

EMPIRICAL STUDIES

Dilemmas in the process of weight reduction: Exploring how women experience training as a means of losing weight

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Abstract

Patients diagnosed with obesity are usually offered group-based behavior interventions which include dietary advice and exercise programs. In particular, high-intensity training—combining weight lifting with aerobic exercising—has been proven effective for losing weight. Moreover, recent studies have shown that persons participating in high-intensity training are more likely to maintain their weight loss compared to persons with lower levels of physical activity. However, most of the research in the field has made use of quantitative methods focusing on the measurable effect of such interventions. Therefore, the aim of this study was to show how the training is experienced from a first-person perspective, namely the patients themselves. Our hope was to shed some new light on the process of weight loss that concerns more than the measurable “impacts” of the training. A qualitative approach was used based on interviews with five women selected from a primary healthcare clinic in Norway. Our results show that experiences of training are connected to the participants’ general experience of being overweight. Both relationships to other people and earlier experiences are important for how the training is carried out and perceived. Five themes were identified supporting this line of argument: (1) the gaze of others; (2) a common ground; (3) dependence of close-follow up; (4) bodily discomfort as painful; and (5) aiming for results—an ambivalent experience. The results highlight the importance of finding the proper context and support for each patient’s needs.

Key words: Obesity, weight reduction, exercise, qualitative study, group treatment

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Introduction

In contemporary Western society, obesity is considered unwanted and problematic. From a medical perspective, obesity is regarded as one of the major public health problems in modern times, causing severe illness, such as cancer, diabetes, and heart problems (Ferraro & Kelley-Moore, 2005). Research also documents that persons with obesity are stigmatized and discriminated against, as well as having to struggle with psychological problems. Women seem to suffer such problems especially deeply (Carr & Friedman, 2005). A Norwegian study has documented a significant difference between young women and men regarding overweight and mental health. Whereas there seemed to be a significant connection between body mass index (BMI) and psychological symptoms—including anxiety, sadness, and low self-esteem—with respect to the female respondents,

there was no such connection for the male respondents (Lien, Kumar, & Lien, 2007). Similar results are also documented in an American study that had nearly 20,000 respondents (Needham & Crosnoe, 2005). According to the sociologists Bell and McNaughton, such gendered differences can be seen in light of the significance the female body has in contemporary Western culture. They argue that a slim and fit body represents an ideal for Western women. Being slender and fit is associated with self-discipline and control, whereas being overweight gives negative connotations, such as laziness and lack of self-discipline (Bell & McNaughton, 2007).

In order to avoid health problems, overweight persons are strongly advised to change their lifestyle. Regular exercise and a healthy diet are considered paramount in order to lose weight (Fogelholm & Kukkonen-Harjula, 2000; Jain, 2005). In the public arena, this message is repeated on a daily basis. In

many published articles as well as on TV shows, weight reduction is allegedly within the reach of everyone who is determined to exercise more and eat less (Groven 2008; Malterud & Ulriksen, 2009 & Rugseth 2006). Despite this public focus on a healthy lifestyle, Norwegians seem to be gaining, rather than losing weight. Statistics show that nearly 20% of the Norwegian population are overweight indicating that they have a BMI of 30 or more, which is similar to statistics in other West European countries (Hjelmeseth, 2007). Consequently, health promotion has become increasingly important and a visible part of public health campaigns, feeding off the current panic over obesity among the population. In these campaigns, health authorities highlight the idea that everyone is responsible for their own health. At the same time, there seems to be a general agreement that those who cannot lose weight on their own should be offered professional help within the health service. According to the World Health Organization, obesity is now regarded as a chronic disease that needs professional treatment. Thus, finding proper treatment has become a public concern and significant funds are directed to developing the most “effective” weight loss programs (Stortingsmelding nr. 16, 2002).

Although caloric restriction is considered paramount in order to lose weight, regular exercise must be carried out in order to generate substantial weight loss, according to recent studies (Borer, 2008; Trapp, Chisholm, Freund, & Boutcher, 2008). In particular, high-intensity training which involves weight lifting (70% of maximal intensity) combined with aerobic exercising (light jogging or stationary ergometer usage) has been proven effective for losing weight (Fogelholm & Kukkonen-Harjula, 2000). Moreover, recent studies have shown that persons participating in high-intensity training are more likely to maintain their weight loss compared to persons with lower levels of physical activity (Franz, VanWormer, Crain, & Pronk, 2007). However, most research in the field has made use of quantitative methods focusing on the measurable “effects” of such exercise programs (Ogden, 2006). Such research provides useful insights into changes in BMI, body weight, muscle strength, and oxygen uptake. However, it cannot provide detailed insights into the patients’ own experiences of training as a means of losing weight as defined by the individuals themselves. Furthermore, such research—by the nature of statistical analysis used—aims to minimize rather than explore individual differences. There is essentially no research currently available about individuals’ thoughts and feelings about training as a means of losing weight. However, two previous

studies have used qualitative methods and explored how women with obesity describe the significance of physical activity in their lives (Ogden, 2006; Rugseth, 2006). Rugseth concluded that the women not only highlighted many negative experiences with physical activity from early childhood, but also described how these experiences generated tension and anxiety when they tried to exercise as adults. A significant finding in Ogden’s study was that her informants associated physical activity with discomfort and pain. Many had problems with daily activities due to their heavy weight and felt pain during physical activity. Therefore they avoided activities that were associated with moderate and high intensity, such as brisk walking and light jogging. As one of them explained it: “Pain in my knees. In my back, in my groin and I could hardly walk at all . . . I couldn’t walk very far. I couldn’t walk upstairs” (Ogden, 2006, p. 278). Taken together, these studies reveal a striking dilemma regarding the current literature’s emphasis on “effective” training: on the one hand, the informants felt an obligation exercise on a regular basis, thereby proving that they were able to lose weight on their own. On the other hand, physical activity was associated with discomfort and feelings of failure—negative experiences which made them stay away from organized training as adults. In other words, as persons with obesity they had problems “fitting in” and finding ways of exercising that suited their needs. Bearing this in mind, there seems to be a gap in the field of obesity research; namely a need for qualitative studies that explores what it is like being a patient in group-based weight loss programs organized by the health service.

During the past 5 years, an increasing number of physiotherapists in Norway have offered group-based treatment for patients diagnosed with obesity. This practice is, among other things, related to efforts undertaken by the health authorities to prevent obesity, since physiotherapists are considered to have special expertise in facilitation of physical exercise for this group (Sosial- og Heledirektoratet, 2004, p. 45). However, there is little research-based knowledge available on the manner in which physiotherapists use their role as “experts” in relation to their patients and the methods they use to motivate them. Moreover, we know little about how patients with problems of obesity react to “expert knowledge.” The same applies to the manner in which patients perceive the experience of engaging in physical exercise in the company of other overweight persons.

Aims

The aim of the study was to show how the training is experienced from a first-person perspective, namely the patients themselves. Our hope is to shed some new light on the process of weight loss that concerns more than the measurable “impacts” of the training. Our point of departure as physiotherapists is a commitment to patient-centered treatment. A better understanding of how training as a means of losing weight is experienced by the patients themselves may foster improved clinical management. Our research questions are:

- How do the patients experience the training?
- How do the patients experience the physiotherapists’ “expert-knowledge”?

The treatment program

In 2005 and 2006, a group-based treatment program was offered to eight women struggling with obesity problems in a particular district of Norway. The program was led by a physiotherapist who had worked in clinical practice for more than 15 years. It entailed weight reduction being the measured outcome for all participants. It emphasized weight lifting—an exercise form which has been proven effective for burning off fat. In addition, the physiotherapist included cycling as a warm-up activity and stretching at the end. The training was organized for 2 hours a week on the “interval principle,” meaning that the participants worked for 1 minute with 60–70% of maximal intensity, then there was a short break, and the same exercise was repeated for one more minute. A total of 12 exercises were performed throughout the one-hour exercise program, making use of all the major muscles in the body. Initially, every participant had been given an adjusted personalized program by the physiotherapist, which depended on their physical shape and general health status. The treatment also included group discussion for 1 hour per month. Topics such as muscle physiology, dietary advice, and how each one would go about changing their own lifestyle were emphasized in the instruction as well as in the discussion group. The participants’ body weight and BMI were measured by the physiotherapist on a regular basis, usually every second week. A weight loss of half to one kilo each month was considered to be satisfactory progress. All the participants were strongly advised to stay in the program for a complete year. According to the physiotherapist, this one-year “membership” would ensure that each participant would not “give up easily.”

Theoretical framework—the lived body

Since our aim was to explore the women’s experiences from a first-person perspective, we have chosen a theoretical framework in which the central concept is experience. In particular, we were inspired by the French philosopher Merleau-Ponty’s theory of the “lived body.” In his theory, the body is seen as fundamental to all human experience, and being a subject is identical to being in the world as a body (Merleau-Ponty, 2002). As he puts it: “It is never our objective body that we move, but our phenomenal body, and there is no mystery in that, since our body, as the potentiality of this or that part of the world, surges towards objects to be grasped and perceives them” (Merleau-Ponty, 2002, p. 121). Understanding the body as our primary source of experience also implies that a person’s lived experiences are an integrated part of the body. This is particularly evident where Merleau-Ponty explains how the present time includes the past time as well as the future. Moreover, he also maintains that the bodily subject is focused toward the future, an indication that human experience can be understood as ambivalent. That the body is understood as fundamentally ambivalent is also expressed explicitly by Merleau-Ponty:

It is not a question of how the soul acts on the objective body, since it is not on the latter that it acts, but on the phenomenal body. We must ask why there are two views of me and the body: my body for me and the body for others, and how these two systems can exist together. It is indeed not enough to say that the objective body belongs to the realm of “for others,” and my phenomenal body, to that of “for me,” and we cannot refuse to pose the problem of their relations, since the “for me” and the “for others” co-exist in one and the same world, as is proved by my perception of another who immediately brings me back to the condition of an object for him. (2002, pp. 122–123)

The extract implies that when we as individuals try to perceive ourselves, we are simultaneously a part of what we try to see. The body is understood as both subject and object; visible and seen, always both so that the two sides of the body can never be reduced to only one of them. In addition, Merleau-Ponty sees the body as relational in the sense that it is inseparably connected to its surroundings. As he expresses it:

But we have learned in individual perception not to conceive our perspective views as independent of each other; we know that they slip into each

other and are brought together finally in the thing. In reality, the other is not shut up inside my perspective of the world, because this perspective itself has no definite limits, because it slips spontaneously into the other's, and because both are brought together in the one single world. (2002, p. 411)

In this way, a person's experiences can be understood as both individual and relational at the same time, which sheds light on the significant findings in our material: the experiences of discomfort, the sense of estrangement, the nausea, the invasive looks others cast on oneself, etc. Later on, we will highlight how these experiences were suppressed in the training context, but elaborated on during the interviews.

Although Merleau-Ponty was preoccupied with the relational aspects of living in a social and cultural world, he did not elaborate on the significance of gender in a person's experiences (Langer, 2008). In order to analyze the women's gendered experiences, we have chosen to supplement Merleau-Ponty's perspective of the body with feminist theory. This includes both current research literature as well as Beauvoir's gender theory, as will be presented in the next subsection.

Gender and body

In social and feminist research, gender is often viewed as something we "do" or "express" rather than merely something we "are" (Werner & Malterud, 2005). This research is mainly inspired by the path breaking work of feminist philosopher Judith Butler. In the 1990s, Butler developed an understanding of gender as a social practice, as opposed to a strict distinction between the sexes as ascribed in biology, and gender as an achieved status. Thus, gender is but a sense of discrete but repeated stylized acts publicly performed, that produces the illusion of an abiding gendered self. And it is these styles that produce the coherent gendered subjects who pose as their originators (Kruks, 2005). Moreover, it is such practices that bring the self, or subject, into being. It follows that any sense we have of deep "inner" subjectivity or of the temporal stability of the self, is an "illusion." Understanding "gender" as social performances implies a change of perspective from matters internal to the individual, exploring interaction with other people in different settings. According to Butler (1990), socially active individuals behave in ways that reflect or express gender (Werner & Malterud, 2005).

However, gender has to be understood not merely as a social practice, but also through the body

(Chambers, 2007). The French philosopher and feminist Simone de Beauvoir—who was inspired by Merleau-Ponty's perspective of the lived body—argues that a historically inherited gender dualism acquires significance in women's lives so that they perceive themselves as gendered. De Beauvoir also maintains that women in the Western world are exposed from early childhood to the gaze of others—a patriarchal gaze. The female body is sexualized and afflicted by shame in a profound way which is not imposed on the male body. Hence, being born with a female body has a significant impact on a woman's life and lived experiences (De Beauvoir, 2000). At the same time, De Beauvoir maintains that women are not merely passive objects. They themselves take an active part in their own socialization process. Hence, aspects of both biology and culture are important. And women's lives are never wholly free of them, yet they are not merely the effect of them either. As Moi interprets De Beauvoir:

A woman defines herself through the way she lives her embodied situation in the world, or in other words, through the way in which she makes something of what the world makes of her. The process of making and being is open-ended; it ends only with death. In the analysis of lived experience, the sex/gender distinction does not apply. (1998, p. 72).

In contrast to theories that emphasize either sex or gender (or their duality) we will consider the body as being performed in a situation as well as being a situation. This means that we intend to grasp the embodied subject, as each woman actually experiences herself from a first-person perspective.

Methods

This article is based on individual interviews with patients from one particular weight-loss program in Norway—a program organized by physiotherapists in the primary health system. Qualitative interviews are well suited to provide insight into the lives, experiences, and understandings of the research participants (Cheek, Onslow, & Cream, 2004). In our study, individual interviews were conducted by one of the authors (KSG) between February and August 2006 at a place of the women's own choosing (three chose their own homes, two chose a local café). The women were interviewed when they had participated in the program for nearly 10 months. Our intention was to interview the women once again after they had finished the program; meaning after 12 months since this was a one-year course. Unfortunately, the physiotherapist in charge of the

group became seriously ill. The treatment therefore stopped after 10 months and a new group treatment did not start until several months later when the institute had found a substitute.

Semi-structured interviews were conducted in order to capture the uniqueness of each participant's experiences while at the same time enabling a focus on the topics in question (Kvale & Brinkmann, 2009). This meant that we worked with a predetermined topic guide covering the main areas of enquiry whilst allowing room for departure to pursue novel topics introduced by the participant. Kvale and Brinkmann (2009) state that interviews may be considered as collaboratively produced narratives, a mutual product of researcher and informant. The researcher's subjectivity becomes a source of knowledge, not defined as bias. In our study, the interview shifted between the researcher introducing new topics and the participant taking the lead. Once in a while, the researcher would also ask follow-up questions. Inspired by our theoretical framework, we were particularly interested in the women's gendered experiences with the training and how these experiences were embodied. For example, when one of the women emphasized the importance of hard training in order to lose weight, the researcher would follow up with the following phrase; "Could you say some more about that?" Similarly, she would encourage the women to "give an example" when they talked about experiences that needed clarification or expansion of a topic. In this way, our strategy was to devise questions and directions that facilitated the deepening and clarifying experiences, thoughts and ideas, thereby assisting participants in revealing their embodied experiences.

As the interviews were done face-to-face, both topics and order could be adjusted for each encounter based upon the researcher's perception as to what seemed most appropriate (Kvale & Brinkmann, 2009). This approach brought up several novel topics. For example, the women were eager to talk about their experiences of medical encounters with doctors. In addition, the women emphasized their negative experiences with training and physical activity prior to joining the treatment program (as illustrated in Table II). In the *Analysis* section we will describe how these novel topics influenced our analytical process.

The interviews were tape-recorded with the women's permission and transcribed verbatim enabling quotations to be highlighted in the presentation of the results. Each interview lasted between 1.5 and 2 hours, resulting in a total of 140 pages of transcribed texts. The study was approved by the

Research Ethics Committee of Medicine in Norway (REF 2.2006.2859).

Participants

Our empirical data consists of five in-depth interviews with women participating in the exercise program presented above. Information about the study was sent to the patients together with a letter requesting them to participate. They were informed about the voluntary nature of joining the study, their right to withdraw at any time, and confidentiality was guaranteed. Five of the eight women participating in the program agreed to join our study. After receiving their informed consent, one of the researchers (KSG) contacted the women by telephone in order to confirm their agreement and to arrange a meeting. Even though this might seem like a "small" sample, they represented a deliberate sample of information-rich participants. In Patton's (2002, p. 230) words, "those from which we can learn a great deal about issues of central importance to the purpose of inquiry".

Our intention was to choose informants participating in the same treatment program so that their experiences could be compared and contrasted. As mentioned above, five of the eight women participating in the program agreed to join our study. These women were a diverse sample in terms of age, weight histories, marital status, education, and area of work. They were aged 35–63 years and had been overweight for more than 10 years (BMI ranging over 35). One of the women had been what she called "big" since childhood. One had started to gain weight in her teens, whereas one had become what she labeled as "overweight" after an operation in her early 20s. After her husband left her for another woman five years later, she gained more weight and became what she called "really large." Two of the women had gained weight especially after they got married and had given birth. Upon joining the program, two of the women had a BMI of 48, one had a BMI of 46, one had a BMI of 42, and one had a BMI of 40. Three of them were married, one was divorced and one was widowed. One of the women had a university degree, two of the women had a college degree, and two had no formal education after high school. The women were at present or previously working in professions providing a service, or care, doing office work, or an academic job on various levels. During the program all but one of the women had lost weight.

To maintain confidentiality of participants in the research, pseudonyms are used throughout this article. In Table I we therefore present only the women's fictive names and weight loss during

Table I. Informants' weight loss during the program.

Name	Weight loss during the program
Elisabeth	12 kilos
Karen	Lost 4 kilos the first 5 months, but regained them the following 3 months
Annie	10 kilos
Vivian	15 kilos
Stacy	12 kilos

treatment, whereas levels of education, marital status, and area of work are not included.

Analysis

Our analysis of the transcribed interviews can be described with what Kvale and Brinkmann (2009) call “bricolage” (p. 233). This means that the researchers may use several “analytic techniques and concepts, as long as they are based on systematic readings of the material, to paraphrase Kvale and Brinkman (p. 233). Our analysis consisted of several phases. For the sake of clarity we will describe this as a stepwise process, but it must be highlighted that the phases overlap and interplay.

First, the transcriptions were read through a couple of times to get a general impression of the women’s experiences with training and physical activity. In this stage, we focused on the topics that first caught our attention, marking them as notes in the margin. The second stage can be described with what Kvale and Brinkmann (2009, p. 205) terms a “meaning condensation”. Meaning condensation entails abridgement of the meanings expressed by the interviewees into shorter formulations. Long statements are compressed into briefer statements in which the main sense of what is said is rephrased in a few words (units of meanings). Then, the central theme that dominated the meaning unit was restated as simply as possible, thematizing the statement

from the informant’s viewpoint as understood by the researcher. Our next step was to find related patterns between the central themes. Bearing our research questions in mind, certain themes were considered to have a common origin, were related or both. When opinions differed between the two researchers, we returned to the transcriptions and discussed them until an agreement was reached (negotiated consensus) (Patton, 2002). The next stage of analysis consisted of yet another reading of the material, this time searching for similar as well as contrasting experiences between the informants. Here, our intention was also to detect nuances in the women’s experiences. Our final step of analysis consisted of “meaning interpretation” (Kvale & Brinkmann, 2009, p. 207). Meaning interpretation goes beyond a restructuring of the manifest meanings of the text to a deeper or more critical interpretation of the text. This level of interpretation included our theoretical framework moving our analysis to a higher level of abstraction. This stage goes beyond what the informants have said directly so as to reveal the opinions and relations that are not evident. Verbatim extracts from the interviewees have been used to show what these interpretations are based upon. Through this process, five themes eventually emerged: (1) the gaze of others; (2) a common ground; (3) dependence of close-follow up; (4) bodily discomfort as painful; and (5) aiming for results—an ambivalent experience.

Results

Our results indicate that the women’s experiences of training are interwoven with their general experience of being overweight. Both relationships to other people and earlier experiences are important for how the training was carried out and perceived while in treatment. In what follows, we will elaborate on

Table II. Topic guide

Main topics	Examples of questions	Novel topics during the interview
Weight-histories	Could you tell me about your weight history?	Medical encounters prior to joining the program
Group-based treatment	Why did you join the program?	Experiences with training and physical activity prior to joining the program
	What does it mean being a participant in this program? What is it like exercising in a group in which everyone is perceived as having obesity problems? What is your relation to the other participants?	Experiences with dieting and weight-cycling prior to joining the program
Experiences with the group training	How would you describe the training? What does it “give you”?	Medical consultations once again
	Why do you choose to continue?	
	How important is it for you to loose weight? How do you experience being “measured” regularly in terms of the weight-in procedure? How would you describe the role of the physiotherapist in charge of the group?	Lack of follow up in fitness gyms

these findings through the five abovementioned themes. We have selected quotes from the interviews to illustrate each theme, focusing both on similar and contrasting experiences from the participants.

The gaze of others

In order to lose weight, all five women had tried to exercise in different settings, including fitness gyms. A recurring trait in their experiences with exercising in fitness gyms is that they quit after a short-time membership. This was mainly because they felt ashamed and uncomfortable within such a setting. Especially, they stressed the gaze of other members as uncomfortable. In the interview with Elisabeth, this feeling of discomfort was exemplified through her recollections from the aerobic classes. Already the first time, she noticed a kind of hierarchy within the group. The slimmest and most sporty women were standing in front so that they could be close to the instructor, whereas Elisabeth felt more comfortable in the back (where nobody could see her). But during the training, she experienced how this position made it difficult to see what was going on in the front. She could not see the instructor and consequently it became problematic following the other members of the group. This made her feel both clumsy and ashamed. In addition, she experienced bodily pain: "Pain in my knees, in my back, in my groin. I really felt like a failure." In a similar vein, Stacy spoke of emotional strain and anxiety relating to training within such a setting: "Sometimes I felt sick before going to the fitness training. I couldn't stand the idea of been stared at." Initially, Stacy tried to suppress her negative experiences. As she explained it: "I decided not to care. But it didn't work. I felt sick and miserable and decided to quit." The experience of being stared at is also evident in Vivian's experiences: As she recalls it during our interview: "It made me feel disgusting. They looked at me because I was fat. . . . What is she doing her with a body like that kind of look. It made me feel like an idiot."

Interestingly, the women explained how they negotiated with themselves as to whether they should continue exercising in this context. As Karen put it: "I pushed myself to go, even though I hated it." But after 2 months of regular training, she decided to quit. This was not an easy decision to make. As Karen recalls it: "I felt relieved, but at the same time I felt like a failure for giving up so easily." Similarly, Stacy put it this way: "I had mixed feelings about it. It was hard telling my husband and children that I had quit. So I felt miserable for several days."

A common ground

The women felt more comfortable exercising within a treatment context organized for patients with obesity problems. They emphasized that exercising together with persons in the same situation as themselves made them feel more recognized and accepted. In addition, they stressed that they felt more at home within this group context. One woman explained: "I do not feel so ashamed of my body here. We are all in the same situation, you see, which is really nice." Several of the women also described the group as a social arena in which they could share their experiences—both positive and negative—with the other participants. "Here I can meet others with the same problems as myself. For everyone have problems due to their weight, right. And we share the same problems. . . . We understand each other," said Karen. Significantly, the women's sense of belonging contrasts to their negative experiences from the fitness center. This indicates that the treatment group provides a common ground in which the women can feel equal, regardless of their body weight. Thus, by sharing each others' thoughts and experience they can better understand each other, and in this way experience togetherness and a sense of belonging.

Dependence of close follow-up

Our participants talked warmly of the physiotherapist in charge of the group treatment. They described her as a warm and caring person who supported and guided them as individuals as well as providing a good atmosphere in the group. In addition, they portrayed her as a skilled professional with expert knowledge on exercise and training. Having experienced a long history of cycles of weight loss followed by weight gain and negative encounters with doctors who told them to pull themselves together and eat less, they finally felt that they had met a professional who was genuinely focused on helping them to lose weight. Elisabeth explained it this way:

She is my motivator. She weighs and measures me. And she makes me keep a record of my diet. I fill out a form and then she gives me advice as to how I can eat healthier meals . . . How I can do even better. So I think it is really nice to participate in her treatment program.

In a similar vein, Vivian described the physiotherapist as her "mentor" and a "very special person." The participants also spoke of the importance of being "followed up" closely. According to the women, they felt more secure and comfortable when

the physiotherapist was present during training giving them feedback and advice on a regular basis. Several stressed that the follow-up of the physiotherapist was of paramount concern for their motivation. Especially they emphasized how it made them more eager to work hard during training. Importantly, the women explained how the physiotherapist could be very strict in her feedback: "She is direct whether it can hurt us or please us. She tells us how to do things better. But I think it important that she also tells me that I can do better. I like the way she pushed us," said Stacy. According to Annie, the participants could tell by the physiotherapist's body language when they were expected to push themselves harder: "One look from her is enough. Can't you do better than that?" But Annie stressed that she did not get hurt by this kind of feedback. On the contrary, she claimed that it enabled her to push herself a bit more, even when she felt she had no more to give.

During the interviews, the women explained how they felt "secure" when the physiotherapist was present in the room and providing close follow-up. This feeling of security largely had to do with them learning to perform the exercises correctly. In particular, they stressed the importance of an "effective" work-out, instead of training in the wrong way. As Elisabeth put it: "So the physiotherapist's feedback on how to do it right makes me feel secure." Vivian explained it in the following way: "When I know that I am in good hands, it makes me feel secure." Such quotations indicate that the women sense bodily insecurity while exercising. In order to feel secure they have become dependent on the physiotherapist's feedback. Significantly, the feeling of dependency is also expressed explicitly in the interviews. According to the women, they could not see themselves continuing with the training on their own. "I cannot do it without her support, it just wouldn't work," said Annie. Vivian put it this way: "I can't let go of the feeling of security. She makes me trust my own body and makes me confident that I will make it; that I will lose weight. So I just have to continue in this treatment program. Otherwise I will not make it."

Bodily discomfort as painful

Whereas the women talked in positive terms regarding the physiotherapist's close follow-up, they articulated their experiences with the training in more negative terms. They spoke of how the training occasionally felt both unpleasant and uncomfortable. Three of the women claimed that they experienced pain. However, the pain and discomfort were interpreted as something they had to endure due to

their heavy bodies causing pressure on the skeleton. Elisabeth described it in this way: "My body hurts, especially my knees. But I think this has to do with me being too heavy. So I really need to lose more weight." Despite the pain in her knees during training, she still claims that the training is good: "You actually exercise your entire body. You go through every muscle in your body. I think that is very important, especially when it comes to burning fat. You have to push your body in order to burn fat and lose weight."

The significance of enduring discomfort is also evident in Annie's experiences. When she joined the treatment program, she had just finished her third semester of *Mensendieck*.¹ Annie talked in positive terms about this way of exercising, emphasizing how the slow movements felt both comfortable and relaxing. The only drawback was that she did not lose weight doing this activity, as the following quotation highlights: "Unfortunately, I didn't lose weight. But it was nice to sense your own muscles. And I really enjoyed the slow movements. It was really nice." By contrast, she recalls how she had to endure bodily discomfort when joining the treatment group: "It felt terrible in the beginning. I was in bad shape and really had to push myself. It was really uncomfortable. Pain in my knees, in my back." Annie's recollections indicate how pushing oneself can initiate feelings of estrangement and discomfort. She talks about how the hard training is perceived as discomforting and painful, placing her in a reflexive relationship to herself. Despite these negative experiences, Annie chooses to continue in the program. However, her decision to continue is closely related to the other members of the group, as the following quotation illustrates:

The others stayed in the program, which made me hang in as well. It sort of motivated me, seeing the other participants pushing themselves. And I had to continue in order to lose weight. My earlier attempts had failed, so this was my best card.

Annie's experiences highlight how pushing oneself is understood as a necessity in order to lose weight. At the same time, the feeling of discomfort that accompanies this pressure is somewhat moderated by noticing how the other participants also seem to endure the same kind of pressure. That pushing oneself despite discomfort and pain is regarded as a positive phenomenon within the group can also be exemplified through Karen's descriptions: "My impression is that everyone who joins this program is very ambitious and hard working. They really wish to get into better shape and lose weight. They are not here for the fun of it. No, they aren't."

Aiming for results—an ambivalent experience

The participants were supposed to be weighed by the physiotherapist every second week. In the interviews the women revealed how they perceived the weigh-in as an ambivalent experience. They reported feeling good when their weight decreased, followed by descriptions of guilt that occurred when the scales showed a weight higher than on the previous occasion. Stacy explained this in the following manner:

I am not reluctant to do it. Obviously, when I feel that I have not been resolute and maybe splurged on some delicious food, stepping onto the scales is not always fun. But it makes you more aware, I believe . . . You pay more attention to what you are putting in your mouth, to be frank. And when we meet and are weighed, that makes you more aware. Because you really want to have lost some weight when you step onto the scales, I really mean that. Some people in the course do not lose weight so quickly, and they tend to lose their fervor, I feel. And being so impatient, I would probably have done the same. However, because I saw the results so quickly, and could see them all the time, it was no problem at all for me.

Stacy claims that the weigh-in procedure makes her more “aware” of what she chooses to eat and not eat until the next time she steps up onto the scales. A lot is at stake in this situation. When Stacy knows that she has gained weight, the weigh-in procedure is a dispiriting experience. On occasions when Stacy has *lost* weight, which she usually has, the weigh-in procedure is unproblematic.² Stacy has obviously given this some thought, because she provides examples of others who have chosen to leave the group when they failed to lose weight. Karen’s experiences can illustrate how the weigh-in procedure does not necessarily make the participants more aware. She lost approximately five kilos during the first 2 months, but then “they just crawled back on,” in her own words. Since then, her weight has repeatedly gone up and down. When our interview with Karen took place, the physiotherapist had not weighed her for a long time. She gave the following reason: “It was a stressful kind of situation . . . I was awfully stressed by the weight thing.” Karen emphasized that stepping onto the scales represented no problem for her initially. Then, she expected the scales to show less than on the previous occasion, which was confirmed by the scales at home. However, when the scales over a period of time showed increasingly higher figures, she perceived the situation as more and more negative. The atmosphere in

the room and the entire situation made her stressed and ill at ease.

By contrast, the other women had been able to maintain the weight loss during their participation in the program. Vivian had lost more than 15 kilos, Annie had lost almost 10 kilos, and Elisabeth and Stacy both lost nearly 12 kilos. According to the women, their good results had motivated them to continue with the program. Elisabeth talked about how her progress had made her eager to lose even more weight. Moreover, she said that she would not be satisfied until she had lost even more: “If I am to reach my ideal weight I must lose 30 kilos. So I have a long way to go. But I want it from the bottom of my heart. I really have to lose all those kilos, so that I can feel free.” Although the women emphasized the significance of achieving results, they were worried about getting “muscles.” They seemed to embrace an ideal as to what their body should look like: slender and tight—with little fat and long, slender muscles. Vivian, for example, explained how she would adjust the training in order to achieve this, namely focusing on many repetitions instead of lifting heavy weights. This seemed to be a common understanding among the participants. In addition, the women explained how they felt much better about themselves when their bodies changed. As Elisabeth put it: “I am starting to like myself again. I notice that my body is starting to feel a bit more like me. I am coming to terms with my body again, connecting better to the person inside the body.” By contrast, Karen explained how her initial optimism turned to despair and emotional distress when she started to gain weight again after a few months. In addition, she talked about how her “bad results” made her feel “kind of depressed”. Comparing herself to the others, she felt “like a failure for not being capable of making the progress that they did,” as she explained it.

Theoretical interpretation

The women’s negative accounts from previous training at a fitness center demonstrate that they are greatly aware of how they think or feel that other people see them. They express strong feelings of being seen as pitiable and that the “gaze of others” is interpreted as a negative one. It seems to follow that how other people’s stares are felt also tend to melt into the women’s own perspective of themselves. If we relate their experiences to Merleau-Ponty’s philosophy, we can see how he expresses the phenomenon: “And there must be, besides the perspective of the For Oneself—my view of myself and the other’s of himself—a perspective of For Others—my view of others and theirs of me” (2002,

p. xiii). If we see this in connection to our participants' accounts, it seems as though they have reflected on their own situation as large and how this has acquired significance in a situation where they are few and contrasted with many slim and fit persons. By becoming aware of how the others look at them, they apply a critical perspective to their bodily appearance, which makes them feel uncomfortable and ashamed of themselves. Moreover, it magnifies their view of themselves as fat and unattractive. According to Merleau-Ponty, the feeling of shame is closely connected to the gaze of others:

Shame and immodesty, then, take their place in a dialectic of the self and the other which is that of master and slave: in so far as I have a body, I may be reduced to the status of an object beneath the gaze of another person, and no longer count as a person for him. (2002, p. 193)

Merleau-Ponty maintains that our existential status is that we are part of a social and cultural world. Cultural norms and values that we share have an impact on our experiences, including experiences of our bodies. That women's understandings of their own bodies are interwoven with cultural assumptions has also been addressed within the sociological research tradition. Several sociologists have argued that the body is now more closely connected to the notion of success, compared to earlier times. According to Shilling (2003), Western culture values the importance of shaping one's body to a slim and fit ideal. Feminist researchers argue that this ideal especially applies to women. Moreover, they claim that the body historically has been closely connected to notions of femininity, and that women's understanding of themselves is closely connected to this assumption. Being slender and fit is associated with self-discipline and self-control, whereas being fat gives negative connotations, such as laziness, lack of self-discipline, etc. In this way, women are responsible for their looks, while at the same time there is a message that they do not have to live with a body of which they are ashamed (De Beauvoir, 2000; Bordo, 1998; Murray, 2008). Such cultural assumptions are also evident in our material. The women repeatedly spoke of how they felt ashamed of their bodies. Moreover, they talked about how their bodies were somewhat "separated" from their inner-selves. It was inappropriate and hindered their "real" personality from showing through. However, after they had lost several kilos, the women felt more at one with themselves. As Elisabeth explained it: "I notice that my body feels more like a part of me again. That it feels more like me."

Discussion

The women's experiences indicate that they are preoccupied with losing weight in order to feel better about themselves. And since acquiring results seems to be of paramount concern, pushing themselves is understood as essential. Moreover, the feeling of discomfort and pain that accompanies the training is understood as a sign of their bodies still being too heavy. In this way, women's feelings of insecurity and discomfort are not given any significance beyond the need to lose more weight. By comparison, one of the women spoke engaged about experiences of well-being and comfort when doing *Mensendieck*, a training practice she nevertheless left, because it did not lead to weight loss. Maybe Annie's experiences can be interpreted as a dilemma of relevance here: that both feelings of wellbeing and comfort, as well as discomfort and pain must be suppressed (if necessary) in order to fulfill norms and ideals about body and health defined by our society? The fact that *Mensendieck* is characterized by low-intensity exercising practices, especially asking participants to dwell on bodily experiences is also worth elaborating on. Perhaps this aspect should be included in training programs for women with obesity problems? This would challenge prevailing notions of "proper" and "effective" training as a means of losing weight. In fact, several studies of training have emphasized that pushing oneself is regarded as both necessary and uncomfortable in Western society. This way of expressing oneself can be understood as culturally acceptable. In order to acquire a fit and healthy body, women need to exercise hard on a regular basis (Markula 2005; Shilling, 2003). According to Engelsrud (2007) this cultural understanding, might be internalised when people suppress bodily discomfort. Inspired by Merleau-Ponty's philosophy, she suggests that the objectification of the body is given precedence in women's experiences with training, while the body's subjectivity is placed in the background. If one relates this line of argument to our material, it is striking how the women talk about the training as something they feel obliged to do—some kind of duty which is not pleasant, but which pays off afterwards in terms of achieving a slimmer and fitter body. The ideal seems to be kept alive in the discourse about body ideals and as a relation to the body that counts culturally. Moreover, one could also argue that the participants in our study have incorporated the biomedical knowledge on which the treatment program is founded. Achieving a measurable effect is regarded as "proper" knowledge and this is also what is given priority by the physiotherapist.

In this article we have documented how training is experienced as something that is connected to a person's general experience of being overweight. Both relationships to other people and earlier experiences are important for how the training is carried out and perceived. These experiences are individual in the sense that each person's life history affects the significance attached to the training. At the same time, experiences of weight reduction are interwoven with cultural and gender relations. The findings show how participation in the training program entails a variety of experiences. The fact that it involves dependence on the physiotherapist, pain, and discomfort as well as the feeling of affiliation and fellowship illustrates how such experiences fluctuate and change during training, as they do in their daily life and encounters with others. The changing character of these experiences can contribute to the discussion of whether weight reduction ought to be the central outcome measurement for all participants. On the one hand, they regard weight reduction as essential. On the other hand, they declare that how others see them as persons is the most important thing. However, they seem to have incorporated the cultural idea that being thin is valuable. To obtain this value, attention on the measurable results helps to create the needed stress and pressure to lose weight. However, there is a striking dilemma attached to this preoccupation with losing weight—namely that such pressure may in turn lead to a loss of willingness and motivation to continue training, and as a result participants may choose to drop out. Karen's experiences highlight how gaining weight during the program initiated feelings of shame and stress. Consequently, she was about to lose motivation and in danger of feeling like a failure. In line with this, Stacy emphasized that some of the participants had quit the program because they were not able to maintain their weight loss during the program. In order to understand what women with experiences like this may be faced with, one needs to take into consideration the health risks of repetitive experience weight loss followed by weight gain, and changes in the body's metabolism, making it harder and harder to lose weight, and hence, to fulfill their own expectations, those from health workers, and from society.³ Bearing this in mind, one could criticize the emphasis that "effect" occupies in the field of research on obesity.

This study shows how the training experiences while in treatment were characterized by discomfort, vulnerability, and dependence. The participants described a vulnerable position dependent on the physiotherapist's follow up. For example, it was found that the women repeatedly suppressed their negative experiences in order to live up to the

physiotherapist's and their own expectations. Unintentionally, the physiotherapist may even contribute to intensification of feelings of estrangement and discomfort, thus weakening rather than helping the women. "Dependence" as a concept has not been used in other studies to describe the relational aspect between physiotherapist and patients. However, several studies have emphasized how doctors need strategies to empower their patients—rather than weakening them. These studies argue that doctors must take responsibility to transform patients' experienced vulnerability into strength, instead of disempowerment by doctor as well as patient (Werner & Malterud, 2005). The term "empowerment" embodies the concept of power. It is a process in which individuals are enabled to take control of their own lives, thus becoming gradually independent of the health worker's follow-up (Cox, 1996). This line of argument parallels Beauvoir's feminist perspective regarding the need to pay more attention to one's (embodied) subjectivity in order to feel free and independent. Our study demonstrates the need for embracing such an approach. In order to achieve this, the physiotherapist needs to look beyond the biomedical focus on "effect," and pay more attention to the participant's experiences during the training. Putting the participants' bodily experiences in the foreground—rather than in the background—could enhance a view in which the "large" body is not primarily regarded as an object that should be changed, improved and reshaped. Feelings of discomfort, estrangement and dependence should be discussed within the group, and different models for understanding these experiences should be allowed to exist concurrently. Thus, the vulnerable position described by the women can be changed into strength or a resource in a context that promotes empowerment through recognition of each person's embodied subjectivity.

Perhaps the training also needs to be organized differently, including the participants' own views as to how the training could be carried out, so that they can find ways of exercising that are experienced as positive. Choice is seen as central if patients are to take part in shared decision making and if physiotherapists are to offer a patient-centered approach (Ogden, 2006). In this way, the women would feel more inner motivation, rather than outer motivation (Elfhag & Rössner, 2008). This in turn, might inspire the women to continue training as a lifelong habit. Perhaps a combination of exercises done under the physiotherapist's instructions and a more "exploring" approach could make the training more positive and fun? Such an approach requires time as well as confidence in the participants' situation, and means that both the patient and the physiotherapist's

interpretations are discussed. And it takes a perspective which enables them to view the body as a “lived experience.” We think such an approach could be worth a try in clinical practice. Especially to women who have experienced repeated cycles of weight loss and gain, and negative experiences in encounters with doctors and other health workers. Being met with recognition could strengthen their belief in themselves so that they could trust their own bodies and, eventually, become more independent of the physiotherapist’s close follow-up.

For further clinical improvement we suggest that the research field should be supplemented by investigations into both the opinions and experiences of persons who take part in the training program, as well as into the institutional frames and gender insights that are created and utilized.

Methodological considerations

The use of qualitative interviews in this study has proved valuable in highlighting how experiences were embodied as suppressed in the training context, but elaborated on in the interviews. There are, however, some methodological considerations to reflect upon for this study. The first concerns the timing of the interviews. We received information from the participants only once during their participation in the program. Hence, their experience might have changed with the treatment program over time. Moreover, they spoke about events that had occurred many years before entering the program. However, according to Merleau-Ponty, memories are embedded in the body and as such are former events of the past then present. As he explains it: “I belong to my past. I preserve my oldest experiences, which means not some duplicate or image of them, but the experiences themselves, exactly as they were” (p. 491).

Another aspect concerns our choice of sample. It must be emphasized that our results are based upon a small-scale study with five women recruited from the same treatment context. In qualitative studies, however, sample size is considered less important than the variation in data that the sample generates (Miles & Huberman, 1994). As noted earlier, our participants were a diverse sample in terms of age, weight histories, marital status, education, and area of work. Bearing this in mind, our findings may be interpreted as highly valid in the context in which they have been produced. Moreover, since most treatment programs offered to patients with weight problems are group-based, our study has revealed an area that needs further research—namely, how to involve the participants’ own experience so that physiotherapists can provide more personalized

care. The themes revealed in this study thus need to be further examined in more depth in future studies.

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Notes

1. Mensendieck-exercises, named after its originator Bess Mensendieck, is a form of low-intensity training. By emphasizing slow movements, it aims to build strength; although not in the form of “pumping up” the muscles to maximum size. Focus is put on developing the core musculature in a thorough and basic manner to enable us to carry our bodies in a correct manner. This can be best achieved with tranquil and gentle exercising, which also enables persons suffering from injuries or problems in the spinal or neck area to engage in it safely. The exercises themselves are unique both in their manner and the way in which they are performed. All movements are performed in a prescribed manner and nothing is left to chance. Bess Mensendieck was preoccupied with the idea that a correctly performed exercise is worth hours of exercising in the wrong manner (Dahl-Michelsen, 2007). Movements based on the Mensendieck tradition is currently being used all over Europe, particularly in the Netherlands and Norway, the latter having a physiotherapist education founded on Bess Mensendieck’s ideas (Oslo University College).
2. Now, when Stacy has lost more than 12 kilos, she is mostly concerned with “stabilizing her weight.” In the quote she primarily mentions experiences from her initial months of exercising when she had a goal of losing even more weight.
3. An increasing number of these women are now turning to weight loss surgery in order to fulfill norms and ideals about body and health (Odgen, 2006; Throsby, 2008). However, surgical procedures also have their drawbacks—side effects which are not necessarily health promoting in the longer run (Wysaker, 2005).

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