well, we give health promotion messages, ante-natally, post-natally, um and for children as well under school age, preschoolers, um, we talk to expectant mothers about smoking, diet, um, postnatally we'll talk about exercise, um, contraception, that kind of thing. And with children, um, again diet and exercise, we get involved in.

So does weight come up quite a lot?

Yes, it comes up quite frequently actually, yeah.

In what sort of areas, what would happen, can you think of an example where someone was presented to you with a weight problem?

Um, well quite often mothers after they've had babies, um, have problems with their weight. Although they don't actually come out and talk about it, but it's something that I can bring up if I feel that there is a need to. Um, I've had one or two mention it to me, mention that they're unhappy with their weight um, and usually in those cases I can say that, I refer them into the [exercise referral] programme which is the exercise on prescription type programme. Um, and talk to them a little bit about diet and talk about where they can get help with their diet, really. So it does come up.

Is there ever a situation where it doesn't crop up and you think in your role as a nurse that really it should be something that perhaps should be discussed?

It comes up. It can in cases, particularly with postnatal depression, where mums are quite depressed, you know? I sometimes would mention weight as a possible cause of depression and also because exercise can lift the spirits and it's a way of beating post natal depression as well, and depression generally, so...

We will come back to that in a little while because what I would like to do first of all is chat to you about your own history of weight, can you just tell me a little bit about your, how you feel about yourself and what's happened with your weight?

Okay, I was quite a skinny child, um, and then I had quite an overweight mum actually who went on a diet when I was 12 years old and lost quite a lot of weight, she lost about five stone. Um, and I was watching all this and became quite engrossed in the whole diet thing and um, it actually become a bit of a problem.

How old were you then?

I was 12, um, and eventually I was diagnosed with an eating disorder, I was diagnosed with bulimia when I was about 16-17 and got treatment and got over it very, very quickly with cognitive behaviour therapy, so since then it is always something that I have to watch, um, I've always been, certainly since I had my first daughter who's four and a half I've been overweight but it's hasn't been a big issue with me. Um, I then had my son 8 months ago and since then it is a big issue because I know I'm not having any more children so I do want to lose the weight now. So at the moment I'm just, I've slimmed down, I can get into my pre-baby clothes um, but they're still a little bit on the tight size and I would like to lose another stone. So that's where I'm at the moment.

So has your weight fluctuated do you think?

Um, yeah, I was generally, I was quite big as a teenager until I got the treatment for the bulimia and then I started eating sensibly, and then it stayed quite stable until I had my daughter, so that was a period of about 10 years. Um, I maintained my weight, ate very carefully, exercised but I had the time, um, and then it's just, I've been about a stone, one to two stone overweight since then.

So which was, that's not that long ago?

That's four and a half years ago, yes, four and a half years ago.

So you've been a nurse during that period of time of being what you would consider to be normal weight and also what you would consider to be slightly overweight?

Yes.

Interesting, has your attitude towards overweight patients changed?

Um, yes I suppose it probably has because when I was slim I suppose I had very little tolerance of overweight, not tolerance, but I couldn't...wasn't as sympathetic as I am now, um and I just thought, "oh, it's so easy". And also it was easier, it's easier when I was in my early twenties to maintain my weight, where as metabolism changes, you know, your shape changes after you've had babies and it's just not as easy, so I was, um, yes definitely I thought "why aren't you doing something to lose the weight?" Whereas now, I definitely feel sympathy. I just think I know how hard it is to make the time to exercise, to have the time even to plan a healthy meal and to cook for yourself when you are just rushing around.

Do you think that's the main fact why you have problems with weight?

Yes, I think it's lack of time.

This is quite a tough question, take some time to think about it, or if you can't we will move onto another one, but can you think of an example of having to approach an overweight patient when you've considered yourself to be normal weight, can you think of an example when you would have done that?

I don't think...(long pause) I think it's quite difficult, because when I was slimmer I was a paediatric nurse so I was more dealing with children, it wasn't so much adult patients at the time. There would have been overweight parents and I certainly looked after a couple of obese children actually, um, but since I've been, since I've had my daughter that's when I did my Health Visitor training, so I'm now dealing with adults more.

Okay, so we'll focus a little bit more on that side of things. It would just have been quite interesting to have heard whether there was a difference in, because sometimes there really can be in the way you approach things, or whatever. So in today's world, if someone that you were looking after, very, very overweight, can you, I don't know if you can think of an example at the moment, to have something in your head? Can you imagine a situation where you've got an overweight patient recently? What would be going through your mind, not so much what would you do with them, but what would go through your mind initially when you saw them?

Um, well it actually happened yesterday in clinic I saw a lady who was really quite overweight, um, and it sounds really awful but I did think "how did you get so big?" because she really was very, very big. She had two children. That was the first thing that kind of went through my mind. I mean the consultation wasn't about her, it was more about the baby, and I didn't know her, so it is quite different to if you've built up a relationship with someone which is what I do in my job, and then you feel that you can mention things more easily, at that time I

couldn't. There was no opportunity; it wasn't about her and her weight. Her husband was also big, and the babies were big and solid.

Yeah, so in that situation you would be inclined to leave it?

In that situation I would, yep, but if I knew someone, if I'd build up a relationship, if I'd seen them ante-natally, post-natally and followed them through and, you know, perhaps knew them at eight months, at the eight month check and things were coming up then, I think that's when I would say something.

How would you broach it?

Um, how would I broach it? It's difficult isn't it? It depends on what kind of context.

Think about some examples of patients that you've spoken to perhaps?

Yeah, I mean how we work as Health Visitors it's all very chatty, very conversationalist, conversational, um, they don't know what we're trying to do by speaking to them, you know, they just think we are coming round to have a chat, so it's difficult because I've got no standard way of bringing up something like that. It would have to happen naturally in the conversation, or I would kind of gear the conversation towards weight and exercise. It's difficult, there's no standard question, or...

So do you look for cues in the conversation?

Yes, yes, absolutely that's what most of our work is about picking up on things and open ended questions um, and trying to get conversation going.

Okay, so do you get any support for your weight management?

Um, no, absolutely not! (laughter)

Fair enough! No, that's direct! Is there any kind of weight management support that you think would be useful to you?

I would like some time to exercise, I'd like somebody to look after my children so I could go and exercise.

Thinking of your role as a nurse, is there anything, I think it's quite a unique role in the sense that we are, as nurses, expected to know what the messages are, we don't always necessarily follow them for the very reasons that you've stated ... do you think that there is anything particular that nurse need for weight management, over and above the kind of ordinary woman in the street if you like, is there anything more specific that nurses need for support?

Um, I don't think there's anything over and above the average person out there, but I think, I think for nurses it can be quite difficult. I think they're more prone to putting on weight for a start because of shifts, I think shifts don't help when your body's all out of sync and you're eating all over the place, I always found that I had to watch that really quite carefully because if you're going off doing nightshift you could be eating during the day and eating at night as well to keep yourself going, but then, saying that, you're also up and down the ward all day if you're nursing, you're up and down the ward all day and you know, you're on your feet quite a lot so you should be burning a few calories, um in my job it's quite sedentary, it's sitting around quite a lot, um, so I can't say that there's anything that they need over and above anyone else.

If anything crops up, or springs to mind then put it in the notebook and we'll have a chat. Just interested to know if there's anything over and above what maybe you'd get at Weight Watchers or something, you know, it's just interesting to know, particularly in view of the fact that we know the messages. So what would help you in your life, apart for somebody looking after your children?

What would help me? Oh, lots of things. Not having to work full time would help.

You have a lot on your plate.

Mmm, I do. Um, I think it's just that really, I think my issue is completely time, totally and utterly time.

So going back, we mentioned earlier that you talk to overweight patients, how, you've said that you feel that you're a little bit overweight at the moment, how do you think that affects your role, really, when you are talking to an overweight patient, how does it make you feel?

I feel okay talking to an overweight patient. I feel quite comfortable talking to people who are overweight, um, and I feel that they look at me and think "well, perhaps she does know what she's talking about" um, and I actually remember thinking the same thing when I was having my therapy for my eating disorder. I had an overweight therapist and I remember thinking, that made me feel so much more comfortable than having someone really skinny sitting there who just possibly couldn't understand what I was going through, so hopefully I think that makes them feel a little bit more comfortable. Um, I feel actually more uncomfortable with really very glamorous, um, very slim women who, you know, have just had a baby two months ago and are completely back in their size eight jeans, that makes me feel a bit more uncomfortable that speaking to an overweight person.

Yes, yes, so you would say you have more empathy?

Definitely.

How would you assess if a patient's overweight?

Um, obviously we don't use any tools like the District Nurses, like the Practice Nurses would, you know, we don't measure BMI or anything like that, so it's just visual really with us. And asking them if they feel overweight, if they feel comfortable with themselves, if they're happy.

Yeah, so you kind of make a judgement?

Yeah, yeah, on appearance, totally on appearance.

What does the term overweight mean to you?

Um, thinking of it purely clinically it's um, it's being above the ideal range for your height isn't it? Your weight being above the ideal range for your height. Um, but to me, what personally wise do you mean? It's the feeling of being uncomfortable I think.

Do you think the health promotion messages we give about overweight are effective?

Um, no, no I don't actually, because obesity is going up all the time isn't it? People aren't, there's just, there's too much, there's too much junk food, too much access, there's too much money I suppose for people to buy these rubbishy things, so no.

So when you give advice to an overweight patient are you saying that they follow it or they don't follow it?

I think possibly quite a lot of the advice I give, people don't follow.

People don't follow it?

No.

What do you think the pressures are, you've mentioned some, do you think that um there are pressures particularly on women in society. What do you think those pressures are?

Um, well there's always been a pressure to be slim and to look lovely, and with husbands you worry about them meeting someone else, um, uh, it's just sizes are going down, aren't they? You've got size zero girls now and it's not, it doesn't so much affect me now, I can look at things and see it for how it is, see it in, you know, realistic context now, but when I was younger it did used to really affect me, images, media images, magazines, I was constantly leafing through magazines thinking I want to look like that.

Who's it harder for, men or women?

I think it harder for women, but I think it becoming hard equally for men. I think there's more pressure on men too.

Yeah, I think you're right, I think there's a huge amount of pressure. Is there anything that you um, think particularly, just sort of as a summary question, about dealing with overweight or caring for overweight patients, in your role, is there anything that we've missed out do you think that we should have covered?

Um, not that I can. Not that springs to mind, no. Um, I just think that it's quite difficult for the people that I see who are overweight because there is the added pressure of having young children, I just think it's very, very difficult when you've got young children, to, to get, well it's time, to have time to have the money as well, and to be able to go to the gym. I know exercise can be free too and there's other ways of doing it. Um, it's just difficult, I think my clients are in quite a difficult situation.

Do you see yourself as a role model, the nursing role as a role model?

Um, I'd like to see myself as a role model, but no, because I don't, I can say to someone: "what you need to do is, you need to exercise, you need to eat more healthily" - and I know that I need to do that myself and I know that there are quick ways of, you know, losing weight, there are ways to, I could have a healthier diet and it isn't going to take any time and it isn't going to take any money, but I don't actually. I think because a lot of the time I'm just too tired, I just want the convenience food because I'm just tired. Um, so no I don't do as I say, so why should I expect them to?

Can I just ask how that makes you feel though?

Um, yeah this is how I feel actually about the job at the moment. Because I am obviously in the system as well with an eight month old baby I know a lot of what we say as Health Visitors I don't do, I don't follow my own advice about my own children, so I think why should other people follow my advice, so I'm not feeling particularly good about my job at the moment, I'm feeling that it's not, I just don't, it doesn't feel important sometimes. Um, I can't explain it, I just remember as a nurse I was so satisfied, I really loved nursing, but this job I really find quite difficult, I'm not entirely sure I'm cut out for it.

Oh, that's a shame. That is a shame. (long pause)

Yeah, but it's just, I don't know, bits of it I really enjoy but bits of it I don't.

Can I just return to the weight thing again, so if you had to sum it up in maybe a couple of words or kind of an emotion, can you sort of maybe give a couple of words to describe that feeling that you mentioned. (About the job?) About the

weight, when you are dealing with overweight patients, when you mentioned, you weren't doing what you are telling everybody else to do, is there a way...

Oh, yeah, I feel quite hypocritical and a bit patronising in a way almost as well. Um, what other words would I use? (long pause) I don't know.

And earlier you felt that there was an empathy with the patients, so is there a bit of a tension there?

Um, what with overweight...?

Well, you mentioned that you feel hypocritical, but also that you have empathy with the patient when you were a patient you felt that, you felt more comfortable... So in a way you've got lots of conflicting emotions going on there haven't you – does that make you feel in any particular way...?

I feel quite uncomfortable because I feel I'm just kind of preaching to people almost um, and giving the advice that I'm supposed to be giving but whether I actually believe it myself, I don't.

Do you think that overweight's bad?

I don't think it's bad, I think, no I don't think, No, I wouldn't say it's bad.

What do you think, "is it harmful?" is what I'm basically asking you, is it actually harmful to be overweight?

Yes, well I don't know because you can be fit, very fit and fat, but you could be very unfit and thin, so it doesn't have to, it can be harmful obviously but it depends, it depends on how far it's gone, how overweight you are, whether you're exercising. I think exercise is a huge thing, um, so it doesn't have to be harmful, but it can be, yes. I think it should be avoided um, and people should take steps to bring their weight down, certainly.

If you're successful in losing the weight you said you would like to lose, do you think that will change your perspective on overweight patients?

No, because I feel like I've been there and experienced it.

Yeah, okay, thank you. Um, is there anything else related to your own perceptions of weight or nursing overweight patients that we haven't covered in the interview that you would like to talk about?

No.

There may be something that crops up for you that you can put down in the notebook for next time.

Okay.

That was lovely, thank you very much. (End of interview 1)

Interview 2

Thank you for coming to see me today. Shall we start with the note book, what sort of notes did you make?

Well I've just written one entry really, um, which I'm just reading and just about how I initiated the subject of weight um... yep.

Would you be happy for me to take that?

Yes, that's fine.

Fantastic, thank you. Well, I'll let you keep the notebook, what I'll do is just take that out and you can use it for shopping list or doodling or some such thing. (laughter) Thank you, I appreciate that, thank you, and I'll include that in the data. Is there anything there that you want to talk about?

No, I don't think so, no nothing, no. I was just kind of, um, yes that was shortly after I saw you, so yes.

Just some thoughts? I'll have a look at that a bit later on, but thank you for that. So what I basically found was, there was a tension for some of the participants between being a nurse and a woman, so it was very much like being in a different role. Have you got any thoughts on that?

About the difference with being a nurse and a woman, as in terms of weight?

Yes.

Well I think it's, it's, when you are a nurse it's, you put on a uniform, or, you know, my uniform is you know, my badge and my work bag and you know, my set of scales um, and you're just, you're just, I'm just a Health Visitor I'm not me when I'm in that role, um, and I feel very different, I'm a very different person when I'm at work to when I'm at home. I am completely different, so definitely for me it's incredibly separate. People wouldn't really realise, I just think um, yes, I'm completely different, I'm completely different at home to how I am at work.

So would that also feature if you were looking at overweight people, not patients, but people, what do you think about them?

In my normal life?

In your normal life, not as a nurse.

In my normal life I would be far more scathing, I think, which is really strange, but definitely I am of overweight people than when I'm at work.

I'm quite critical when I watch tele

Yeah!

- and I see overweight people and I'm thinking but I am one! (laughter)

Yes, that's right.

Yes, it's, but as a nurse how do you kind of delineate that woman and then sort of step into the role of a nurse?

I think I just step into the role as soon as I go to work. I'm just different, completely different person. I'm much more confident at work. I actually, I think it's again, you know, it's always with me time, I get time to think about things a bit more, whereas at home it's just kind of off the cuff remarks that I haven't thought about because I don't have time to think about anything really.

So overweight patients as a nurse, what do you think there?

I'm sympathetic because the group that I deal with are like me and I'm really, really sympathetic towards them.

Yes, and how does that manifest what do you do whilst you're caring for them; how would that be demonstrated?

Um, well just the way I talk to people really and I do try to show some empathy, um, and just, I don't want them to, I don't want to bring my own experiences into my work, but um you know, just I would say constructive sentences as if to say, "I know what you're talking about because I've been there."

When you're talking to an overweight patient, if you can think of an example of one, in your head now, when you're approaching them, what I'm interested in knowing is kind of the knowledge that you use to make that sensitive communication with them, so it's not so much about the messages it's about how you make the decision about how to approach them. So whether it's knowledge that you've gained from your course or theory or reading or whatever, or is it that with a previous patient this is how you've gone about it and so that's the way you might try and go about it this time? Or is it that you know that patient really well and you know that there's a specific way that you should approach them?

Yes, I think it more the second that you said, it's, I don't, I don't mention weight until I know someone very well unless they mention it to me and then I'll talk about it in a very standardised way. But if it's someone that I know, that I've built up a relationship, say ante-natally, post-natally, through the six weeks or you know, however many months, um then that's when I would feel much more comfortable and it would be easier because I'd know them and how they approach things. And that's you know, like a lot of Health Visiting, it doesn't just go for weight, it's about everything to do with Health Visiting.

So if you had a completely new patient and you probably thought to yourself "I do really need to bring up this topic", what sort of knowledge would come to bear? Would it be "oh, I've dealt with a similar type of patient, you know, I've sort of, something in them I recognise, this worked for me before so I'm going to try it" or do you just go for it?

I think if I really had to mention it at, with a brand new patient, which would be not very often, um, I would probably just go for it, in whatever way feels right for that particular women.

So you've got different methods?

Yes.

Could you explain some of those methods for me?

Let me just think, I mean I did deal with an overweight, on the first visit actually which is unusual, um, an overweight man and woman um, and he was worried but he had actually made a few little comments about his weight through the visit and in the end I said "Is your weight something that bothers you and would you like to do something about it because I could refer you to the exercise programme?" and he said "Well actually, yes that would be quite good and I would like to do that." - so I sent him the form. So it's, I do pick up on their cues because I'm not, you know, my primary role isn't um, when I go in to see families, it's children, we do deal with the whole family, but it's child first and then we look at the other issues. It's just picking up on cues really. But yes, I can, if I've got the cues there I will act on it.

And that's because it's something that's worked for you in the past?

Yeah, possibly.

Or have you been taught to do that, did somebody say to you...?

Nobody's taught you, nobody teaches you how to do it.

Okay, so it's an instinctive...

Yes, it's just, it's not standardised, I mean you have to do it how it feels right and use different approaches with different people, so it's not necessarily because I've done it in the past, it's just whatever feels right at the time, but nobody teaches you anything about how to bring up topics like that, in a sensitive way.

No, is that something that you think might be useful?

Um, I think it would be useful, but again I think it's very difficult to teach because it does depend on how you are, how you say things and how your clients are and how they take things and see things.

I know, I think you're right.

So, it's so individual.

So is there a, the tension of being overweight and yet talking to patients about being overweight, is there anything there that you've thought about since the last interview?

Um, well again, it's um... sorry, lost my train of thought there.

It's about being overweight and talking to patients about overweight, I just wondered since the last chat.

Again, it still feels quite hypocritical for me to sit and give advice and messages when I'm not necessarily taking it myself, although I am more so now, so...

Has the taking part in the research affected you in any way?

Yes, it has, it has affected ...(pauses)

In what way?

Well, since I've spoken to you I've just realised that um, actually my weight is probably affecting me more than I thought, um, because it was interesting just having some time to focus on you and you know, your issues which you don't really get. So um, yes, it's affected me, I've dropped down my hours at work and I started to exercise and um, started to eat a bit more healthily, not all the time, but just, you know, making an effort now really, so yes, it has affected me.

That's interesting, so do you think it's quite a positive?

Mmm, definitely.

Sorry, that was a very leading question.

No, it has been positive.

Yes, so what do you think, since we last spoke, I think in your last interview you mentioned that time was a real factor for you. What do you think your barriers are to your weight management?

Working full time, I think, isn't it?

Yes, you mentioned being time deprived and tired.

Childcare...

Do you think that your main barriers to, sorry rephrase, what do you think are your main barriers?

Um, time definitely time, um, stress at the moment as well, not at the moment, I mean, it's always been about stress as well because I do tend to eat when I'm stressed, I'm an emotional eater and um, I've got a lot going on at the moment so that's a big barrier, although that is something that I should be working on really, um, yes, I would say time and stress.

One of the things that other nurses have mentioned in their, when I talk to them about support, actually it might be interesting to hear what you say first before I sort of... With support from the employer is there anything else that you've thought of in the meantime that they could do to help you with weight management?

Well, I suppose they could provide healthier, healthy food at work. I mean it's, I often think, um, I end up going and stopping at the nearest shop and buying a load of rubbish because it's all they have um, and there's no, I think it would be nice to have some kind of delivery van or something coming to your work place with healthy food because I would definitely buy it if it was there, I know they, I think they do somewhere in [name of place] now they have a van. I don't know how healthy it is, but that would help.

Yes, we have sandwiches here, they're not particularly healthy. It's still crisps, chocolate and the rest of it.

Yes, but healthy food.

One of the nurses, a lot of the nurses said similar things too, it would be nice to have access to exercise facilities and access to health foods and I think the practical things are really quite important. One of the nurses mentioned that they felt that because they are so busy and they were kind of putting themselves last, I think it has resonance with all the nurse I spoke to, that they put the patients and everybody else first and I know that's something that came over in your own interview and that they almost felt that it would be useful to have some kind of empowerment in their role to say "Well look, this is my case load but I do have to

have time for me in the middle to sit down and eat a proper lunch.” - and I don't know what your thoughts were?

Oh, without a doubt. It's just dreadful because you can go the whole day without eating and then you're absolutely hypoglycaemic and you need, I just find myself stopping off at the nearest garage and getting a bar of chocolate to keep me going because the food that they, the other food they have there, the sandwiches and everything are just rubbish anyway and yes, there's, you do feel almost um, in the NHS that you're some kind of martyr; you have to keep going and going and going for the sake of everybody else, and um, you feel almost guilty if you take a lunch break, like you're stealing time from them.

I know, and it is that guilt I think that comes over quite a lot.

Yeah, it does, I mean it's your time, it's crazy, you don't get paid for it but you're so used to working unpaid overtime and that's what keeps the NHS going.

Yes, I know, and buying our own stationery!

(laughter) And everything else!

Yes, um what do you think the health effects of weight are?

Um, well the obviously heart disease, stroke, diabetes risks and depression I suppose as well, mental health problems, it affects you. Um, those are the obvious ones, just poor self esteem.

Yes, do you think you can be overweight and be healthy?

Yes, I still think you can be overweight and healthy without a doubt.

What do you think about weight and society? Do you think, is weight an issue?

Um, I think weight is a huge issue still at the moment, um, especially I think I said last time about size zero models and everything it seems to be more and more now a super super skinny, um, it's definitely, yes a massive issue for society; it's costing the NHS however much, you know obesity and everything as well, so that's a huge drain.

Do you think the health education messages are effective?

Um, no I don't because I think there's a lot of other factors in people's lives it's not just about their weight, there are lots of things that effect their weight, you know, finances, time, stress, those kind of things that you know if you don't deal with those things you're never going to be able to help someone to get their weight under control.

So when you are giving health education messages how much of those aspects are you able to discuss with them?

Yes, I'm able to discuss pretty much anything really, um, in my job it's quite easy because that is my job. I can delve as far as I like really. Um, so I wouldn't find that an issue to say "Do you have the money to go to the gym, or do you, you know, do you need some help?"; "can I get you on the exercise programme?" - which I think is fantastic - which would cut down the cost, um, you know there are other things that are alternatives if you can't afford exercise and healthy food. I'm talking a lot about exercise but you know it obviously it goes for healthy food as well.

It is a crucial factor.

I think exercise is really important.

You mentioned the psychological issues, are they anything that you would deal with?

Mmmm, definitely, yes. Yes, I could explore that quite easily. If, if weight comes up I could quite easily explore and I do explore other aspects of it and you know, family, "are your family overweight?" um, and how far back it goes and childhood experiences and um, you know, habits and things.

Thank you. Have you ever been a patient?

Um, yes.

And did your weight affect you when you were, kind of a role as a patient?

Um, no I don't think so, I think, no, when I've been a, I suppose there's always the paranoia because the only time I've really been a patient is when I've had babies or had my wisdom teeth out, there's this kind of paranoia going into surgery, (laughter), isn't there, that what are they going to look at when you're under the anaesthetic, and will they think I've got fat thighs?

One of the nurses very carefully got one of those self tanning things (laughter) before she went into surgery and that's that, yes, it's quite worrying, isn't it?

It is, yes, absolutely, yes, I definitely had that thought go through my mind.

And do you think that's about our image or our self esteem?

Yes, it's all to do with self esteem isn't it and what the perfect ideal person is.

And yet even who we might regard as being perfect and ideal still have angst about themselves, don't they?

Mmm, absolutely.

Do you know, as a matter of interest, do you know your BMI?

I think it's about 28 now, or 29, between 28 and, 28.8 may be, something like that.

Can I be very rude, you don't have to answer this, how old you are?

31.

Would you do me a favour, I'm not expecting artistic wonderment, but what I would like you to do if you don't mind, is to draw me, matchstick figure's fine, a drawing of a woman who you would see as normal size and a drawing of yourself, how you perceive yourself compared with the normal woman, would you mind doing that?

(laughter) That's a nightmare.

I don't think anyone really likes the drawing bit because I can't draw for toffees.

No, I'm not good at drawing.

And I laugh at myself using that analogy.

So what, a slim person, you want me to draw a slim person?

Whatever you see as normal, doesn't have to be slim as such but someone you would see at normal weight and someone, someone you would compare yourself really with that person.

Okay. I think a normal woman is quite curvy, should be anyway. Um.

I get the idea (laughter).

Something like that, and then me?

Yes,

Oh no, um. I think I've got fat arms (laughter) It's not, now I've drawn it the same size, mm, it's more proportions I think. I think I've got really bit thighs and bum. It looks awful. (laughter) I just see myself as a pair of thighs and bum really and quite chunky there and those arms are definitely bigger than that and more rounded, yes, I suppose...

That's your perception? Okay, thank you. (laughter) Make sure I've got the right number on it letter and things. So just going back over some of this, I don't want to miss anything out; There was a lovely term called 'gentle hypocrisy' which one of the nurses said about the way they are very tolerant and empathetic with overweight patients and yet there's still this judging in many ways ... would you agree with that?

Just explain again?

Well, there was a tolerance in empathy of nurses with overweight patients and yet there was this kind of critical judgement of patients, was that something that you had thought about?

Mmm, Yes, I would definitely say, because if I see very obese patients I definitely have felt like how do you get to that size? You know, what do you do to be like that? - so definitely.

We talked about time. The nurses who distance themselves from the body was interesting. So do you regard yourself as your body being part of you or do you see it as something else that you've got to deal with – 'it's my body'?

No, I think my body is part of me, I see it as part of me actually I don't see it as a separate thing um, and it's all kind of tied up with how I'm feeling and my stress, because I can lose weight and put on weight so quickly and um, I know it's all to do with how I'm feeling about myself about life, about everything really, so it's definitely intrinsically tied up with me. I wouldn't see it as a separate thing.

You can tell how my life is going by my weight, pretty much a good indicator.

Yes, it's awful isn't it? (laughter)

It's bad news, yes. So what is it about weight specifically that bothers you?

For me, personally, I don't like the feeling of being unhealthy and um, sluggish and I don't like the look, I don't like looking in the mirror when I'm overweight. I don't like it when my clothes feel tight.

Is it a physical and kind of, well, it is a physical type thing for you, is it?

It's physical and mental because if I have lost a bit of weight and my clothes are feeling loser, I walk taller, I'm more confident, I look people in the eye more. Um, I just feel so much better about myself. I notice other people, and just such change just from a few pounds.

As a nurse, physically, how does your weight affect you?

As a nurse, um it's the same thing because it's so tied up with me, it's the same. I feel less confident at work, less able to concentrate, I suppose, because I'm constantly thinking "oh, I feel really fat today", um, so it affects me the same way as it affects me in normal life. A lot of the time I can overlook it but I do kind of sit on the floor at people's houses and think, "Do my thighs look really big?"

(laughter) How, has taking part in this research study affected your nursing practice, do you think?

I think it has because I have definitely um, been a bit more conscious of the things that I'm saying to people and um, how I'm saying things and noticing people's weight actually, which you know, some times before I probably wouldn't have noticed. Whereas I'm kind of thinking about it consciously now as something that could potentially come up in the future in interactions with them, that I could raise if I needed to um, and I feel a bit more confident about raising it now as an issue.

That's good, what do you think's happened to make you feel more confident?

I'm just more aware of it really, that it is an issue um, and that perhaps being overweight myself I might shy away from it, um, from talking about it because it makes me feel uncomfortable, and just, yes, just generally just being more aware and more confident to bring things up because I've, you know, I know how I feel about it myself. And it's the same with um, breastfeeding, and my, my feelings about breastfeeding, my personal experiences. Once I tackled those issues about how I felt about it myself I could then deal with it constructively um, with other people.

That's a really interesting point. So you kind of feel that, just checking this with you, that the fact that you've given it some thought now, mulled it over means you feel better able to deal with it in your practice?

Yes, definitely, because I've thought about it in relation to me and my own feelings about my weight and talking about my own feelings about my weight - which I never do - has kind of brought it out and released it and made me see a bit clearer when it comes to clients.

Oh good, it's an interesting take on it. Everyone's had kind of different reactions to it. What do you think I might have learned from doing the research study?

Um, I think that you've probably learned that women's weight is just completely tied up with their self esteem and how they feel and, you know, the stress. I should imagine, the stress that nurses are under just causes huge problems with their weight and their self esteem and no time to think about themselves and that um, will have a knock-on effect on clients and patients.

Do you think that is specific to nurses or do you think that it would be different if it was a group of women that I picked from the street that did office jobs or something? Is there something specific for nurses?

Um, I think there's specific pressures for nurses, you know, we are all working under a very, very stressed system at the moment and we're all, I think we're all very stressed. We're all suffering low morale you know, pretty much um, and I think we all go above and beyond the call of duty for the job because we have to and um, I think that's hugely stressful for everybody.

Was there anything that you were hoping to get from taking part in the research?

Um, I just, I'm very interested in any research, really and I was really interested to see the results and it's something that I always wanted to do when I was looking at research myself as a student and I always thought how cool it would be to be a participant in a study. It would be really good and I would really like that. Um, so yes, just um, the experience of doing it really and um the results, seeing the results that you've helped to create, which is quite a nice thing.

Have you enjoyed taking part?

I have actually.

Oh good. If I were to do training for nurses who'd never been overweight and they were going to be caring for overweight patients, what would I include in that training?

Um, communication, sensitive communication, although I said you can't teach it, I think if you're, if you're with nurses who have never been overweight it might be worth kind of trying to give them some pointers, really, on being sensitive because it is an incredibly sensitive topic. Um...

The empathy thing I think is quite a difficult topic -

Yeah, yeah

- and yet the nurses who have not been overweight that I chatted to about the study, not included in the study, have said that they've actually found it quite difficult to talk to overweight patients because they felt that the patient wouldn't necessarily think that they knew what they were talking about, because they've not been there. So it's a double edged sword, isn't it?

Yes, that's difficult actually, it's probably even more difficult, isn't it? - because the client doesn't feel comfortable, and I've been in that situation um, myself with the therapist who was overweight and I felt definitely more comfortable with her than I would with a slim, slim one.

And in many ways that's something that maybe I can reassure nurses about in so much as a lot of the nurses who are overweight think I can't tackle that because if feel too uncomfortable and hypocritical and yet, it may be that it's probably better that they're ... It would be interesting to get the patients take on it. Um, I think we're nearly there. Um, is there anything, if you were the interviewer, interviewing me - are there any questions you would like to ask me?

Um, I don't think so.

Most people have had the opportunity to really grill me.

Really?

I think it's fair because I've asked you some very personal questions and I'm prepared to answer anything that you ask me, so if you want to come back to that, that's fine. Um, it can be about my weight, or anything like that. Um, and the other question was 'are there any issues related to you own perceptions of weight and nursing overweight patients that we haven't covered that you would like to have a chat about'?

Um, no. There's one thing that springs to mind that might be quite interesting, it's, I remembered just after I did the um, study last time, um, the interview last time, I was in Tesco's and there was a Practice Nurse or a District Nurse, one of the nurses from um, my workplace was there and um, it's quite interesting. I had a whole trolley, because I don't buy my fruit and veg at Tesco's so I had a whole trolley full of rubbish because I had no fruit and veg in there, and um, it was all kind of kids food, frozen chips and such like. And um, I just, I remember piling it up and she was at the checkout next to me and I remember thinking, "Oh my God, she's going to think 'she is so unhealthy, look at all that crap in her basket'". So I thought that was quite funny. But then this nurse herself, thinking back she was actually overweight herself, um, I didn't actually look and see what she had but I think there's just this paranoia that you should be...

Do you think you're judged by professionals?

I think probably not because I wasn't judging her and looking see what she had in her basket, but, um you know, I felt that everybody was judging me, but I think that's my own paranoia really.

So just one final check that I've not missed anything. So we went through all the findings I think, didn't we? - and there's nothing else there I don't think. I think what it really boils down to is communicating about sensitive issues, 'emotional labour': kind of nurses looking after everybody else putting themselves last, and this 'cognitive dissonance': and I think that's quite an interesting thing, this tension between understanding and knowing about how to lose weight and yet not doing it and that really does interest me because I would like to work out how

nurses are dealing with that kind of dissonance and how they struggle with that. And 'struggle' is a word that seems to be used a fair bit as well.

I think you deal with it by separating yourself, separating you and your job. That's how I deal with it, I don't, as I say when I go out to work I am [name] the Health Visitor, I'm not [name] the mum, the wife, the sister, the daughter I'm just the Health Visitor and I'm not really me, I'm just a Health Visitor.

One of the nurses described her uniform as a shield.

It is, yes, yeah, yeah.

- Which I thought was a really interesting term to use.

Yes, it is, and there's no actual uniform for me, but I still feel like I am wearing a uniform.

Because you've got another hat, a metaphoric hat on.

Yeah, exactly, exactly and that's how I deal with any of the hypocrisy that I do, you know, what I say to people and don't actually do myself.

So final thoughts on overweight patients, anything else that you can think of?

No, I don't think so.

I think that's all then, thank you very much.

You're welcome.