Exploring the lifeworld experiences, lifestyle changes, and well-being, of individuals with type 2 diabetes who consume alcohol

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Contents

ABSTRACT

Background: Alcohol consumption has physical consequences for the progression of type 2 diabetes (T2D), but as well as mental and social consequences affecting individuals' sense of well-being and potential to adapt to the T2D diagnosis. Furthermore, individuals with T2D who consume alcohol require lifestyle changes, including alteration of alcohol consumption that are not easily achievable. The impeding factors for lifestyle changes related to the lack of supportive social networks and the blaming culture towards these individuals for the lack of control and poor diabetes management, continuing alcohol drinking, and unwillingness to change lifestyles.

Aim: To understand the lived experiences of individuals with T2D who consume alcohol in dealing with the existential challenges they face in altering their lifestyles and constructing meaning from their altered life-world, and what are the factors that lead these individuals to a sense of well-being.

Design: The current study uses interpretive phenomenology to acquire an in-depth understanding of the lived experiences of individuals with T2D who consume alcohol concerning the initiation and sustainment of lifestyle changes and the achievement of living well with T2D and the development of a sense of well-being.

Method: The current study conducted a total of 12 in-depth one-to-one interviews with individuals with T2D who consume alcohol. The study uses a purposive sample for selecting participants from the North of England in the UK that were at the time part of a diabetes support group. The analysis of the collected data used the thematic analysis framework.

Findings: A total of four themes emerge from the findings, namely; a) Influences of collective determinants influence on lifestyle changes, b) Contextual and cultural framing of lifestyle changes, c) The embodiment of intersubjective interactions, and d) Being and well-being with T2D.

Conclusions: Alcohol consumption for individuals with T2D has symbolic signification for attaining and maintaining social group membership that affects efforts for lifestyle alterations. Also, the unregulated and poorly labelling of alcohol drinks, and the dominance of the medical model of care further impedes the initiation and sustainment of lifestyle changes. Health professionals can support the lifestyle change processes by respecting the personhood of individuals with T2D who consume alcohol, incorporate family members in the caring processes and work with these individuals to become attuned with the T2D situation and grow by making self-fulfilling plans for the future.

ACKNOWLEDGEMENTS

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To retain the anonymity of the research setting and those who took part in the research, many people I am grateful to will have to remain unnamed: these include all the participants who agreed to participate in my project and the gatekeepers that permitted me to conduct my study in their support groups. I hope they are already aware of how much I valued their time and assistance.

Lastly, but certainly not least, I want to express my gratitude and a wholehearted thanks to my beloved ones that provided the emotional support and the unabated belief in me. Also, I wish to express my gratitude to my brother Stefanos who was always there for me not only as a brother but also as a friend and mentor for my project.

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PUBLICATION/ CONFERENCE PRESENTATIONS

PUBLICATION (see Appendix I)

1. Mantzouka, C., Morrall P., Gilmartin J., & Waite-Jones, J., 2017. Well-being, type 2 diabetes and alcohol consumption: a literature review. *Primary Health Care*, **27**(3), pp. 26-30.

ORAL / POSTER PRESENTATIONS (see Appendix II)

1. Humanising Care, Health and Wellbeing Conference, University of Bournemouth, Bournemouth, UK, 21 June 2018 "Exploring the lifeworld experiences, lifestyle changes, and well-being, of individuals with type 2 diabetes who consume alcohol". (Oral Presentation)
2. The RCN international nursing research conference 2016, Edinburgh International Conference Centre, “Exploring type 2 diabetes, alcohol use and lifestyle modifications: a systematic literature review”. (Poster)
3. Healthcare PGR Conference 2015, University of Leeds, Leeds, UK, 21 October 2015 “Exploring the experiences and the well-being of individuals diagnosed with type 2 diabetes and use alcohol”. (Oral presentation)
4. Faculty of Medicine and Health Conference, University of Leeds, Leeds, UK, 23 June 2014 “Exploring patients’ and health care professionals’ perception concerning health needs of individuals with type 2 diabetes, substance abuse and depression”. (Poster)
5. Healthcare PGR Conference, University of Leeds, Leeds, UK, 24 October 2014 “Exploring the life-world approaches of individuals with diabetes type 2 who engage in alcohol over-consumption in the North of England”. (Poster)

CHAPTER 1: INTRODUCTION

1.1. Structure of the thesis

Chapter 1 of the thesis commences with the researcher's reflections on type 2 diabetes (T2D), alcohol consumption, lifestyle changes and well-being, and identifies how and why this topic was personally important. Consequently, a background review on the above key ideas identifies the relevance and usefulness of endeavouring on these issues.

Chapter 2 of the thesis commences with a systematic literature review on the key issues concerning T2D, alcohol consumption, lifestyle changes and well-being. This review identifies that increased alcohol consumption has physical consequences for the progression of type 2 diabetes (T2D), but as well as mental and social consequences affecting individuals' overall sense of well-being and potential to adapt to the T2D diagnosis. Furthermore, the review highlights that any lifestyle alteration is an effortful process requiring personal maturation and growth for individuals with T2D who consume alcohol. Moreover, this effort demanding process for lifestyle changes lead individuals with T2D who consume alcohol to prefer an illusory adaptation instead of genuine lifestyle change. The lack the supportive social networks of promoting change and the blame culture whereby individuals with T2D who consume alcohol are personally responsible for the poor management of diabetes and alcohol drinking further compounds their unwillingness to achieve genuine lifestyle changes. The current systematic review sequentially concludes by developing the research question, aim and objectives of the current study.

Chapter 3 provides a critical presentation and discussion on key issues that underpin and frame the current study, namely; a) the life-world, b) the Humanising Framework of Care and c) the notion of well-being. The chapter critically presents and discusses the origins, definitions and multiplicity of views present in the literature on the life-world concept, and links of the life-world theoretical underpinnings with the objectives of the current study. Consequently, the chapter presents the Humanising Framework of Care and critically analyses key issues concerning the framework and identifies how this will guide the thinking of the current study. Finally, this chapter concludes with the discussion on well-being and the analysis of well-being with the eventually positioning of the current study on the notion of well-being to be adopted in the remaining chapters to interpret the findings and attribute meanings to participants experiences.

Chapter 4 provides an overview of the implemented research methodology and commences by discussing the underlying epistemology and theoretical perspective that informs the methodology, along with the rationale behind all choices made relating to methodology. The current study uses interpretative phenomenology as most suitable for acquiring an in-depth understanding of the experiences of individuals with T2D who consume alcohol regarding their lifestyle changes and the notion of well-being. The study uses a purposive sample for selecting participants from the North of England in the UK that were at the time part of a diabetes support group. Also, the study discusses and deals with ethical issues relating to data collection and uses the thematic content method to analyse all the collected data.

Chapter 5 analyses the collected data by breaking down the data into small and simplified conceptual parts and sequentially grouping some of these parts in manageable clusters based on their conceptual similarity (or not) creating categories and themes. Direct quotation from the raw data supplement the interpretations of each category, and each category concludes with an interpretive statement. Consequently, the analysis proceeds with aggregating the summative interpretive statements of each category into explanatory abstract patterns that produce the themes of the study. The analysis of the data provides a total of four themes, namely; a) Influences of collective determinants influence on lifestyle changes, b) Contextual and cultural framing of lifestyle changes, c) The embodiment of intersubjective interactions, and d) Being and well-being with T2D. Consequently, the analysis proceeds in developing links and relationships amongst the themes, thus creating a tentative conceptual framework entitled the Framework of Well-being with T2D (FWT2D). The FWT2D provides tentative explanatory understandings how the well-being of individuals with T2D who consume alcohol relates to and affected by intra-personal, interpersonal and extra-personal factors.

Chapter 6 discusses the themes and framework developed in chapter 5 and relates them to other studies by further clarifying the meaning of the findings, comparing and contrasting the findings to the broader literature and discussing key issues arising from the results to contextualise them within the broader academic context. Furthermore, this chapter includes the study's strengths and limitations, and the researcher's reflections at the end of the study to identify how the study influenced the researcher and how the researcher may have influenced the findings.

Chapter 7 concludes the study by providing a summary of the study’s key findings and issues and demonstrating how the study aim and objectives are met and answered. Lastly, the chapter discusses the limitations of the current study, the implications for practice and the recommendations for policy, practice and further research.

1.2. Chapter outline

This introductory chapter provides the rationale for the study, including the researcher’s pre-understanding of and background information on type 2 diabetes (T2D), alcohol consumption and well-being. Also, this chapter provides statistics regarding T2D and alcohol consumption, a summary of the research problem and the overall structure for the thesis.

1.3. Pre-understanding/ Reflection

My own personal and professional experiences, as a nurse and as an individual and member of various societal groups informs as well the way I understand and conceptualise nurse related issues, matters and problems. The foreground of my personal and professional ontology of interpreting nursing phenomena builds on my epistemological curiosity that accepts the existence of multiple truths and realities as expressed in individual narratives that derive from my professional, historical and socio-cultural pre-understandings of phenomena. The reflective disclosure before the commencement of a research project reveals these pre-understandings. It places the study within the researcher's ontological and epistemological context and provides the reader with a better understanding of the decisions made throughout the study and why the narrative unfolds as it does (Finlay, 2003). Within this section, I reflect on my pre-understandings concerning individuals with T2D who consume alcohol to provide the broader context in which I situate my study and how I anticipate the needs and support required from these individuals in initiating and sustaining lifestyle changes.

My professional experiences of working with individuals with chronic conditions stimulated my curiosity to understand how it feels for a person to abruptly need to alter their lifestyle because of a diagnosis of a chronic condition, such as T2D and how can these individuals feel well with their altered lifestyles. Also, equally important for me as a professional is to understand the meaning that individuals with chronic conditions such as T2D attribute to concepts such as health, happiness and well-being. Questions such as "can an individual with T2D have a sense of healthiness and feel well"? And if so, what preconditions enable the creation of a new perspective on health and well-being? What is the role of the nurse in a chronic condition such as T2D and what should the mindset be of a professional nurse? Is monitoring and treating T2D sufficient or should the role expand to include support for those enabling factors that lead to re-interpreting health and well-being? Supplementing these questions is the realisation that lifestyle change for individuals with T2D unavoidably includes alterations in food consumption. Still, most individuals link food consumption with alcohol consumption to celebrate, to socialise and to feel content. So, the emerging question is how can an individual feel happy and well if the two typical expressions of happiness, contentment and well-being, namely; food and alcohol, require radical alterations both in content and quantity.

At a personal level, the diagnosis of a very close and dear person with T2D requiring lifestyle modification as a result of the diagnosis made the above questions immediate and personal. On learning about the diagnoses with T2D of this close person to me, I felt devastated, depressed, and a sense of loss. I did not want to accept the news of the diagnosis, I was in denial, and I felt disillusioned. I knew that life for us would not be the same, and how can I know that he will ever again feel happy and content with life. I did not know how to deal with the situation and how to support both myself and my beloved one. The provided services and care felt hurried and insufficient, and our needs fragmented with limited and unconnected information concerning lifestyle modification. Also, this beloved person of mine requires the reduction of alcohol consumption as part of his lifestyle changes, and this made adapting to the new lifestyle harder for him.

Furthermore, as part of my internship as an exchange student at the University of Tampere in Finland, amongst other clinical responsibilities, I was responsible for informing chronically ill patients about their required lifestyle changes. It became apparent to me that individuals requiring lifestyle modifications found the processes challenging and required support. Furthermore, participating in the social life in Finland, I witnessed overconsumption of alcohol amongst the local population as part of socialising activities. Moving to the UK for my postgraduate studies, again, I witnessed overconsumption of alcohol linked to lifestyle. Hence, I reinforced my belief that certain lifestyles can lead to alcohol overconsumption and once diagnosed with a chronic condition, this may compound the obstacles for initiating and sustaining lifestyle modifications. As part of my Master's thesis at the University of Aberdeen, I studied the experiences of chronically ill patients who required lifestyle modifications. I gained further insights into the related difficulties in altering lifestyles.

My history, life experiences and studies shape and influence my current motivation to study individuals with T2D who consume alcohol and understand the preconditions and barriers for adapting to new lifestyles that could lead to sentiments of happiness and well-being.

1.4. Background

1.4.1. Type 2 Diabetes

The current study focuses on the experiences, lifestyle changes and sense of well-being of individuals with T2D who consume alcohol. The current study accepts that T2D is a chronic condition with a significant impact on the individual's lifestyle and the notion of well-being. T2D occurs when the body does not produce sufficient levels of insulin or the body’s cells do not react to the produced insulin causing an increase of blood sugar level leading to potentially long term damages, dysfunctions and failures of various organs (ADA, 2008; NHS, 2014). There is a steady increase in T2D incidences worldwide (see table1.4.1a).

Global Increase of T2D by 2035

- Current global estimated percentage of individuals with T2D is 2.8% - It is expected to increase to 4.4.% by 2030
- The number of people with T2D will increase from 382 million to 592 million between the years 2013 and 2015

(Wild et al. 2004; Siddiqui et al., 2014)

Table 1.4.1.a. - created by the Author

The ageing of the population and the increased urbanisation of developing and developed countries are the two major contributing factors for this increase (Wild et al., 2004). The literature expects a significant increase in T2D globally in the next years, making T2D the seventh leading cause of death worldwide (Long et al., 2011; WHO, 2013).

Developed countries such as the USA, Australia, Western European countries and the UK experience an upward trend in numbers of individuals diagnosed with T2D, with numbers set to double by the year 2030 (view table 1.4.1b) (Wild et al., 2004). In contrast, Eastern European countries display a significantly lower increase in the projected numbers of T2D diagnosis and some Eastern European countries, such as Bulgaria and Estonia, the projection displays even a minor decrease in T2D diagnosis. There is a widely accepted assumption that T2D is primarily a disease of affluent and developed countries closely linked to lifestyle choices such as the quality and quantity of food consumption and as well as increased alcohol consumption (Baliunas et al., 2009; Ginter and Simko, 2012). In the UK it is estimated that individuals with T2D will double by the year 2030 and with an estimated 16% of deaths resulting from T2D (Diabetes in the UK, 2011; Basu et

	The current number of individuals with T2D	2030 estimate numbers of individuals with T2D
USA	17.7 million	30.3 million
Australia	1.7 million	3.3. million
Europe	33.3 million	47.9 million
UK	3 million	5 million

(Lindström et al., 2010; WHO, 2013; NHS, 2014)

Table 1.4.1.b. - created by the Author

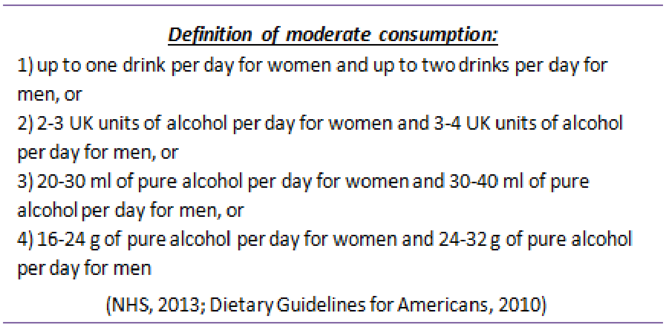
al., 2014). Currently, T2D is the fifth leading cause of death in the UK and accounts for approximately one-tenth of NHS expenditure (Paulweber et al., 2010; Hex et al., 2012).

Lifestyle modifications for individuals with T2D include beyond food as well as self-regulation of excessive drinking and alteration of drinking habits (Tang et al., 2008; Inzucchi et al., 2012). Lifestyle modifications are key for individuals with T2D who consume alcohol, and this currently includes the development of structured education, lifestyle advice and self-monitoring training sessions (NHS, 2013; NICE, 2009). However, these enabling mechanisms require appropriate staff training, sufficient time, proper resources and pertinent emphasis on psychosocial aspects relating to T2D. Such enabling mechanisms are not always available, limiting the implementation of already developed guidelines for supporting individuals with T2D who consume alcohol (Nakar, 2007; Home et al., 2009; Hex et al., 2012).

1.4.2. Alcohol consumption

Alcohol is a psychoactive substance linked to human culture, to dietary habits, and social, spiritual and life events (Burns et al., Gately, 2008; Bakhshi and While, 2014). Alcohol consumption occurs mostly in the context of social networks often promoting social interaction and integration, peer bonding and a sense of belonging, and boosting conviviality and sociability (Zhou et al., 2013; Yoon 2015). However, alcohol diffuses throughout the body and can produce multiple synergistic and potentially detrimental effects contributing to the onset and exacerbation of chronic conditions including T2D (Athyros et al., 2008; Fernández-Solà, 2015).

Further data indicate that significant numbers of individuals exceed moderate levels of alcohol consumption (see Table 1.4.2.a), with 3.3 million deaths in 2010 attributed to alcohol amounting to 5.9% of the total global deaths (WHO, 2014). The European region is one of the prime consumers of alcohol per capita worldwide, and alcohol is the third most important risk factor for disease



Definition of moderate consumption:

1) up to one drink per day for women and up to two drinks per day for men, or
2) 2-3 UK units of alcohol per day for women and 3-4 UK units of alcohol per day for men, or
3) 20-30 ml of pure alcohol per day for women and 30-40 ml of pure alcohol per day for men, or
4) 16-24 g of pure alcohol per day for women and 24-32 g of pure alcohol per day for men

(NHS, 2013; Dietary Guidelines for Americans, 2010)

Table 1.4.2.a. - created by the Author

burden (Mason et al., 2009; WHO, 2014). The UK is amongst the countries with the highest levels of alcohol consumption, ranking 15th in the world. An estimated 1.6 million people are considered alcohol dependent in the UK with 1.2 million alcohol-related hospital admissions per year and with a total of 8748 deaths in 2011 directly related to alcohol (NHS, 2007; NHS 2012; LAPE 2013).

The literature identifies that even moderate alcohol consumption can amplify the perception of appetite in response to food stimuli and can trigger various mechanisms that potentially can promote weight gain (Traversy and Chaput, 2015). Furthermore, the literature associates sixty different types of diseases and injuries with alcohol consumption from moderate levels to increased levels of consumption including misuse of alcohol, abuse of alcohol, dependence on alcohol and addiction to alcohol (Martin, 2008; Mason et al., 2009; Wrycraft, 2012). The two widely used classification systems for standardising the criteria of diagnosing alcohol use are the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification (ICD). Alcohol abuse following DSM-IV occurs when from the four relevant criteria, at least one is met in 12 months. In contrast, the classification for alcohol dependence occurs when a minimum of three of the seven relevant criteria is met in 12 months (see table 1.4.2.b).

DSM-IV classification

Alcohol abuse is defined as the recurrent use of alcohol that leads to:

1. failure to fulfil obligations
2. the development of physically hazardous behaviours,
3. legal problems due to the alcohol use
4. social and interpersonal problems due to the alcohol use

Alcohol dependence beyond the above criteria further includes:

1. the continuation of alcohol use despite related problems,
2. the increase intolerance of alcohol
3. the development of withdrawal symptoms

(APA, 2000; AllPsych, 2011; Kopak et al., 2014)

Table 1.4.2.b. - created by the Author

In 2013 a revision of the DSM-IV classification system occurred resolving ambiguities between alcohol abuse and alcohol dependence, taking into consideration the ICD-10 classification criteria and ameliorating problems associated with diagnostic orphans (APA, 2013). The revised DSM-V classification merged alcohol abuse, and alcohol dependence disorders moved from a categorical classification assessment (i.e. abuse and dependence) to a dimensional assessment (i.e. based on graded levels of severity) and deleted the recurrent legal problems criterion for substance abuse from DSM-V and added the new criterion of craving (Reichenberg, 2013; Kopak et al., 2014). Therefore, DSM-V defines alcohol problems as alcohol use dependence (AUD) and is based on the number of criteria (see table1.4.2.c). People meeting a) 2–3 criteria indicate a mild disorder, b) 4–5 criteria indicate a moderate disorder and c) with six or more indicate a severe alcohol disorder (APA, 2013).

DSM-V diagnostic criteria for alcohol dependence

1. Drinks more than intended, or for longer than intended
2. Efforts to control or cut back on drinking have been unsuccessful
3. Large amounts of time are spent obtaining, using or recovering from alcohol
4. Cravings (the presence of a strong desire to drink)
5. Recurrent use resulting in problems at work, home, or school
6. Continued use despite recurrent social or interpersonal problems resulting from drinking
7. Curtailing important activities in favour of alcohol use
8. Alcohol use despite potentially hazardous outcomes (drinking and driving for example)
9. Continued alcohol use despite the knowledge that alcohol use is causing or exacerbating a persistent physical or psychological problem
10. Tolerance or a need for increased amounts of alcohol
11. Withdrawal symptoms

(Reichenberg, 2013; Kopak et al., 2014)

Table 1.4.2.c. - created by the Author

The ICD-10 classification while sharing similarities with the DSM-V, nevertheless there are as well differences with most eminent the fact that ICD-10 is the creation of WHO taking into consideration global perspectives, whereas DSM-V is the creation exclusively of US perspectives. Also, ICD-10 treats alcohol use as a health condition, rather than a mental disorder, and includes in its' classification a multidisciplinary perspective, rather than exclusively psychiatric perspective (table 1.4.2.d).

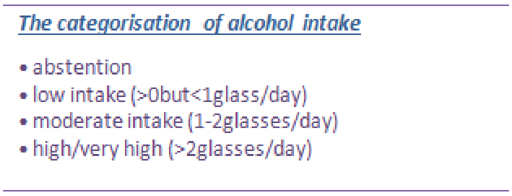
ICD-10 classification of alcohol dependence

1. Strong desire or sense of compulsion to take alcohol,
2. Impaired capacity to control substance-taking behaviour in terms of its onset, termination or levels of use,
3. A physiological withdrawal state when alcohol use is reduced or ceased,
4. The existence of evidence of tolerance to the effects of alcohol (increased amounts of alcohol in order to achieve intoxication),
5. The preoccupation with alcohol use despite clear evidence of harmful consequences

(WHO, 2014)

Table 1.4.2.d. - created by the Author

The literature taking into consideration the above categorisations and studying linkages between alcohol consumption and conditions such as cardiovascular diseases or type 2 diabetes identify that quantity and frequency of alcohol has a significant impact effect (Koloverou et al., 2015; Li et al., 2016). While there is a notable discrepancy amongst countries on defining the levels of alcohol consumption or the ways of measuring alcohol consumption, nonetheless most studies use the continuum of low intake to very high intake (Heianza et al., 2013; Koloverou et al., 2015; Kalinowski & Humphreys, 2016; Li et al., 2016). On one side of this continuum is the low consumption that consists of > 0 but < 1 glass/day, that moves to moderate consumption that consists of 1–2 glasses/day and at the other end of the continuum is high/very high consumption over two glasses/day (Koloverou et al., 2015; Li et al., 2016). The current study uses this categorisation of alcohol consumption as described in table 1.4.2.e. and participants included in the current study were those that consumed alcohol from low intake to high intake spectrum.



The categorisation of alcohol intake

- abstention
- low intake (>0but<1glass/day)
- moderate intake (1-2glasses/day)
- high/very high (>2glasses/day)

Table 1.4.2.e. - adapted from Koloverou et al., 2015

1.4.3 Well-being and the lifeworld of individuals

Alcohol consumption and T2D separately can negatively affect individuals' notion of well-being. However, combining alcohol consumption and T2D in a single case has for individuals a two-fold increase risk of exhibiting negative feelings and a diminished sense of well-being (Schram et al., 2009; Brook et al., 2011). The literature uses the term "well-being" to describe the happiness of individuals, to signify the presence of positive feelings and denote the absence of negative feelings and anxiety, and to portray a fulfilling existence that includes all the makings for a pleasant life (Deci and Ryan, 2008; Kahneman and Deaton, 2010).

Hemingway (2011), uses the lifeworld approach to assert that a person's well-being consists of the totality of experiences and beliefs that enables the individual to achieve good health, avoid early morbidity and mortality, and overall create a sense of security, self-respect, happiness and potential for development. Furthermore, the lifeworld approach anticipates well-being as the embodied experience that has multiple qualities and consists of dwelling and mobility, whereby dwelling implies the adjustment to a condition, and mobility implies the moving on with this condition (Galvin and Todres, 2013). Hence, dwelling acquires the quality of peacefulness and mobility acquires the quality of exploring new places, things and possibilities. The unity of dwelling and mobility creates a sense of adventure horizons that offer a new place of promise (Galvin and Todres, 2013). Therefore, only when individuals with T2D who consume alcohol accept their T2D condition and move on in changing their lifestyle will they be able to feel “at peace” and “at home” with their state (dwelling) and will be ready to move on and explore new possibilities (mobility).

1.5. Rationale/ Justification

The underpinning rationale of the current study assumes that individuals with T2D who consume alcohol find it difficult to modify their lifestyle, thus affecting their existential dimensions of well-being. This assumption partially emerges from the literature that identifies a constant increase of individuals with T2D who consume alcohol in the UK and partially on the researcher's pre-understanding of T2D and alcohol consumption. Furthermore, the study builds on the importance of empowering individuals with T2D who consume alcohol to achieve a sense of well-being and on the bi-directional negative influence that T2D and alcohol consumption has for lifestyle modification and overall sense of well-being.

1.6. Summary of the research problem

The research problem for the current study is to acquire an in-depth understanding of the lived experiences of individuals withT2D who consume alcohol concerning the existential challenges they face in changing their lifestyles, in constructing meaning out of their new lifeworld and in achieving a sense of well-being in their new lifestyle. Well-being is more than the mere absence of illness, but the current health service culture gives primacy to targets, efficiency drives and audit pathways dismissing to a significant extent the human dimensions of well-being and in the process compartmentalise and dehumanises the provision of care. The current research focused on the complex ways in which individuals with T2D who consume alcohol understand their lifeworld, their embodied notion of well-being, and the required support for adjusting to and sustaining new lifestyles.

CHAPTER 2:
LITERATURE REVIEW

2.1. Literature review

2.1.1. Chapter outline

The current chapter presents a systematic scoping review of the literature on T2D, alcohol consumption, lifestyle changes and well-being with the overall intention of identifying the available evidence on the issues, clarifying concepts and identifying key factors relating to these concepts. Furthermore, this review considers the existing gaps in the research and the literature concerning the above concepts. It concludes with the formation of the research question, aim and objectives of the current study.

2.1.2. Search strategy

Successful completion of a systematic scoping review requires a systematic framework for searching the relevant literature. According to Younger and Boddy (2009), the use of a variety of databases in the search strategy increases the potential of retrieving the great majority of relevant articles. Moreover, the use of multiple databases ensures that important articles are not missed (Younger and Boddy, 2009). The current study takes extra care to include as broad as possible databases and in specific uses the following databases: British Nursing Index (BNI), Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline, Embase, Global Health, PsycINFO, Ovid MedLine, and Leeds University Library's Journals.

Equally important with the extensive database inclusion, is the formulation of a search strategy that would enable the researcher to identify the most relevant articles and evidence. According to Young (2004), the search strategy commences with the identifying the relevant keywords for conducting an electronic search, and suggest as appropriate to write down the title of the study and underline the most frequently appearing and relevant words. In the current study ‘type 2 diabetes’, ‘well-being’ and ‘alcohol consumption’ were the main keywords emerging from the study’s title. Young (2004) further suggests that the researcher should identify synonyms of the original keywords and alternative phrases to avoid overlooking important studies. The synonyms and alternative keywords used in the current study are ‘diabetes mellitus’, ‘alcohol use’, ‘alcohol abuse’, ‘alcohol dependence’ and ‘alcohol addiction’. In addition to the above keywords, ‘lifestyle modifications’ and ‘lifestyle changes’ were used as keywords because lifestyle modification is considered an important concept for this topic and is relevant to the current study and may or not affect individuals with T2D who consume alcohol.

To further expand and refine the electronic search, the current study uses all the above keywords individually or in combination. Also, the study uses Boolean operators to expand the search by joining two or more keywords with the use of “AND” and exclude two or more terms with “OR” (Timmins and McCabe, 2005). To further narrow the search, the study, also, uses the following keywords: ‘type 2 diabetes’, ‘alcohol’, ‘well-being’, ‘social’, ‘sociological’, ‘social stigma’, ‘nurse’ and ‘nursing’. All the above keywords, when used alone, retrieved a very large number of articles. However, the study refined the electronic search using advanced searching filters, such as limited in English language, grey literature and human, and Boolean operators.

Complementing the above search criteria is the identification and justification of the time frame used to conduct the electronic search. The literature asserts that the time frame included in the search strategy requires a careful and balanced act to obtain sufficiently up-to-date and the most recent and timely articles on the topic. It also requires to be broad enough to allow the retrieval of sufficient literature to understand the issues of the search and possible significant changes in the meaning of the concepts searched as developed over time (Høye and Severinsson, 2007; Bish et al., 2012; O’Leary et al., 2017). The current study considered this need to balance most recent time-frame as possible, but as well broad enough time-frame to acquire appropriate and sufficient understanding of the topic. In 2003, the Department of Health (DoH, 2002) created the National Service Framework for

Diabetes document outlining a new strategy for delivering and developing diabetes networks and for developing standards of integrated service for individuals with T2D with overall intent to fully integrate these services and become part of mainstream care provision for T2D by the end of 2007 (DoH, 2002). Hence, from 2008 onwards the National Service Framework for Diabetes was fully implemented. The current study considers this a turning point in the care and services for T2D in the UK.

Furthermore, in 2008 the National Collaborating Centre for Chronic Conditions produced on behalf of NICE an updated version of clinical guidelines for T2D that since informs the practice and care processes for individuals with T2D in the UK. Moreover, at the end of 2007, the Department of Health and the Home Office updated the government alcohol strategy, setting out clear goals and actions to promote sensible drinking and reduce the harm that alcohol can cause (DoH, 2008). This updated strategy, goals and actions took effect from 2008 and onwards. Finally, NICE (2007) as well updated the guidelines with regards to the promotion of health and well-being in late 2007.

Following the above, the year 2008 is the point at which a series of updates, strategy developments and service integrations with regard toT2D, alcohol management and well-being occurred and significantly altered and shifted the services and care provided. Therefore, the year 2008 and onwards was an appropriate time-frame for the electronic search to retrieve a sufficiently up-to-date and adequately broad collection of literature to conduct my literature review. The initial electronic search of the literature review took place on 2014 with an additional search undertaken on March 2018 using the same inclusion criteria, the same keywords and the same search databases as in the original search to update the literature. Hence, the time-frame search limits of the current study are from 2008 to 2018.

The current study complemented the electronic search of the literature with an additional search of the grey literature on the T2D and alcohol consumption to ensure that the review did not miss including potentially important articles on the topic. The databases searched to retrieve grey literature are; "www.greylit.org", "library.leeds.ac.uk/grey-literature" and "www.opengrey.eu". The search of grey literature databases used the same keywords as above, and the same Boolean operators of "OR" and "AND" linking the same keywords as with the search in the main databases. The electronic search to further narrow the retrieved grey literature used additional filters that included the following: documents of conferences, dissertations, governments and reports in English language and excluded newspapers and book reviews.

2.1.3. Inclusion and exclusion criteria

The initial advanced search in the year 2014 with all the above filters and parameters retrieved a total of 1374 potentially relevant articles. The second follow-up search in the year 2018, for the years 2015 to 2018, retrieved a total of 88 potentially relevant articles. The advanced search of the grey literature retrieved a total of 79 potentially relevant documents. The total of potentially relevant literature retrieved from the original search in 2014, the second follow-up search in 2018 and the search of the grey literature added to a total of 1541 articles and documents. Consequently, 187 articles were removed from the search as duplicates leaving a total of 1354 articles. The researcher continued the screening of the articles by reading the titles and abstracts of the 1354 articles to identify which articles were relevant to the aim and objectives of the current study. From this screening, the researcher excluded a total of 1242 articles because the title and abstract were not relevant to the aim and objectives of the current study. Consequently, the researcher read the full-text of the remaining 112 articles and collated their content against the inclusion/ exclusion criteria developed by the current study to identify which of these articles met the eligibility criteria for inclusion in the study.

The inclusion criteria for the retrieved articles included; a) individuals diagnosed with T2D; b) alcohol consumption; c) studies relating to lifestyle changes/modifications; d) studies that focused on individuals’ well-being; e) studies written in the English language; and f) studies after 2008. The exclusion criteria for the retrieved articles included; a) patients diagnosed with type 1diabetes; b) if the individuals studied were engaged in other substances rather than just alcohol; c) results from newspapers and book reviews; d) articles that focused on laboratory tests and drug development for diabetes; e) results not in the English language.

Following the assessment based on the eligibility criteria for inclusion in the current study of the 112 full-text articles, the researcher identified a total of 33 full-text articles that met these eligibility criteria. These 33 articles were included in the current study (24 articles from initial search + 3 articles from follow-up search + 6 articles from grey literature) (see Prisma flow diagram, Figure 2.1.2a.). The study used Hawker's appraisal framework (2002) (Appendix III) for assessing the quality of all the retrieved studies from the mainstream databases and Tyndall's checklist (2008) (Appendix VI) for assessing the quality of the grey literature.

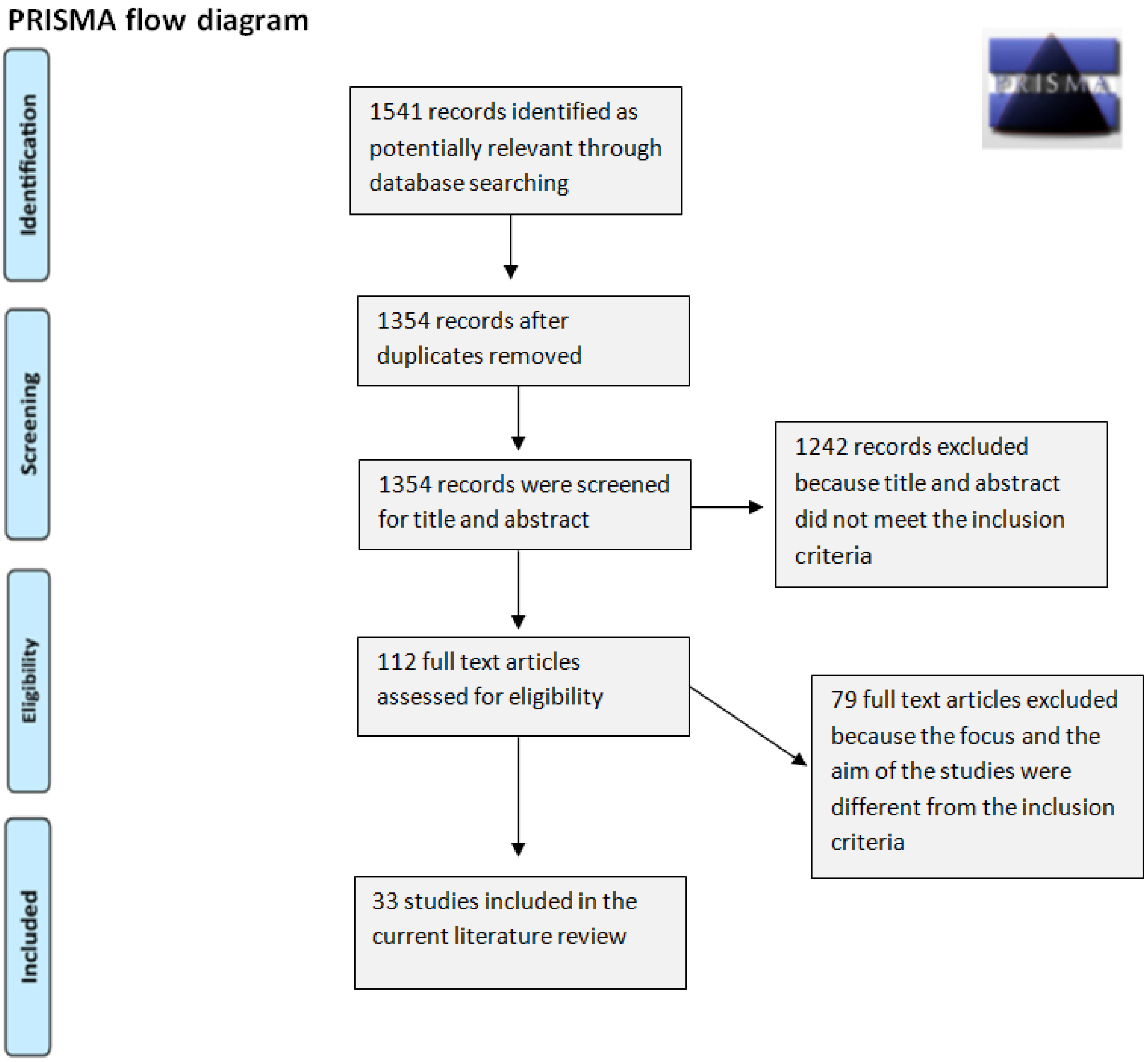


Figure 2.1.2.a. – PRISMA flow diagram adapted from Moher et al. (2009)

2.2. Results of the systematic literature review

This section presents the results of the systematic literature review. The literature review aggregates the emerging results and develops them into thematic units. A total of five thematic units develop, namely: a) T2D and alcohol consumption linkage, b) well-being of individuals with T2D consuming alcohol, c) the illusion of change as a barrier to genuine lifestyle modifications, d) health professionals' role in supporting individuals with T2D, and5) stigma, social networks and well-being in individuals consuming alcohol (Mantzouka et al., 2017).

2.2.1. Type 2 diabetes and alcohol consumption linkage

This thematic unit suggests that increased levels of alcohol consumption and reoccurring episodes of relatively heavy drinking can lead both to the onset and the adverse development of existing chronic conditions, such as T2D. The literature acknowledges an explicit relationship between overconsumption of alcohol and increased body weight, higher blood pressure and instability of insulin production (Baliunas, 2009; Shield et al., 2014; Saucedo, 2013). Specifically, the literature argues that increased levels of average alcohol consumption lead to increased risk of developing T2D due to the possible physiological effects that alcohol has on increasing the body weight and the concentrations of fats in the blood, hence causing hyperglycaemia (Baliunas, 2009; Shield et al., 2013). While both Baliunas (2009) and Shield et al. (2013) assert that a relationship exists between alcohol overconsumption and T2D, and suggest this relationship to have physiological explanations, nevertheless both admit that this biological relationship and explanations are unclear and are still a matter of further research.

Similarly, Saucedo (2013) and Wu et al. (2011) assert that there is an explicit relationship between overconsumption of alcohol and T2D. However, they expand on Baliunas (2009) and Shield et al. (2013) views, to assert that this relationship emerges from social, environmental and psychological factors. Saucedo (2013) and Wu et al. (2011) associate alcohol consumption with social, environmental and psychological factors, which adversely affects the potential of individuals living with

T2D to self-manage. The argument that social, environmental and psychological factors are responsible for alcohol overconsumption, which consequently leads to the inability to cope with T2D diagnosis, is further highlighted by this literature (Katon, 2008; Wu et al., 2011; Saucedo,2013).

Furthermore, Katon (2008) identifies that depressive symptoms that may result amongst others from alcohol consumption can, in turn, negatively affect the adherence to T2D treatments and lifestyle changes leading to poor diabetic self-care. Likewise, Yalcin et al. (2008) propose that psychological factors such as ill-being remain one of the main barriers in improving outcomes in individuals with T2D because it discourages them from setting targets for their future that include the self-management of their condition. Finally, Gorter et al. (2011) link alcohol consumption with the inability or unwillingness of individuals to take responsibility for their T2D medication and self-care.

The above studies acknowledge an existing relationship between alcohol consumption and T2D, and consider this relationship to emerge from physiological, psychosocial and environmental factors. Furthermore, most of the studies conclude that there is a need for incentivising better coordination between healthcare providers and individuals with T2D, and for tailoring treatment and care to specific individual needs (Saucedo, 2013; Gorter et al., 2011). Also, the reviewed literature identifies that alcohol consumption has an undeniable impact on the health of individuals with T2D, but this effect is admittedly unclear and a matter for further study requiring long-term studies for verification (Yalcin et al., 2008; Baliunas, 2009; Shield et al., 2013).

Furthermore, the above obscurity of the relationship between alcohol consumption and T2D becomes more complicated by the limitations emerging from the quantitative nature that most of the relevant studies have and the variations that exist between cultures where the studies took place. For example, Wu et al. (2011) acknowledge that a discrepancy might exist in the findings because Chinese people that were involved in the study are less expressive by nature and socially conservative, hence decreasing the likelihood of seeking professional help for dealing withT2D. Similarly, Katon (2008) and Saucedo (2013) argue for both quantitative and qualitative studies to better understand the relationship between alcohol consumption and T2D, and in the future to include individuals that may already have serious diabetes complications and are unable to perform self-care behaviours (Wu et al., 2011; Knott et al. 2015).

Part of the reviewed literature suggests that there may be a hypothetical positive effect of low to moderate levels of alcohol consumption and T2D. This hypothesis contravenes most of the literature that identifies an explicit negative effect of alcohol consumption on T2D, and terms this as a U or J shaped curve relationship (Baliunas, 2009). The U or J shaped curve relationship refers to those individuals that abstain from alcohol consumption to be of greater risk of developing T2D in comparison to individuals with a low-to-moderate average consumption of alcohol. In contrast, for higher levels of average volume of alcohol consumption, the risk relationship reverses putting these individuals at greater risk than abstainers in developing T2D. Therefore the emergent hypothesis is that low-to-moderate average consumption of alcohol may indeed reduce the risk of developing T2D (Baliunas, 2009).

However, the hypothesis that low-to-moderate consumption of alcohol can potentially limit the risk of developing T2D is controversial in other parts of the literature. In part, this controversy stems from the difficulties in actually measuring alcohol consumption as different types of literature define alcohol consumption in different ways and different types of alcohol may have different effects (Rehm and Shield, 2014). Furthermore, the hypothesis that low-to-moderate consumption of alcohol can potentially limit the risk of T2D is susceptible to biases because such a hypothesis does not make the distinction between lifetime abstainers and former drinkers (Rehm and Shield, 2014). Also, current survey data measuring alcohol consumption are lacking complex modelling techniques, thus omitting multiple dimensions relating to alcohol consumption (Rehm and Shield, 2014). Lastly, causally linking low-to-moderate consumption of alcohol to a reduced risk of developing T2D creates greater ambiguity that it intends to resolve because it is unclear whether alcohol consumption itself is a protective factor or if moderate drinking is a marker for healthy lifestyle choices that may account for some of the observed protective effects (Shield et al., 2014).

Furthermore, the literature acknowledges that the societal contributions of individuals withT2D who consume alcohol are comparatively lower than others in society. The reviewed literature considers both T2D and alcohol to be a financial burden for any society as it reduces the overall productivity because individuals with T2D who consume alcohol demonstrate increased absenteeism in the workplace and likeliness to take early retirement compared to non-diabetes individuals (Breton et al., 2013; Rehm and Hingson, 2014). This part of the literature suggests that individuals with T2D who consume alcohol will benefit from the development of supportive intervention programmes that would improve both the physical health and well-being and as a consequences control of productivity-related costs (Breton et al., 2013).

This section suggests that alcohol consumption can lead both to the onset and the adverse development of existing chronic conditions, such as T2D. The higher the levels of alcohol consumption, the greater the risk for diabetes development and the exacerbation of T2D situation. This section linksT2D and alcohol consumption to physical, psychological, social and environmental conditions and while there are no clear explanations of how the linkages develop, nevertheless these linkages seem to be univocal in literature. Also, society views individuals with T2D who consume alcohol as burdens relating to costs and productivity. Finally, dealing with alcohol consumption and T2D requires the development of supportive and person-tailored support programmes.

2.2.2. The well-being of individuals with T2D

This thematic unit suggests that education, information giving, and knowledge development of individuals with T2D who consume alcohol has a positive effect on their quality of life and in creating a sense of well-being. Kneck et al. (2012) in a phenomenological study on learning to live with T2D consider education, sharing of experiences and making sense of life to be essential in overcoming tensions and challenges emerging from the T2D condition. However, Kneck et al. (2012) argue that such understanding of the self or the lifeworld is not straightforward because sentiments of vulnerability, powerlessness and distress inevitably creep into the world of individuals with T2D. Consequently, these sentiments create tensions between how individuals with T2D want to live their lives and the way they must live their lives due to the T2D situation that in turn, leads to a sense of ill-being. Individuals with T2D can regain a sense of harmony and well-being only when they strick a balance between the idealised lifestyle and the daily reality created by their T2D condition (Kneck et al., 2012; Boehm et al. 2015).

While Kneck et al.'s (2012) study focuses on the experiences of individuals with T2D and does not refer to alcohol consumption, nevertheless the craving sentiments associated with alcohol consumption and the difficulty in altering lifestyles can further intensify the tension between the idealised lifestyle and the imposed lifestyle from the T2D situation. This disharmony between the idealised and the pragmatic is what Kneck et al. (2012) consider fundamental in creating sentiments of ill-being, and only when the individual overcomes these sentiments can achieve mastery of one's life and create a sense of well-being. Kneck et al.'s (2012) study is subject to the limitations associated with qualitative studies and the heterogeneity of the collected data regarding ethnicity, culture, and context, nevertheless this study highlights the importance of the concept of well-being for individuals with T2D, which can result from the balance achieved between the idealised and pragmatic worlds of individuals with T2D.

Kalda et al. (2008) in a quantitative study, examine the factors that influence the quality of life for individuals with T2D and conclude that their quality of life is significantly lower than that of the general population. The key factors leading to an improved quality of life for individuals with T2D are well-informed and motivated individuals that believe they are in a position of positively influencing their condition (Kalda et al., 2008). Similarly, Min (2010), in a systematic review, considers that appropriate educational provision to individuals with T2D is essential for them to manage and cope with their condition effectively. Both, Kalda et al. (2008) and Min (2010) draw links between well-informed, well-educated and self-motivated individuals with T2D and their potential to implement a problem-focused coping strategy that enables the alteration of the stresses relating to their situation, rather than adapting an emotion-focused strategy that is counter-productive to coping with stresses.

However, both Kalda et al. (2008) and Min (2010) concede that the provision of information and education to individuals with T2D, while necessary, nevertheless alone are an insufficient precondition for coping and managing T2D. Kalda et al. (2008) assert that while the well-educated individuals with T2D can have greater autonomy, nevertheless assume in their study that not all health professionals are ready to work in partnership with individuals with T2D in assisting them to gain such information or education. Min (2010) similarly considers that knowledge of the disease alone is insufficient for coping with it. Changes in behaviour do not occur automatically and usually incorporate other complicating factors such as depression or alcohol consumption that may impede adaptation to the new lifestyle and overall negatively affect the quality of life.

Also, Manderson and Kokanovic (2009) study on minority and immigrant groups' experiences and patterns of adaptation to the T2D situation highlight the role of cultural and societal variables in adapting to T2D condition. They correlate individuals’ capacity to adapt to T2D and achieve a sense of well-being with cultural and contextual variables. Cultural and community expectations and the potential inability to meet these expectations due to the T2D condition triggers sentiments of uneasiness, unfulfillment and inadequacy that negatively affect their levels of well-being (Manderson and Kokanovic, 2009). Manderson and Kokanovic’s (2009) study considers these reduced levels of well-being to emerge from the negative feedback loop of everyday circumstances that create stress, worry or anxiety, and which further leads to complicating the diabetes condition. Thus precipitating further stress and anxiety and perpetuating the vicious circle that leads to sentiments of further decline in well-being.

Manderson and Kokanovic (2009) in the same study suggest that the cultural context not only placed expectations on the individuals for achieving cultural expectations but also influences the way individuals speak about their condition and the support they seek. Wu et al. (2011) complement these findings with their conclusions in a quantitative study linking cultural aspects of expressiveness and social interaction to well-being. Wu et al. (2011) assert that the cultural unwillingness to share and discuss experiences of T2D may lead to stoically accepting the condition without rationalising it and as a result to experience unhappiness and discontent that eventually de-motivates individuals’ and wane their willingness to improve their life quality. Manderson and Kokanovic (2009) also make references to the health and medical culture that acts as a deterrent for lay individuals with long-term complications to share experiences, feelings and anxieties easily.

Both, Manderson and Kokanovic (2009) and Wu et al.’s (2011) studies highlight the role of culture and context as influential factors for individuals with T2D in achieving (or not) a sense of well-being. This view is pertinent to the current study as it not only relates to the rationalisation (or not) of T2D but also relates to alcohol consumption as a cultural and contextual condition that may influence the willingness of individuals with T2D who consume alcohol to share (or not) experiences and communicate their alcohol-related issues. The same loop, as mentioned by Manderson and Kokanovic (2009) of related cultural stress, T2D and a decreased sense of well-being, can find application as well to individuals with T2D who consume alcohol. The culture of alcohol consumption leads to or complicates pre-existing diabetes conditions, hence precipitating further alcohol consumption, which leads to further stress, anxiety and maladaption to the diabetes condition, and further decreases the sentiment of well-being.

In summary, the literature considers that merely providing education and giving information to individuals with T2D is not sufficient in supporting them to achieve a sense of well-being. Beyond education and information-giving equally important is the potential for individuals with T2D to rationalise their condition and achieve a balance between the idealised way they envisage living their lives and the pragmatic way they find themselves currently living their lives. This rationalisation enables these individuals to come to terms with T2D condition. Such balancing between the idealised and the pragmatic requires the development of problem-solving skills, the potential to attune to the new lifestyle demands and the minimisation of emotional reactions. Eventually, once individuals develop problem-solving skills, rationalise their condition and adopt a pragmatic stance, then they are ready for moving on and achieving their personal and social expectations, creating a sense of well-being.

2.2.3. The illusion of change as a barrier to lifestyle modifications

The current thematic unit focuses on individuals’ sense of well-being after the need to alter lifestyles and the notion of well-adjustment to such alterations. Johansson et al.'s (2009) phenomenological study of individuals with insulin-treatment with at least four months from diagnosis, query their acceptance of their new lifestyle conditions and conclude that such individuals try very hard to appear as if everything is as usual and put on a façade of normality. Johansson et al.’s (2009) study suggest that there is a roller-coaster of sentiments upon the diagnosis withT2D, but once the diagnosis is made individuals rapidly attempt to appear as if adjusted to the T2D situation and as if T2D situation never affected their lives. In other words, individuals with T2D, according to Johansson et al. (2009), put on a defensive appearance of acceptance of the T2D condition by not wanting to discuss their condition or express feelings about it, not necessarily because they have accepted or adjusted well with the T2D condition, but because they want to appear as unaffected by the situation and feel accepted by others as healthy and avoid the label of sickness. For Johansson et al. (2009), most of the individuals with T2D put in a lot of effort to avoid making diabetes become part of their life and try hard to hide it or exclude it from their life to avoid the label of ill-health.

The underpinning assumption in Johansson et al.’s (2009) study is that individuals with T2D appear to adapt to new lifestyle demands. However, this adaptation is a false or illusory adaptation and not a genuine adaption to the T2D situation. Ahlin and Billhult’s (2012) qualitative study echoes this view with their study on lifestyle changes of women suffering withT2D by presenting the difficulties and inner struggles in achieving genuine lifestyle changes. Ahlin and Billhult (2012) maintain that the inner struggle of individuals with T2D relates to their efforts to live with the illusion that they do not have diabetes or do not have to make lifestyle changes. Making lifestyle changes creates great levels of inner tension and an esoteric struggle for individuals with T2D, as such changes lead to feelings of emptiness, and to defining life as meaningless eventually expressing an unwillingness to change if they are unable to live as usual (Ahlin and Billhult, 2012; Benavides et al., 2017).

In essence, both Johansson et al. (2009) and Ahlin and Billhult (2012) make the point that lifestyle changes for T2D are not easy, that health professionals should not confuse well-adaptation with a façade of surface acceptance of the need to change and that individuals with T2D continuously struggle with their inner self about the need and usefulness of lifestyle changes. Handley et al.’s (2010) phenomenological study agree that individuals with T2D face a continuous state of emotional turmoil, ranging from denial to shock and fear when confronted with the need to change lifestyles. Ahlin and Billhult (2012) further develop this argument by suggesting that lifestyles changes for individuals with T2D do not have positive connotations even though they may be necessary and sometimes these individuals struggle with change and prefer to live with the illusion of appearances, rather than genuinely accept the lifestyle change. Johansson et al. (2009; 2016) view this struggle as the struggle not to become one’s illness and not allow the illness to dominate one's life.

Furthermore, Ahlin and Billhult (2012) consider that a series of urges that are outside the intentions of the individual may aggravate the inner struggle of these individuals. These urges act as barriers to change and are a constant reminder of the changes occurring in their lives. One such urge that may act as a barrier and become a constant reminder of a bygone life was the urge to consume alcohol. Grado (2013) in a survey study on alcohol abuse and aggravation of T2D amongst others, suggests that there is an association of T2D and alcohol consumption, whereby alcohol consumption increases the risks of mal-adaptation or consists an additional barrier for adapting to the new lifestyle. Similarly, Malpass et al. (2009) consider that individuals with T2D struggle to alter their lifestyle, but differ in their analyses from Grado (2013) in that they assume multiple lifestyle changes are easier, less problematic and more beneficial than singular lifestyle changes. Malpass et al. (2009) assert that multiple lifestyle changes can be mutually supportive in contrast to singular lifestyle changes. In this manner, lifestyle changes relating to T2D and alcohol may indeed be less problematic than merely lifestyle changes due to T2D. However, Malpass et al. (2009) accept that the result of their findings did not reflect all the participants in the study and that this is not something widely agreed across the literature, as some participants and parts of the literature found multiple lifestyle changes to be counterproductive. Finally, Jansink et al.’s (2010) qualitative study concluded that advice-giving and lifestyle counselling is an important task for overcoming the barriers of lifestyle modifications.

In summary, the current thematic unit considers that individuals with T2D have difficulties in modifying their lifestyles as required by their T2D condition and often underwent an illusion of change. This illusion of change maintains the focus on appearances of being accepted by others as healthy. Moreover, individuals with T2D seem to prefer this illusory adaptation instead of the genuine adaption toT2D, as genuine lifestyle changes create great levels of inner tension and esoteric struggles. For most individuals with T2D, change is something that is not positive even though necessary because lifestyle changes signify the victory of T2D over their lives and domination of their lives by T2D. In contrast, lack of change signified resistance to the non-healthy condition of T2D. Furthermore, individuals with T2D who consume alcohol have additional barriers and struggles for adapting to new lifestyles. This struggle in accepting change and moving on is what the literature defines as the sensation of ill-being and considers lifestyle counselling important for overcoming the barriers of lifestyle modifications and achieving a sense of well-being by individuals with T2D who consume alcohol.

2.2.4. Health professionals' role in supporting individuals with T2D

This section reviews the role of health professionals in supporting individuals with T2D who consume alcohol to positively adapt to lifestyle changes and achieve a sense of well-being. Health professionals have an important role in the caring process of individuals with T2D. According to Collins (2009), the treatment of T2D is at large done either in primary care or secondary care specialist centres with nurses being the prime providers of care and with GPs in some rare cases providing treatment as well. A series of studies demonstrate that the information and knowledge provided to T2D by health professionals are important because it can empower individuals with T2D who consume alcohol to remove barriers that impede lifestyles alterations and can support these individuals throughout the change process of lifestyles in retaining their quality of life (Collins, 2009; Hicks, 2010).

Gorter et al. (2011), in a quantitative survey study, develop correlations between individuals with T2D taking responsibility in setting their care and treatment targets and the quality of life for these individuals. In their study, Gorter et al. (2011) commence from the point of view that self-efficacy, self-management and self-care are essential elements for effective management and care of diabetes. However, their study results contradicted up to a point the assumption that health professionals sufficiently prepare individuals with T2D to self-care and adequately empower them to self-manage, as the majority of participants while agreeing to take responsibility for their care, nevertheless are unwilling to set treatment targets. Gorter et al.'s (2011) study highlight that in cases that individuals with T2D and health professionals partner in defining treatment targets, this produces more effective self-care behaviours. However, in cases, health professionals are the ones that set targets and individuals with T2D merely take the responsibility to follow them this inevitably leads to misunderstandings between these individuals and health professionals curtailing their sense of ownership of the treatment.

Similarly, Turner (2008), in a grounded theory study explores the experiences of individuals with T2D and assesses their received education concluding that individuals with T2D lacked the opportunity of posing questions after an education session on T2D and did not have ongoing educational support by health professionals. Like Gorter et al. (2011), Turner (2008) asserts that there are very limited cases in which individuals with T2D exert autonomy in setting treatment targets. In most cases, individuals with T2D follow directions ov what to do to manage their T2D. Both Gorter et al. (2011) and Turner (2008) conclude that such a lack of ownership regarding treatment targets create sentiments of unhappiness and make the care and treatment appear as patronising.

The need for health professionals to support individuals with T2D take ownership of their treatment targets is a recurring theme in the relevant literature. Dutton et al. (2013) and Hicks' (2011) studies complement the above findings by suggesting that individuals with T2D feel that they have minimal input in the decision-making of their care and that these lack of autonomy negatively affects their coping strategies. Moreover, the individuals with T2D who exhibit greater levels of willingness to cope with their condition and exert readiness to adapt to T2D are those with higher education, self-motivation and good mental health (Turner, 2008; Hicks, 2010; Gorter et al., 2011).

Schulman-Green et al. (2012), meta-synthesis of qualitative studies explore the experiences of living with a chronic illness such as diabetes and highlight the importance of health professionals' role in supporting individuals with T2D to reconcile emotions and in assisting them in deriving meaning from their illness experiences. Schulman-Green et al. (2012) go on to suggest that the problem in reconciling emotions in T2D emerges from the over-focus of health professionals on the management of illness needs, rather than in addressing the emotional or existential challenges of living withT2D. Illness needs focus on assisting individuals with T2D to carry out a set of tasks and learn skills necessary for individuals to take care of their bodies, whereas assisting individuals with T2D to self-manage and successfully cope with T2D condition requires growing as a person, as well as transitioning from a focus on the illness needs to integrating the illness into the context of the individual’s life (Schulman-Green et al., 2012).

Lamers et al. (2010) concur with the previous findings and in a randomised control trial amongst others conclude that the enhancement of quality of care for individuals with T2D calls for much more attention directed to the emotional aspects in dealing with T2D than is currently. The role of health professionals is to assist the individual with T2D in processing emotions, adjusting to theT2D diagnosis, integrate it into daily life, and make meaning from the new lifestyle alterations (Schulman-Green et al., 2012). In essence, the role of health professionals includes working with individuals with T2D to develop those regulatory tasks and skills relevant for coming to terms with a changed life and a changed self as a result of T2D, to seek normalcy in life through the pursuit of meaningful activities and to determine the meaning of the illness in their lives (Vassilev et al. 2011; Schulman-Green et al., 2012). In other words, the role of the health professional is not merely the transmission of information or some formulaic educational provision, but the development of person-specific relationships with individuals with T2D who consume alcohol leading them in re-evaluating life, in achieving personal growth and in attaining personal satisfaction.

In summary, the literature considers that the role of health professionals is to assist individuals with T2D in self-managing T2D condition, self-caring, and taking responsibility for their situation. However, the literature considers that in most cases, individuals with T2D were unwilling to set treatment targets and health professionals are the ones who usually set targets that individuals with T2D merely follow. Such imposition of targets by health professionals inevitably lead individuals with T2D in misunderstanding these targets and in fragmenting and limiting ownership of the treatment and caring processes by individuals with T2D. This lack of ownership further creates sentiments of unhappiness and make health professionals appear patronising. Therefore, the literature suggests that health professionals should focus on addressing the emotional and existential challenges of living with T2D and support these individuals in growing as a person and integrating T2D in the context of the individual’s life.

2.2.5. Stigma, social networks and well-being of individuals with T2D who consume alcohol

This section analyses the role of social networks in achieving well-being for individuals with T2D who consume alcohol. The literature concedes that an explicit relationship exists between successful management of T2D and the increased social support from various networks. A series of studies support that the greater the levels of social support, the higher the possibility for individuals with T2D potential to self-manage. In contrast, poor social support leads to poor self-management of T2D and is generally a predictor of poor adherence to the prescribed treatment, care and lifestyle modifications (White et al., 2009; Schiøtz et al., 2012).

While this general view is somewhat recurrent in the literature, nevertheless not all social networks are the same or have the same degree of influence. For that matter, not all social networks have positive effects on the self-management of the T2D condition. Vassilev et al. (2011), in a review article exploring the links between social networks and self-care practices of chronic ill individuals, distinguishes between social networks as dyadic relationships and social networks as community affections. The dyadic relationships include the individual with T2D and partners, relatives, friends, and neighbours, whereas the community affections include the individual with T2D and family, religious groups, ethnic groups, locality or neighbourhood.

Furthermore, Vassilev et al. (2011) suggest that such social networks do not always function in a supportive manner in enabling individuals with T2D to self-manage, as social networks have a significant impact in defining social normalcy or deviance. Relationships with significant others, especially with family may be a constant reminder to individuals with T2D of the personal responsibility they bear for their inability to control their lifestyle and for poor management of health leading them to deviate from perceived normal health ideals (Vassilev et al., 2011). Such sentiments emerging from the relationship of individuals with T2D with their social networks can lead to developing a type of stigma that typifies the individual as deliberate weak-willed (Vassilev et al., 2011). Stigmatisation emanating from social networks has a further negative impact on shaping the everyday management of T2D and is often associated with the withdrawal from social activities adding to the sentiment of diminished well-being (Vassilev et al., 2011).

Similarly, Nash (2014) in a descriptive qualitative study, conceptualises stigma as a risk factor and barrier in managing diabetes. Nash's (2014) study focuses on individuals with T2D who have mental health issues and concludes that the source of stigmatisation for these individuals is their mental health condition that as well impedes them to dealing with T2D. Such stigmatisation described by Nash (2014) also leads to the loss of their credibility, putting into question the veracity of their complaints and their genuine willingness to manage the T2D situation.

Williamson's (2012) study classifies individuals that over-consume alcohol as one of the most heavily stigmatised members of society and the ones in most need for support to alter their lifestyles. Williamson (2012) considers that the stigmatisation of individuals that consume alcohol devalues their identity with significant ramifications on their capacity to participate in social exchanges and to access social benefits, including treatment and recovery support. The stigma associated with alcohol consumption creates the social perception that these individual are weak or are "bad" people, unwilling to lead a healthy life (Williamson, 2012). While Williamson (2012) considers blaming families as counterproductive, nevertheless suggests that families may inadvertently encourage someone with an alcohol problem to develop a home environment that makes it hard for them to abstain because of excessive stress created by this environment or of easy availability of alcohol.

The above literature, while considering that social networks have a significant role in supporting and empowering individuals with T2D to self-manage their situation, at the same time are cautious of the role that social networks can have. Social networks, including family, can induce a sense of blame that may lead to stigmatising the individuals with T2D for their lack of control, poor management of their health and their unwillingness to modify their lifestyles. Also, individuals that consume alcohol encounter similar blaming and stigmatising attitudes from social networks, including family, with the additional accusation, that they lack credibility, the strength of character and the will power to alter their lifestyles. The current review of the literature has not identified any studies relating to the stigmatisation of individuals with T2D who over-consume alcohol. Still, from the variety of studies done separately on T2D and alcohol, stigma created and perpetuated by social networks becomes a significant barrier for these individuals to alter their lifestyles and achieve a sense of well-being. While individuals with T2D who consume alcohol need support from social networks, nonetheless social networks can pose the risk of stigmatising these individuals and in this way further hinder their potential for lifestyle modifications.

The literature suggests, therefore, that when providing education, support and care to individuals with T2D to place as well emphasis on the structures and functions of their social networks. In this way, health professionals can work towards strengthening the social networks of individuals with T2D as part of the caring process and can as well educate the individuals' social networks on T2D management hence supporting their social networks in supporting them to develop health-promoting and self-managing behaviours (Schiøtz et al., 2012). Nash (2014) considers that the stigma created by social networks results from their lack of appropriate training and education in T2D. Finally, White et al. (2009) affirm that family and friends of the individual with T2D require support and education as they may as well feel following the T2D diagnosis unsupported and with a diminished sense of well-being.

In summary, the reviewed literature concludes to the general statement that the greater the levels of social support, the higher the possibilities of individuals with T2D to self-manage. However, social networks do not always function in a supportive manner enabling individuals with T2D to self-manage because social support networks also have the power to define normalcy or deviance from normalcy in society. Hence, social networks as regulators in defining normalcy remind individuals with T2D of their responsibility for the lack of control or poor health management inducing a sense of blame of their inability to achieve lifestyle modifications and consequently stigmatise the individual as being intentionally weak-willed. Therefore, individuals with T2D who consume alcohol, while they need the support from social networks, including family and friends, nevertheless these individuals potentially run multiple risks of being stigmatised by their social networks thus further inhibiting their potential to alter their lifestyle and achieve sentiments of well-being. The argument concludes by highlighting the usefulness of social networks in the care management and support of individuals with T2D and in assisting them in developing health-promoting behaviours and sentiments of well-being.

2.3. Summary of the literature review

The reviewed literature identifies that increased alcohol consumption intensifies T2D complications and affects the overall well-being of these individuals. Person-specific and individually tailored treatments and caring plans can assist individuals with T2D who consume alcohol deal with the physical, psychological, social and environmental aspect that affect their alcohol consumption and T2D. Part of this treatment includes the educational provision, information giving and knowledge development for individuals with T2D who consume alcohol. Beyond education and information giving, the well-being of individuals with T2D who consume alcohol relates to the rationalisation of their condition and the achievement of a balance between the idealised and the pragmatic life reality. Eventually, these approaches create sufficient preconditions in individuals with T2D who consume alcohol to move on, achieve their personal and social expectations, and create a sense of well-being. The role of health professionals in supporting individuals with T2D who consume alcohol is to address the emotional and existential challenges of living with T2D and assist them in self-managing, in taking ownership of the treatment process, and in nurturing these individuals self-development. However, such personal maturation and growth of individuals with T2D who consume alcohol is not an easy process as these individuals often prefer an illusory adaptation instead of genuine adaption because lifestyle changes signify the victory of T2D condition over their lives. In contrast, the lack of change signifies a sense of resistance to the non-healthy condition of diabetes. Social networks can furthermore impede lifestyle modifications by stigmatising individuals with T2D for lacking control and overall willingness to modify their lifestyles. Therefore, including the social networks of individuals with T2D who consume alcohol in the management and care can lead to supporting them in supporting the individuals with T2D develop health-promoting and self-managing behaviours.

2.4. Research question

From the current review of the literature, one apparent issue is the absence of the individuals' voice in expressing their experiences of living with T2D and concurrently struggling to alter their alcohol consumption patterns. There is some literature focusing on the negative impact of alcohol on T2D or the negative effect of alcohol as a stigma generating source that negatively impacts lifestyle changes. However, there is a relative paucity in the literature on drawing links between individuals with T2D and alcohol consumption and on understanding the felt experiences of the required lifestyle changes on the well-being for individuals with T2D who consume alcohol. The current study intends to fill this gap in the literature with regards to the health needs of these individuals and explore the feelings and perceptions of individuals with T2D who consume alcohol on their potential to alter lifestyles and achieve well-being. The current research question is suitable for qualitative methods, and the current study implements hermeneutic phenomenology to conduct, collect and analyse the data.

According to Bettany-Saltikov (2012), after the localisation of the problem statement, the research question needs further development. The method used to develop the research question further is "P.E.O.". In the acronym of P.E.O. the P stands for the population, E stands for exposure, and O stands for outcomes. The use of the P.E.O. method is appropriate in formulating the current qualitative research question because this method refers to qualitative questions and is the equivalent of P.I.C.O. for quantitative studies (Bettany-Saltikov,2012).

Following the above P.E.O. method, the research question developed as follows:

What are the lifeworld experiences, lifestyle changes and well-being of individuals with T2D who *consume alcohol?*

2.5. Aim and Objectives of the study

The current study intends to acquire an in-depth understanding of the lifeworld experiences, lifestyle changes and well-being of individuals with T2D who consume alcohol. Furthermore, the current study intends to gain insight on the enabling or limiting factors that affect the support of individuals with T2D who consume alcohol. Lastly, the intention is to understand the potential relationship between individuals with T2D who consume alcohol and their sense of well-being.

Therefore, the aim of the study is:

> to acquire an in-depth understanding of lifeworld experiences, lifestyle changes and well-being of individuals with T2D who consume alcohol.

The objectives of the study are:

- To explore how individuals with T2D who consume alcohol experience its effects on initiating and sustaining lifestyle changes
- To identify the processes by which individuals with T2D who consume alcohol develop meanings from their experiences of lifestyle modification
- To explore how individuals with T2D who consume alcohol understand the support role of healthcare professionals in meeting their emotional and existential challenges.
- To conceptualise the lived experiences of individuals with T2D who consume alcohol in adapting to the required lifestyle changes.
- To explore how individuals with T2D who consume alcohol perceive the role of social networks in achieving a sense of well-being.

CHAPTER 3:
THE THEORETICAL FRAMEWORK

3.1. Introduction

The current chapter presents the theoretical framework underpinning the current study. The chapter commences with a critical discussion and analysis of the origins, definitions and views of the life-world approach. Consequently, the life-world approach is analysed and related to care and well-being, leading to the critical presentation of the Humanising Framework of Care as developed by Galvin and Todres (2013). Also, the chapter presents the rationale for selecting the Humanising Framework of Care for this study and concludes by critically discussing the definitions and types of well-being and justifying the definition and type selected for the current study.

3.2. Life-world Approach

3.2.1. Origins

The name often associated and credited with coining the term "life-world" is that of Husserl. In his book entitled *Crisis* Husserl introduces the life-world as the foundation for all sciences, while reference to the word or the concepts of life-world is found as well in his earlier works (McConnell-Henry et al., 2009; Bengtsson, 2013; Moran, 2013). Other authors such as Heidegger, Merleau-Ponty, Gadamer and Van Manen further the concept of the life-world and develop variations of the term providing a set of differentiated understandings and conceptual nuances (Bengtsson, 2013; Karlsson et al.,2014). An example of two such distinct variations of the life-world is the phenomenology of existence and the phenomenological hermeneutic (Bengtsson, 2013). Hence making the concept of life-world an interesting and a variable term, but also possibly an ambivalent and confusing concept with paradoxical or even contradictory features (Moran, 2013; Karlsson et al., 2014). The literature uses the term life-world to mean different things and with variability of definitions as will be explicated in the remaining of the current chapter.

The basic underlying assumption of the life-world concept is that it consists of everything possible for an individual to experience (Bengtsson, 2013). The life-world is in simple terms, the place where the individual as a lived body with emotions and thoughts exists. Therefore it is the starting point of any experience and knowledge, and any world that is not part of a life-world is merely fictional (Karlsson et al.,2014; Honer and Hitzler, 2015).

3.2.2. Definitions

The term life-world is an amalgamation of human *life* and the *world*. In this sense, life is always part of a world or as the literature terms it, life is always as worldly, and the world is always what it is for a living being, ergo the life-world cannot exist without the subject, and the subject cannot exist without the life-world (Bengtsson, 2013; Honer and Hitzler, 2015). This initial definition of life-world as an all-encompassing concept whereby the totality of human creations and developments are pieces of the life-world leads further in accepting that not only each individual has a life-world, but that the life-world is factual, real, genuine and pure (Lee, 2012; Bengtsson, 2013; Moran, 2013).

Husserl contrasts the life-world with the world of science, and concludes that the life-world is the direct manifestation and the unquestioned foundation of everyday life; it is how the world presents itself to us and, as such, is self-evidently real and definitely there (Rich et al., 2013; Moran, 2014; Honer and Hitzler, 2015). Whereas, science is an abstraction and idealisation of the world depicted with an extra-ordinarily order in various laws and theories, and therefore does not capture the real and pure, but merely captures pieces of the world in ideal abstracts (Moran, 2013, 2014). Moreover, science itself cannot exist without the life-world, but on the contrary, presupposes the life-world since the scientific worlds are pieces of the life-world. Therefore this literature asserts that the life-world provides the structure and "subsoil" for any science to exist (Moran, 2014; Ashworth, 2015). Husserl postulates the notion of life-world as the "zero-point" of all experience and knowledge, including scientific knowledge. He goes on to assert that the life-world acts, not only as a counterpoint to scientific knowledge of equal value but as one that transcends science with any scientific knowledge presupposing the life-world to exist in the first place and therefore attributing greater significance to the life-world project, rather than the scientific project (McConnell-Henry et al., 2009; Moran, 2014).

Husserl's initial conception of the life-world as the place where a-priori or pre-given understandings of the world occur provides certainty that these understandings are genuine and real of the constitutional aspects of a phenomenon (Rich et al., 2013). However, the Husserlian pre-scientific or extra-scientific view of the life-world, while rationally cannot be dismissed, nevertheless poses certain issues not least of which the connotation that the immediacy of any given world experience allows claims of pure and genuine understandings of these experiences resulting to a pure and genuine understanding of the natural world (Heimbrock, 2001; Moran, 2014). The criticism mounted to the Husserlian view of life-world is that experiences of phenomena while important, are usually taken-for-granted without much, if any, thought to go into them incorporating them in the everydayness of life as a habit (Berglund, 2014; Moran, 2014). Experiences that remain largely unelaborated lack meaning and reside primarily in the unconscious, and only when the individual reflects and elaborates on these experiences, they become attainable and conscious.

Furthering, the above criticism of pre-reflective experiences is the notion that while such experience is immediate and transparent, nevertheless it is as well of a primitive mode with mostly unstable features (Mohanty, 1985). The literature distinguishes the life-world experiences in primitive and higher forms, whereby the primitive forms are immediate but largely unconscious, and the higher forms are the product of elaborated reflections lacking immediacy but are conscious (Mohanty, 1985). Indeed Husserl shifts in his later work the emphasis of the life-world from the a-priori and pre-reflective understanding and exploration of experiences to incorporate a reflective attitude and provide meaning to the experiences and therefore making these experiences conscious (Moran, 2013; Rich et al., 2013).

Following Husserl, a series of authors ranging from Heidegger to Van Manen all argue that the life-world view entails an explicit reflective awareness of the experiential content captured via the subjective processes of perception, imagination, memory, and judgment. They define the experiential content of experience as *noema* (meaning) and the processes of perception, imagination, memory and judgment as *noesis* (perception tools) (Wilson, 2014; Ashworth, 2015). The amalgamation of noema and noesis they term as intentionality (Ashworth, 2015).

Given the argument that experiences require reflective elaborations to produce meaningful concepts, intentionality becomes an indispensable part of individuals' life-world and is responsible for directing awareness to objects or events (Dahlberg, 2006; Dahlberg, 2011). Central to the notion of intentionality in the life-world is the assertion whatever we experience, we experience it as something that has meaning and even when we encounter an unfamiliar object, intentionality is active and helps us understand the object, at least as an unknown object (Dahlberg, 2011). Moreover, the meaning cannot be reduced to physical or mental elements of objects or events but emerges from the quality and the usage that objects or events have (Bengtsson, 2013). Furthermore, the utility quality (meaning) of an experienced event or object is neither of equal significance nor independent of other persons with who we interact (Bengtsson, 2013; Rich et al., 2013). The meaning of an experience is correlational and shaped by our engagement with the time, the context of space, the relations with others and our mood or disposition (Rich et al., 2013; Ashworth, 2015; Seamon, 2015). Thus, the life-world has an inescapably subjective and intersubjective character (Moran, 2014).

3.2.3. Towards a life-world view

Summarising the above critical discussion, each person has a life-world that includes the human body living and interacting with the physical, mental, social and existential worlds. The mere being in the various worlds leads the individual to have an experience of these various worlds. Moreover, the embodied experiences of being in various worlds are processed, reflected upon and made conscious by attaching meaning to these experiences based on the quality and utility of the experiences. The quality and utility of experiences along with its' attached meanings correlates to and is influenced by the way an individual anticipates the time the individual lives the experience. Furthermore, the meaning attached to the experiences always relates to other previous experiences, the context the experiences occur, the influence that other individuals' life-worlds have on the experiences and the individual's mood.

This definition of life-world transforms the lived experience into reality, but with subjective and inter-subjective characteristics. Therefore, the life-world approach inevitably produces a subjective reality, because the reflective meaning-making processes are mediated by and created from the very process of articulating and describing the experience that is language, rather than representing or corresponding to some pure and genuine reality (Wilson, 2014). The process of reflection on experiences and the attribution of meaning require that the pre-reflective experience is put into words, developed in language patterns and accordingly narrated and communicated (Wilson, 2014; Heyman and Pierso, 2015).

However, language and vocabularies are a human construction; they are value-laden, and the manner we can, therefore, understand experience is dependant on the type of language, and vocabularies we as individuals speak (Rorty, 1989). Thus, once we start reflecting on the experience and use language and vocabulary to communicate this experience, then the life-world view of the experience is shaped and influenced by the individual's command of language. Therefore, the lifeworld, while being rooted in factual, real and genuine human experiences as directly felt by an individual, nevertheless when this experience becomes conscious and acquires meaning is inevitably influenced by the time, the context, the relations with others and the mood of the individual. Also, the mere thinking of experiences and any attempt to communicate them further shape the meaning of the experiences due to the specific language and words available to the individual to articulate experiences (Heyman and Pierso, 2015).

Hence, the concept of lifeworld has shifted from the Husserlian attempt to define it as absolute and pure knowledge of the world that transcends science to a subjective interrelated understanding of individual world experiences as shaped by language. Interestingly, Habermas expands further on the lifeworld concept to suggest that science is not a result or pre-condition of the lifeworld as Husserl viewed it, but science can and does antagonise the lifeworld and often colonises it (Finlayson 2005; Quinlan et al., 2014). Habermas suggests a dualistic model of worlds, that of the "lifeworld" and the world of "systems"(Lo & Bahar, 2013; Quinlan et al., 2014). By "systems" Habermas refers to established patterns of action and abstract decontextualised rules defined by technical terms orientated at achieving outcomes based on money, market forces and bureaucracy (Lo & Bahar, 2013; Quinlan et al., 2014). Thus, the "system" can and does intrude in the lifeworld of the individual understandings with the imposition of ready-made meanings and explanation for actions alienating the individual from own experiences and from one's willingness to take responsibility of own actions (Finlayson, 2005).

The lifeworld concept emerging from the critical review of the relevant literature and as conceptualised by the current study includes those individual experiences of being and living in the world that consequently the individual processes through reflection and communicates through language as influenced by the interactions with others and the context within which individuals live their lives to create subjective meanings. Furthermore, the current study also integrates Habermas's view of colonisation of the lifeworld by the "system" world, whereby the system-world includes the bureaucratic and technical rationality of managerialism and the medicalisation of care (Rolfe et al., 2010; Goodman, 2014). The colonisation of the life-world of individuals with T2D who consumes alcohol occurs by the imposition of the diagnosis and the implementation of prescriptive treatments and care processes by health professionals ergo intruding in the individuals' understandings and structures of the meaning-making processes.

Such influence on the individual's meaning-making processes results in the objectification of the body and the alienation of the self from one's experiences (Svenaeus, 2010). Moreover, biological disturbances are diseases that have physical manifestations, but illnesses relate to the disturbance of the experiences and meaning-making processes of the individual's being in the world (Svenaeus, 2010). Therefore, the current study accepts that a disease does not necessarily lead to illness, and an individual may have a disease and not be ill. However, when the diagnosis of the disease disrupts the life-experiences and meaning-making processes, then this develops into an illness. Importantly, the caring for the lifeworld of an individual with a diagnosed disease may not directly cure the disease, but can prevent feelings of illness and ill-being, and can offer certainty in the sense of understanding the situation, having a fresh take on life, getting to know one's self better and, through this process, to better deal with biological disease and the required lifestyle changes (Svenaeus, 2010; Karlsson et al., 2014).

The current study considers the diagnosis of T2D as a biological disturbance. However, feelings of being ill require this biological disturbance to disrupt the individual's meaning-making of processes of the diagnosis and the consequent lifestyle changes. The colonisation of the individual's lifeworld diagnosed with T2D by the language of the health professionals and by superimposed treatment and caring processes can alienate the individual rendering the person unable to recognise one's self and leading then to the notion of ill-being. Also, alcohol consumption constitutes a facet of the lifestyle of an individual with T2D and provides, amongst others the background meanings to their existence and potential ways of relating to others. The disturbance of this lifestyle due to their diagnosis with T2D affects their lifeworld and further reinforce the sense of ill-being. Moreover, taking into consideration the above notion of illness and supporting individuals with T2D who consume alcohol to decolonise their lifeworld can provide existential certainty that enables a positive adaptation to their required lifestyle alterations (Karlsson et al., 2014).

3.3. Lifeworld approach of caring and well-being

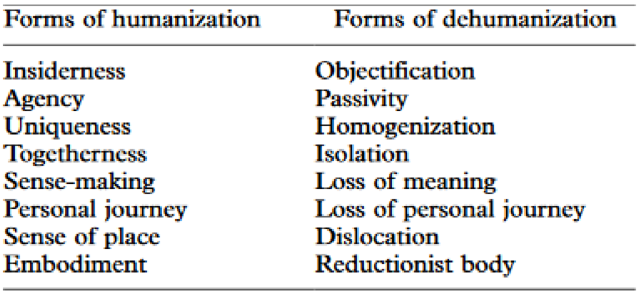
According to the systematic literature review and the emergent aim and objectives presented in the previous chapter, the current study goal is to acquire an in-depth understanding of lifeworld experiences, lifestyle changes and well-being of individuals with T2D who consume alcohol. The lifeworld framework perspective of well-being provides an analytical and explanatory framework for explicating the concept of the well-being of individuals with T2D who consume alcohol based on the humanisation concept of caring. The lifeworld framework perspective emerges on the one hand, from the critique towards the consumer-led and medicalised approach to care, and on the other hand from the societal and governmental imperatives for the humanisation of care and improvement of individuals' well-being (Todres, 2005; Office Department of Health, 2005; Social Care Institute for Excellence, 2008; The Patients Association, 2009; DOH, 2010).

The core view of the lifeworld approach is that care for other human beings goes beyond cure and patient-centred or patient-led care (Dahlberg et al., 2009). The lifeworld approach framework includes the concept of humanisation which signifies a particular view or value in describing what it means to be human and what it means to practice in a manner that makes people feel more human rather than objects of care (Dahlberg et al., 2009; Hemingway,2011; Galvin and Todres, 2013). The lifeworld approach asserts that there is a need to balance the impersonal systems of care and technology with humanising forces, and conceives humanisation of care as a meaningful process leading to the possibilities of well-being and good life (Galvin and Todres, 2013). Well-being, according to the lifeworld approach, is much deeper and more complex than the mere absence of illness. It includes an understanding of people's capacities for interpersonal intimacy, for expressing individuality and creativity, and for an experiential possibility of wellness (Dahlberg et al., 2009; Hemingway, 2011).

The concept of life-world care in the nursing and health-related literature initially appears with Todres' writings (Todres, 2005). Consequently, the concept expands and develops into a theoretical framework care (Galvin and Todres, 2013). The life-world approach to caring and well-being builds on Husserl's philosophical exposition of the life-world and the dimensions of the life-world such as embodiment, temporality and spatiality. Consequently, Todres et al. (2007) and Galvin and Todres (2013) move beyond Husserl and incorporate Heidegger and Merlau Ponty's concepts of being with other, authentic self, human freedom, body subject, and body object in their understanding of the life-world.

3.4. Humanising Framework of Care

The life-world approach further develops to focus on feelings emanating from illnesses of a diagnosed disease by providing a framework of thought for supporting and empowering individuals to resist the colonisation of the life-world and deal with their feelings concerning their illness and ill-being (Scambler and Britten, 2001; Brown, 2011; Galvin et al., 2016). This further systematisation of the life-world approach to caring and well-being created the Humanising Framework of Care (Galvin and Todres, 2013). The prime aim of the Humanising Framework of Care is to reclaim the humanisation of the caring processes (Galvin and Todres, 2013). Such humanisation of care practices and treatments are achievable once the assessment and care planning includes a set of humanising dimensions. The Humanising Framework of Care includes a spectrum of eight dimensions, namely; 1) insiderness/ objectification, 2) agency/ passivity, 3) uniqueness/ homogenization, 4) togetherness/ isolation, 5) sense-making/ loss of meaning, 6) personal journey/ loss of personal journey, 7) sense of place/ dislocation and 8) embodiment/ reductionist body (see table 3.4.a.) (Todres et al., 2009; Galvin and Todres, 2013).



Forms of humanization	Forms of dehumanization
Insiderness	Objectification
Agency	Passivity
Uniqueness	Homogenization
Togetherness	Isolation
Sense-making	Loss of meaning
Personal journey	Loss of personal journey
Sense of place	Dislocation
Embodiment	Reductionist body

Table 3.4.a. - adapted from Galvin and Todres (2013)

However, some parts of the literature criticise the Humanising Framework of Care for presenting the above dimensions in a simplistic binary manner and a polar opposite format leading to the unavoidable inherent presumption that one spectrum of the dimensions dominating the other (Thorne et al., 2004; Galvin et al., 2016). More poignantly, as with any polar opposites, the language illustrating the creative space between the two polar opposites is lacking (Thorne et al., 2004). Furthermore, there is scepticism if the Humanising Framework of Care is sufficiently valid for application to a variety of settings beyond those that studies already exist, thus raising caution on the overall generalisability of the Humanising Framework of Care for effective practice (Sundström and Dahlberg, 2012; Capolongo et al., 2016; Galvin et al., 2016).

Proponents of the Humanising Framework of Care, while acknowledging the emergent issues relating to the polarities mentioned above, at the same time they assert that the above eight dimensions are not to be conceptualised as absolutes, but as means of enabling the reader to imagine a spectrum of possibilities, heightening awareness of life's complexity and used as a sensitising tool in the provision of care (Borbasi et al., 2012; Todres et al., 2009). Furthermore, while acknowledging that the Humanising Framework of Care should be the subject of rigorous research and evaluative scrutiny for continuous refinement, nevertheless like any framework it has primarily a guiding function for understanding the complex and interactional nature of decision-making processes of daily practice reality, for avoiding retrieving to over-simplistic understandings of practice, and for creating a vision and shared culture in providing effective and dignified care (Ricketts and Goldsmith, 2005; McCormack and McCance, 2006; Gillespie and Peterson, 2009; Borbasi et al., 2012).

Therefore the lack of generalisability critique has logical gaps because, like any framework, the Humanising Framework of Care for practice resembles less law-like truths and is more in tune with the concept of trustworthiness. In this sense, the Humanising Framework of Care strives predominantly for transparency of decisions, contextual relevance, sufficient abstractness, and consensual application in the transference of the Framework to various settings, rather than artificially asserting conformity and generalisability to all or very specific settings (Rolfe, 2006; Finfgeld-Connett, 2010).

Another issue emerging from the literature about the Humanising Framework of Care relates to the term "humanising" and that "de-humanisation" of care may paradoxically be necessary for good practice. Heras La Calle et al. (2017) anticipate the term "humanise" in care as a controversial one calling into question a fundamental element of what is to be a health professional because otherwise to suggest that health professionals may indeed provide "de-humanised" forms of care is to consider them as unprofessional. Also, parts of the literature assert that by de-humanising the caring process health professionals free themselves from the cognitive and emotional burdens associated with disease, pain and human suffering, thus protecting themselves from psychological or even physical vulnerabilities that can lead to professional burnout ((Heaslip and Board, 2012; Vaes & Muratore, 2012).

In spite of the degree of internal logic associated with the developed arguments above on the usefulness of de-humanised and detached care, nevertheless, this is not conceived to be a constructive coping mechanism for health professionals. Wilson (2014) study concludes that de-humanised and detached care is usually an indication that health professional lack the necessary awareness in responding to emotionally charged situations. Other parts of the literature argue that de-humanised care may produce counter outcomes for coping with practice emotions alienating health professionals and making them unaware of the sources of their stress, hence threatening their sense of self in the work context (Hayward and Tuckey, 2011; Wilson, 2014).

In contrast, engaging with patients and humanising the care process provides health professionals with long-term understandings of their immediate emotional investment that leads to further self-awareness, professional growth, self-fulfilling behaviours and eventually, influences health professionals potential to overcome negative outcomes arising from connecting and interacting with patients (Hayward and Tuckey, 2011; Van Sant and Patterson, 2013). Therefore, the humanisation of care not only increases the therapeutic effects and produces positive patient outcomes but also enables health professionals to regulate their emotions providing more opportunities for professional development, compassionate practice and transformational caring practices (Hayward and Tuckey, 2011; Phillips, 2012; Van Sant and Patterson, 2013).

At the very core of the Humanising Framework of Care are the holistic qualities that result from the interrelated and interconnected horizons of the interacting individuals (Todres et al. 2007). The Humanising Framework of Care places emphasis on the life-world of the individual and how individual human experiences relate to others and consequently, how they form part of a larger narrative. The Humanising Framework of Care considers the lifeworld (the place where all experiences happen) as having six constituting domains, namely; temporality, spatiality, intersubjectivity, embodiment, identity, and mood (Todres et al., 2007; Dahlberg, 2009; Hemingway, 2011; Galvin and Todres, 2013) (see table 3.4.b.). These domains can assist in delineating different well-being or suffering possibilities (Galvin and Todres, 2013). While these domains may intertwine, nevertheless health professional should assess them separately to acquire understandings of the particular nuances of the individuals lived experience (Todres et al., 2007; Dahlberg, 2009; Hemingway, 2011).

Temporality = is the time where an individual’s experiences take part and each moment of the human experience is part of a story. Time is viewed both quantitatively and qualitatively.

Spatiality= is the place where things have meaning for life – this can be physical or social environments where the individuals experience their lives

Intersubjectivity= how each individual understands one’s own self and shares meanings of his/her world by interacting with others, the culture and the tradition

Embodiment= represents how each person experiences the world (physical, psychological, social) and includes our perceptions of our context and its possibilities or limits.

Identity= is a feeling of “being” or a feeling of belonging that is supported or influenced by histories, contexts and connections that make up the individual and provides one’s sense of self

Mood = is a messenger of the meaning of the individual’s perceptual and interactive situation and includes internal happenings such as happiness, sadness, loneliness etc., and can be influenced by the physical and mental and by all the above domains

Table 3.4.b. - created by the Author

3.5. Well-being

Central to the Humanising Framework of Care is the assessment and attainment of individual sense of well-being. The Humanising Framework of Care by engaging with individuals and placing emphasis on their lifeworld assumes that these individuals will become more self-aware and materialise self-fulfilling behaviours. Thus, increasing the therapeutic effects of care, promoting positive health outcomes and achieving greater levels of well-being. However, the concept of well-being maintains in the literature a quite controversial and nebulous state. The literature identifies various types of well-being that include mental, physical, psychological, social, economic and philosophical well-being and it is not always clear how these relate to each other or which one should be the focus for care (Galvin and Todres, 2013; Wilson et al., 2015). Moreover, there is a controversy in the literature as to who defines the well-being status of the individual or even how this may be defined (Bowling and Dieppe, 2005; Wilson et al., 2015).

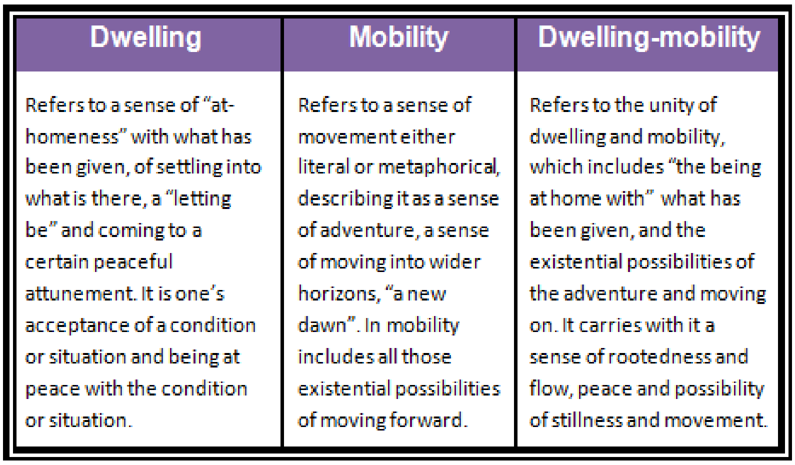
Parts of the literature consider the absence of disease to be central in the well-being of an individual. This view constitutes the central tenet of the biomedical model that is relatively easy for health professionals to measure and is characterised by the negative aspects such as the absence of disease (Bowling and Dieppe, 2005; Wilson et al., 2015). Other parts of the literature view the above definition of well-being as outdated and problematic since it does not take into account the fact that people now live longer and an increasingly ageing population unavoidably acquires diseases they can and need to live with (Huber, 2011). Living with a chronic disease is now more of the norm, rather than an aberration of normality (Huber, 2011). Furthermore, the absence of disease in defining well-being in an unrealistic prospect since the complete absence of disease is neither attainable nor measurable, and there is evidence of people with the presence of disease that are happy and well (Bowling and Dieppe, 2005; Huber, 2011). Also, this view of well-being gives precedence to health professionals' perspectives over the individual's perspective in defining individual well-being. Thus, treating the concept of well-being more of a static process in the continuum of well-being and ill-being, rather than a complementary process of health, whereby well-being and ill-being represent patterns of life at a particular moment (Kun Leddy, 2006; Wilson et al., 2015).

Other parts of the literature define well-being, not by the absence of disease, pain, and discomfort, but primarily by the presence of the individual's capacity to cope, maintain and attain a balance between the challenges of life and the potential to meet these challenges, adapt, and self-manage (Huber, 2011; Wilson et al., 2015). In this literature, the degree of adaptation and self-management signifies the degree of the individual's well-being (Huber, 2011; Wilson et al., 2015). This definition of well-being links with the sociological and public health model of care and takes in consideration the individuals' capacities for learning and achieving important individual goals, and restoring equilibrium in life following life challenges typified by the positive perspective of attaining coping capacities, rather than reacting to and repairing health conditions (Kun Leddy, 2006; Hemingway, 2011; Huber, 2011).

The critique of this definition of well-being relates to the complexity of assessing the well-being needs of individuals. Such assessment requires health professionals to take in consideration the unique context(s) in which the individual exists along with the multiplicity of influencing factors that affect the individual's capacity to develop coping mechanisms to address challenges, and the potential to adapt to these challenges (Huber, 2011; Wilson et al., 2015). Also, measuring individuals' well-being in this definition becomes equally complex and challenging because the individual is the prime source in defining their well-being. By stipulating the individual as the person that defines well-being, this unavoidably entails subjective influences and feelings without the possibility of retorting to some objective measurement or an outside observer, such as a health professional for an objective definition (Miao et al., 2013; Wilson et al., 2015). Lastly, the dominant discourse of conceptualising well-being remains the biomedical model that focuses on disease and sickness causation thus further impeding the alteration of professional and organisational attitudes towards the conceptualisation of well-being (Kun Leddy, 2006; Hemingway, Wilson et al., 2015).

The current study will adopt a positive and strength-based perspective of well-being as developed by the sociological school of thought, focusing on the individuals' capacities to grow, develop and restore equilibrium in life following the life challenge of T2D diagnosis. In particular, the type of well-being that will underpin the current study is the philosophical well-being as developed by Galvin and Todres (2013). The basis for the rationale of this choice is the fact that this can become the pre-condition for making other kinds of well-being possible. Also, Galvin and Todres (2013) conception of well-being emerges from the Heideggerian phenomenological tradition and this links nicely with the life-world theory and the Humanising Framework of Care, already adopted by the current study. Furthermore, Galvin and Todres (2013) definition of well-being has beyond the descriptive power of explaining the characteristics of well-being also directional power that suggests actions for achieving or moving towards well-being. Finally, the fact the people live longer and, therefore, probably be living with some chronic diseases, along with the subjective nature of well-being makes much more sense to adopt a positive perspective of capacities development in defining well-being.

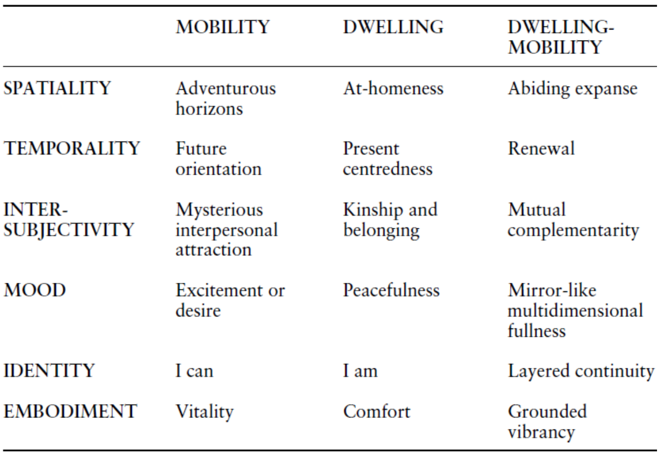
In their work, Galvin and Todres (2013) commence the definition of the theory of well-being by incorporating two main dimensions, namely; a) dwelling dimension and b) mobility dimension. By the term "dwelling" Galvin and Todres (2013) refer to the individual's potential to come to terms (or in their words "to come home") with one's situation, and to use past experiences to arrive and settle into the present moment by accepting things as they are. Interestingly, the term "dwelling" for Galvin and Todres (2013) does not imply the eradication of pain or disease but instead signals the intentional process of using ill-health or disease as a wake-up call for accepting and attuning to the present moment. By the term "mobility" Galvin and Todres (2013) refer to the individual's potential to move forward and to the future by finding meaningfulness and identifying possibilities on future projects. It incorporates the developing of plans and the intention of actualising a variety of behavioural and experiential possibilities in the future. Finally, from these two dimensions of "dwelling" and "mobility", Galvin and Todres (2013) extrapolate the third dimension of "dwelling-mobility" dimension. The "dwelling-mobility" dimension is essentially the unification of the "dwelling" and "mobility" dimensions where the individual combines feelings of acceptance of the current situation and feeling of intense energy to move forward reflecting the sense of well-being at its deepest fullness (see table 3.5.a.).



Dwelling	Mobility	Dwelling-mobility
Refers to a sense of "at-homeness" with what has been given, of settling into what is there, a "letting be" and coming to a certain peaceful attunement. It is one's acceptance of a condition or situation and being at peace with the condition or situation.	Refers to a sense of movement either literal or metaphorical, describing it as a sense of adventure, a sense of moving into wider horizons, "a new dawn". In mobility includes all those existential possibilities of moving forward.	Refers to the unity of dwelling and mobility, which includes "the being at home with" what has been given, and the existential possibilities of the adventure and moving on. It carries with it a sense of rootedness and flow, peace and possibility of stillness and movement.

Table 3.5.a. - created by the Author

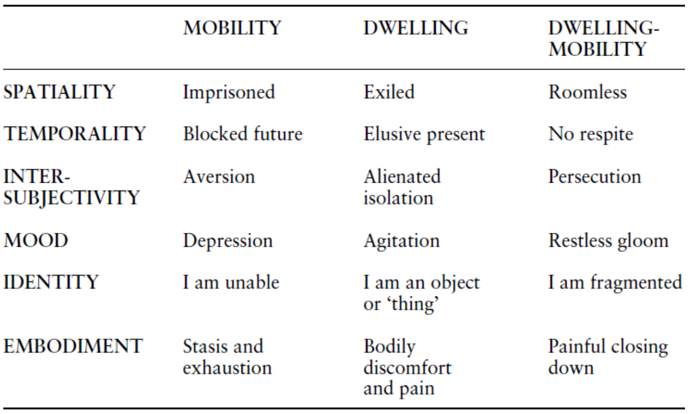
Consequently, Galvin and Todres (2013) elaborate on their definition of well-being to create the means for assisting health professional in assessing well-being and for developing actions to assist individuals in achieving well-being. They recognise that the above three dimensions of well-being do not occur in a vacuum but within the context of the fundamental structures of the Humanising Framework of Care that include six experiential domains, namely; spatiality, temporality, inter-subjectivity, mood, identity and embodiment. Furthermore, Galvin and Todres (2013) go on from this to develop a typology of wellbeing and delineate the various well-being possibilities (see table 3.5.b.). The typology of well-being consists of a horizontal row at the top defining the well-being possibilities and a vertical column (on the left-hand side) that includes the six experiential domains where the three well-being dimensions of the top horizontal row can take place. For each well-being possibility and each experiential domain where this can take place, Galvin and Todres (2013) describe a particular quality of well-being that constitutes the domain of a particular kind and level of well-being afforded to human existence.



	MOBILITY	DWELLING	DWELLING-MOBILITY
SPATIALITY	Adventurous horizons	At-homeness	Abiding expanse
TEMPORALITY	Future orientation	Present centredness	Renewal
INTER-SUBJECTIVITY	Mysterious interpersonal attraction	Kinship and belonging	Mutual complementarity
MOOD	Excitement or desire	Peacefulness	Mirror-like multidimensional fullness
IDENTITY	I can	I am	Layered continuity
EMBODIMENT	Vitality	Comfort	Grounded vibrancy

Table 3.5.b. -Well-being typology. Adapted from Galvin & Todres, 2013

Also, Galvin and Todres (2013) go even further to develop a typology of what the opposite pole of the well-being spectrum may be and define it as a typology of suffering. Similarly, as with the well-being typology, they develop a horizontal row at the top defining the possibilities of suffering and a vertical column (on the left-hand side) that includes the six experiential domains where the three well-being dimensions of the top horizontal row can take place. For each suffering possibility and each experiential domain where this can take place (see table 3.5.c.), Galvin and Todres (2013) describe a particular quality of suffering that constitutes the domain of a particular kind and level of suffering afforded to human existence.



	MOBILITY	DWELLING	DWELLING-MOBILITY
SPATIALITY	Imprisoned	Exiled	Roomless
TEMPORALITY	Blocked future	Elusive present	No respite
INTER-SUBJECTIVITY	Aversion	Alienated isolation	Persecution
MOOD	Depression	Agitation	Restless gloom
IDENTITY	I am unable	I am an object or ‘thing’	I am fragmented
EMBODIMENT	Stasis and exhaustion	Bodily discomfort and pain	Painful closing down

Table 3.5.c. - Suffering typology. Adapted from Galvin & Todres, 2013

The current study uses the typology of well-being and the typology of suffering, as developed by Galvin and Todres (2013) and described above, to analyse and discuss the findings of the current study. These typologies provided the means of articulating via the 18 domains the sense of well-being (or not) of the study's participants. At the same time, it allowed space for assessing the participants' sense of well-being and idenifying in the participants of the current study the possibilities of future directions in achieving greater levels of well-being.

3.6. Summary

The life-world approach of experiencing, knowing and adapting to challenges derives from the phenomenological tradition. It relates to the individual's potential to make meaning out of their lived experiences and the challenges emerging from disruptions provoked by a diagnosis such as T2D. The life-world approach to caring and well-being focuses on the domains of embodiment, temporality and spatiality. The current study uses and expands on the above three domains as the Humanising Framework of Care adapted by the current study includes six constituting domains, namely; temporality, spatiality, intersubjectivity, embodiment, identity, and mood. These domains assisted the current study in delineating different possibilities of well-being or suffering possibilities of individuals with T2D who consume alcohol. The well-being typology adapted by this study emerges from the notion of dwelling, i.e. "feeling at home" with one's own life and once life changes and challenges occur to have the potential for mobility, i.e. to move towards in attaining a sense of "homeness" again.

CHAPTER 4:
RESEARCH METHODOLOGY

4.1. Introduction

The current chapter outlines the methodology implemented to study the life-world experiences of individuals with T2D who consume alcohol and answer the research question as developed in chapter two. The current study aims at acquiring an in-depth understanding of the life-world experiences of individuals with T2D who consume alcohol and understanding their experiences of lifestyle changes and their notions of well-being. Therefore the research methodology needs to possess the appropriate qualities for capturing the experiences of lifestyle modifications, the felt effects that the initiation and sustainment of lifestyle changes have on these individuals, the role of healthcare professionals in dealing with their emotional and existential challenges of lifestyle changes, and the role of social networks in achieving a sense of well-being when altering their lifestyles. Therefore, essential in capturing all the above is a research methodology that focuses on experiences, on the potential to acquire in-depth understandings and on providing the means for abstracting and theorising from the collected data to appropriately and adequately answer the research question.

The current chapter includes the rationale, the philosophical assumptions and the epistemological underpinnings that informed and justified the choice of research methodology. Furthermore, the current chapter based on the chosen methodology presents the research design and the research instruments used. Also, the current chapter presents and justifies the selection of setting in collecting the data, the sampling selection technique, the data collection method and the data analysis method. The consistency between rationale, epistemology, methodology and methods is essential for the validity of any study and for answering systematically and logically the practicalities of the who, what, when, where and how of the study took place (Beglar and Murray, 2009; Gerish and Lacey, 2010).

Finally, the appropriateness of answering the research question and achieving the aim and objectives of the study also played a crucial part in deciding on the methodology and methods. Moule and Goodman (2009) argue that the choice of research design explicitly emerges from the research question and the study's purpose and should take into consideration the researcher’s own beliefs and to a degree reflect the researcher’s skills and expertise of the research design since otherwise, the researcher is unable to conclude the study. Similarly, the choice of the research design, methodology and methods of the current study emerge from the research question, the aim and objectives of the study, and from the researcher’s epistemological position and skills of successfully concluding the study.

4.2. Research design

4.2.1. Introduction

This section introduces the research philosophy that will frame the research design of the study. The research philosophy has a direct effect on the quality of any research study and, therefore, the researcher before commencing the study needs to elaborate and consciously choose the research study's philosophy (Dahlberg, 2011). Smith (2009) suggests that by elaborating on the research philosophy before the study commences, the researcher is in a much better position to understand the implemented methodology fully and to clarify the research design further and develop a well-justified argument on the appropriateness of all research decisions taken throughout the study. According to Denzin and Lincoln (2018), the research philosophy involves the concepts of epistemology and ontology, and by explicating and clarifying these concepts, the researcher creates the necessary pre-conditions for appropriately constructing the research methodology and research methods.

4.2.2. Epistemology

Epistemology relates to the nature of knowledge and how people can acquire knowledge (Ritchie, 2013; Denzin and Lincoln, 2018). According to Denzin and Lincoln (2018), the epistemological position of the researcher refers to the different assumptions the researcher holds concerning his/her relationship with the world and identifies how the researcher relates to the various ways of acquiring knowledge of the world. The main idea underpinning epistemology is how we can learn about the world and what gives shape to our knowledge (Ritchie, 2013; Denzin and Lincoln, 2018). Similarly, a series of researchers support that epistemology refers to the researcher’s system of beliefs and ideas about the world and the way knowledge is produced or created (Lindsay, 2007; Creswell, 2013).

The research literature developed a series of categorisations on the various available epistemological positions. These categorisations include epistemological positions of two broad categories, namely; a) the positivist epistemology and b) the non-positivist epistemologies. Also, the research literature further distinguishes the non-positivist epistemologies to produce four distinct non-positivist epistemologies, namely; a) interpretive epistemology, b) constructivist epistemology, c) realist epistemology and d) post-modern epistemology (Krauss, 2005; Parahoo, 2014).

Researchers that adopt a positivist epistemological position focus on providing casual explanations of their data and work towards generalising the findings of the study by making inferences and prediction of what will happen on similar, as in the study, occasions in the future (Krauss, 2005; Lindsay, 2007). The literature associates positivist epistemology with quantitative research methodology (Doyle et al., 2009).

At the other end of the epistemological continuum is interpretive epistemology. The interpretive epistemological position aims at acquiring an in-depth understanding of personal experiences or knowledge or feelings of individuals, using inductive logic and accepting the existence of multiple realities. In interpretive epistemology, the researcher works towards transferring the study's findings to similar contexts, rather than generalising the results to all the same settings (Lindsay, 2007; Glasper and Rees, 2013; Nieswiadomy and Bailey, 2018). The interpretive epistemological position supports that each situation and experience is unique, and each person experiences situations or sentiments in different ways. According to Lindsay (2007), understanding these unique and multiple realities enables researchers to provide better and more elaborated explanations of events and situations. The best tools for acquiring these multiple realities are the use of unstructured or semi-structured interviewing because these data collecting techniques allow for the exploration of emotions and the description of feelings. The interpretive epistemological position aligns to qualitative research methodology and unstructured or semi-structured interviewing techniques (Doyle et al., 2009; Glasper and Rees, 2013).

The current study aims at acquiring an in-depth understanding of the life-world experiences of individuals with T2D who consume alcohol and understanding their experiences of lifestyle changes and their notions of well-being hence the most appropriate epistemology for answering the research question and achieving the study's objectives is the interpretive epistemology. Also, the interpretive epistemological position is congruent with the researcher’s views of knowledge construction. Therefore the choice of interpretive epistemology emerges from the appropriateness of this epistemological position in answering the research question that involves understanding the multiple meanings attributed to unique human experiences and realities, and from the researcher's personal belief that there is no single or correct answer about the topic under investigation but more elaborated and sophisticated explanations.

4.2.3. Ontology

Ontology relates to the researcher’s beliefs on the form and the nature of reality, and the way the researcher conceptualises the means of knowledge production (Lincoln et al., 2018). Saunders et al. (2007) and Staiton-Rogers (2006) understand ontology as the theory that takes into consideration the nature of the phenomena within the lifeworld by exploring the constituting components of the lifeworld and how these interact and relate to each other. The research literature develops a series of categorisations on the various available ontological positions, namely; objectivist ontology and subjectivist ontology (Bryman, 2012).

Researchers that adapt an objectivist ontological position accept that the phenomena and their meanings are independent of everyday actions or other individuals and they strive to present this everyday reality of their participants in an objective manner (Bryman, 2012). Researchers undertaking this objectivist ontological position assert that the social world is qualitatively similar to the natural world and therefore, they aim at finding the single truth that explains phenomena as do natural sciences. The objectivist ontological position links with and follows from the positivist epistemological position and dictates that quantitative research methodology as the most appropriate in achieving the goals of the ontological position (Lincoln et al., 2018).

On the other hand, researchers that adapt a subjectivist ontological position accept that the phenomena have multiple meanings, that the human imagination subjectively creates reality and that individuals hold different views of their reality (Lindsay, 2007; Parahoo, 2014). According to Parahoo (2014), the subjectivist ontological position focuses on the feelings and beliefs of individuals, how they communicate and interact with each other, and finally attempts to understand and present why people experience similar situations differently. The main aim of the researcher in the subjectivist ontological position is to provide an interpretation of the participants' interpretations of their lived experiences. The subjectivist ontological position links with and follows from the interpretive epistemological position and dictates that qualitative research methodology as the most appropriate in achieving the goals of this ontological position (Lincoln et al., 2018).

The current study aims to understand the meanings that individuals with T2D who consume alcohol attribute to their condition and their lifestyle and consequently understand and explain why they hold the views they do for their T2D condition and their lifestyle. Thus the subjectivist ontological position is most appropriate for achieving the research aim and objectives. Also, the subjectivist ontological position is congruent with the already selected interpretive epistemology. Therefore the choice of the subjectivist ontology emerges from the appropriateness of this position in understanding the nature of reality as anticipated by the participants of the current study and is consistent and congruent with the interpretive epistemology already selected in framing the current study.

4.3. Methodology

The literature defines methodology as the set of theoretical principles that constitutes the framework for providing information and guidelines on the manner the research study is carried out (Sarantakos, 2013; Mason, 2018). The methodology essentially translates the abstract philosophical concepts of epistemology and ontology into research language allowing the researcher to acquire practical answers to the research question of the topic under study (Mason, 2018). The literature broadly categorises social research as having two types of research methodologies, namely qualitative or naturalistic methodology and quantitative or experimental methodology, and with some researchers supporting that the mixing of these two methodologies can lead to a third type of methodology termed as a mixed-method methodology (Lindsay, 2007; Glasper and Rees, 2013; Creswell, 2014).

The experimental methodology is a study done in a controlled setting or situation. It involves the conduct of an experiment or a measurement and the literature links experimental methodology to the positivist epistemology and objectivist ontology. For healthcare, the experimental methodology has limitations as it is not possible most of the time to control the environment where the study takes place. In cases, the researcher can control the environment; this may create the false impression that the study results can become readily applicable to real-life situations (Lindsay, 2007). According to Glasper and Rees (2013), the experimental methodology involves people that are randomly allocated in an experiment or in carrying out measurements using most of the times randomised control trials and cohort studies (Lindsay, 2007; Glasper and Rees, 2013). Hence, the experimental and statistical nature of this methodology, along with its' congruence to the positivist epistemology and the objectivist ontology makes the experimental methodology unsuitable for guiding the current study.

The naturalistic methodology collects data in the participants' natural environment or setting and includes methodological sub-categories such as grounded theory, ethnography and phenomenology (Lindsay,2007; Gasper and Rees, 2013). In this methodology, the researcher does not have to control the environment, but the researcher collects data from participants in their natural environment. The literature links this methodology to interpretive epistemology and subjectivist ontology (Lindsay, 2007; Gasper and Rees, 2013). The current study has already identified as the most appropriate for achieving the aim of understanding the lived experiences and well-being of individuals with T2D who consume alcohol the interpretive epistemology and the subjective ontology. Also, the individuals studied by the current research remained in their natural environment and setting, and the researcher did not create an experimental environment. Therefore, the most suitable and congruent methodology to study the current topic is the naturalistic methodology.

In quantitative studies, the researcher translates experiences or issues into numbers to objectively count them, make comparison and produce results in tables or figures (Burns and Grove, 2009). The main goal of the quantitative researcher is to formulate a hypothesis related to a phenomenon and by using experimental controls to confirm or disprove this hypothesis (Morse and Mitcham, 2002; Gerish and Lacey, 2010). The quantitative researcher uses large groups of participants and presents the results in numerical fashion (Morse and Mitcham, 2002; Burns and Grove, 2009; Gerish and Lacey, 2010). Similarly, Creswell (2014) supports that in quantitative studies, the researcher focuses on positivist perspectives for developing knowledge such as creating a hypothesis and afterwards, uses measurements to test the hypothesis. The quantitative research design includes experiments, surveys and data that produce statistical information (Creswell, 2014).

In contrast, qualitative studies support that reality is different and unique for each individual, and every individual has different experiences and perceptions. Holloway and Galvin (2016) support that qualitative research focuses on the person and the aim is to acquire holistic and unique perspectives and understandings of individuals' experiences with an overall aim of gaining in-depth information about these experiences. Moreover, the literature asserts that qualitative research strategies are appropriate for exploring something new or something where there is a lack of knowledge and understanding (Morse and Mitcham, 2002). According to Creswell (2014), in qualitative studies, the researcher focuses on constructivist perspectives and includes methods such as phenomenology, ethnography, grounded theory and case studies.

The main distinction between quantitative and qualitative research methodologies is the type of research questions that each methodology can answer and the knowledge that the researcher wishes to gain. Qualitative methodologies answers to the "how" and "why" a phenomenon occurs, whereas quantitative methodologies answer to the "how much" and "what" is the case in the phenomenon under study (Morisson, 2002). Also, in cases where the researcher wants to cover a greater number of population and wishes to generalise the results, then quantitative research is more appropriate. Whereas, in cases where the researcher wants to gain an in-depth understanding of individuals' ideas and perceptions and wishes to transfer the results to similar fields, then qualitative research design is appropriate (Moule and Goodman, 2009; Bowling, 2009).

The current study follows the qualitative methodological approach because the aim is to answer how it is to require lifestyle changes due to T2D and why individuals with T2D who consume alcohol feel as they do. Also, the researcher of the current study wishes to acquire an in-depth understanding of the views held by individuals with T2D who consume alcohol. Thus allowing for insights into the lifeworld experiences of these individuals and consequently, transfer these insightful understandings to similar settings supporting nurses in emphasising on the well-being of these individuals rather than only the medical aspects of treating T2D.

Furthermore, the qualitative methodology includes methodological sub-categories such as grounded theory, ethnography and phenomenology. The grounded theory methodology aims at inductively creating a theory that will explain the social actions or interactions according to the collected data from the participants who experienced the phenomenon under study (Petty et al., 2012; Glasper and Rees, 2013). According to Glasper and Rees (2013), the researchers analyse early data to describe human situations and issues so that they can develop a theory to fit this situation by using interviews, observations and documentary sources.

The ethnographic methodology aims at examining the shared patterns of behaviours and cultural beliefs by studying culture patterns in a community or group (Petty et al., 2012; Glasper and Rees, 2013; Nieswiadomy and Bailey, 2018). In ethnographic methodologies, the researcher becomes part of these cultures and lives within the culture for months or even years to collect data through direct observation of the groups and may follow up with clarifying interviews (Petty et al., 2012; Glasper and Rees, 2013; Nieswiadomy and Bailey, 2018).

Lastly, the phenomenological methodology studies specific phenomena and focuses on understanding the unique experiences of individuals on a specific phenomenon (Smith, 2009; Petty et al., 2012). The phenomenological methodology focuses on the participants’ unique experiences to acquire the subjective point of view of the individuals (Smith, 2009; Petty et al., 2012). The literature further categorises the phenomenological methodology into two distinct groups, namely; a) transcendental phenomenology and b) interpretive (or hermeneutic) phenomenology (Smith, 2009; Petty et al., 2012).

According to Petty et al. (2012), transcendental phenomenology aims to understand the pure characteristics of the phenomenon that makes the phenomenon what it is and without which it could not be what it is (Munhall, 2007). On the contrary, interpretive phenomenology does not aim at acquiring the pure or essence in the collected data. The aim is to acquire the participants' interpretation of the lived experience of the phenomenon under study (Munhall, 2007). Both types of phenomenological methodology collect data of spontaneous thoughts and feelings, and the researcher usually implements in-depth one to one interviews to collect the data (Glasper and Rees, 2013; Nieswiadomy and Bailey, 2018).

Like all other aspects of qualitative studies, the research approach is rationally and relationally justified and emerges logically from the study aim and objectives (Parahoo, 2014). The research question the current study examines has the aim of understanding the lifeworld experiences, lifestyle changes and well-being of individuals diagnosed with T2D who consume alcohol and, therefore, these unique experiences can best be interpreted and understood by hermeneutic phenomenology.

4.4. Phenomenology

Following the above distinctions between the qualitative and quantitative methodology and after rationally justifying the decision of the current study to implement the qualitative methodology, this section undertakes a more focused review of the implemented methodological sub-category. The qualitative methodological sub-category used in the current study is that of interpretive phenomenology. Phenomenology by the nature of the word means the study of phenomena and has its roots in philosophy. Etymologically, it derives from the Greek word *phenomeno*, which means to show itself, to put into light or manifest something that can become visible in itself and, *logos*, which means study (Van Manen, 1997).

The term phenomenology first appears in 18thcentury literature in the writings of Lambert, Herder, Kant, Fichte and Hegel referring primarily to philosophical and theological concepts (Moran, 2000, p.6, quoting from the entry: *'Phänomenologie'* in Ritter, 1974). However, the literature considers Edmund Husserl as the founding father of what is currently known today as phenomenological research methodology (Dahlberg, 2011). Husserl lived during the intellectual period of the 19th and early 20th centuries and witnessed the breakdown of philosophy as an independent discipline and, being a mathematician himself, believed and tried to establish philosophy as a rigorous science capable of explaining phenomena in the same rigorous fashion as mathematics (Munhall, 2007; Bhar, 2019).

Husserl believed that philosophy lacked the rigour of science and mathematics. Therefore to achieve the notion of rigour in philosophy Husserl, in a systematic fashion and with mathematical accuracy, sought the essences of phenomena to understand what are the things themselves and in this way to explain the world (Yegdich 2000; Dahlberg, 2011). By using this approach, Husserl was able not only to broaden the field of investigation for philosophy but also capture the essence of phenomena and to clarify their fundamental concepts (Dahlberg, 2011).

Husserl wanted to investigate the very nature of phenomena, to understand and explain what makes a “thing” what it is and without that characteristic, it could not be what it is (Bowling, 2009). Husserl tried to attain the genuine and true from the things in them and provided the basis for the world’s existential status (Van Manen, 1997;

Dahlberg, 2011). He believed that for someone to achieve this, they had to approach things without any hypothesis or idea concerning the topic under investigation. Even Husserl himself admitted that it was difficult for the individuals to delete previous pre-conceptions to acquire the pure essence of things and suggested a series of steps to limit these presuppositions by using phenomenological reduction, phenomenological epoché and bracketing (Dahlberg, 2011). Phenomenological reduction relates to narrowing the researcher's attention to what is essential, phenomenological epoché involves the suspension of the researcher's commonly held beliefs, and bracketing refers to the suspension of the researcher's natural attitude towards the world, while at the same time preserving the context as fully and purely as possible (Dahlberg, 2011). Husserl’s idea of phenomenology provides a more rigorous background, especially for sciences in human research interest like psychology, sociology and nursing. However, the basic issue with Husserl’s idea about phenomenology is the notion of bracketing and reduction to which Husserl does not answer how to do this bracketing and reduction (Dahlberg, 2006; McConnell-Henry et al., 2009).

The literature describes how the phenomenological methodology developed from the initial Husserlian philosophical underpinnings by other key scholars such as Heidegger and Merleau-Ponty. These scholars detracted from the original phenomenology of Husserl and in the process developed two major types of phenomenological research methodologies, namely; a) the transcendental phenomenology (also known as Husserlian phenomenology) and b) the hermeneutic phenomenology (also known as Heideggerian phenomenology) (Dahlberg, 2006; McConnell-Henry et al., 2009). Even though the two types of phenomenology have some philosophical and epistemological difference, nevertheless, both have the same goal of exploring the lived experiences of the individuals (Dahlberg, 2006; McConnell-Henry et al., 2009).

The transcendental phenomenology asserts that the knowledge and the experiences of individuals arise from consciously using the idea of bracketing to objectify research findings, and hence achieve scientific rigour (McConnell-Henry et al., 2009). The researcher puts aside any preconceived ideas and presents the true sense of lived experience without interpreting the collected data (McConnell-Henry et al., 2009). The hermeneutic phenomenology asserts that knowledge and the experiences of individuals arise from exploring and interpreting the meaning of being part of this lifeworld, argues that people by nature are interpreting beings and promotes the subjective nature of human existence and the idea of interpretation (Dahlberg, 2006; McConnell-Henry et al., 2009). For hermeneutic phenomenology, it is not only acceptable but also necessary for the researcher to have and use own previous assumption to interpret the research phenomenon, and in partnership with participants creating meaning and contextual understanding of lived experience (Dahlberg, 2006; McConnell-Henry et al., 2009).

The current study is informed by the life-world framework and guided by interpretive epistemology, subjectivist ontology, and as such hermeneutic phenomenology is the most congruent and appropriate methodology to understand the embodied meanings of being for individuals with T2D who consume alcohol. The current study implements hermeneutic phenomenology to acquire the subjective understandings of the individuals' interpretations on the concepts of lifestyle modification, adaptability in the new situation, future possibilities, feelings and daily interaction. These subjective interpretations are presented in a narrative form, facilitated by participants' experiences and feelings and are followed by the researcher's interpretations.

4.5. Sample size, sampling strategy and recruitment of participants

4.5.1. Sample size

The current qualitative interpretive phenomenological study does not seek to present trends based on numbers or acquire the essence of things but rather aims at exploring, understanding and interpreting the experiences of individuals with T2D who consume alcohol. The sample size of such qualitative studies is usually small as the aim is not the breadth of participants' views, but the depth of their understanding of the lived experiences of the phenomenon under study (Lindsay, 2007). Furthermore, the sample size in qualitative research also depends on the results of the initially collected data. The initially collected data usually signals if more data should be collected or not. The literature uses the term data saturation to refer to the signal for terminating data collection, and this occurs when similar themes and categories arise, or data repeats itself in the already collected interviews and no new data emerges (Richards and Morse, 2013).

Therefore in interpretive phenomenology, like in any qualitative methodology, accurate foreknowledge of the sample size cannot occur as the sample size is affected by the concept of data saturation (Dahlberg, 2011). However, the literature provides a rough guide or estimate for phenomenological studies concerning the sample size (Smith, 2009). The sample size for phenomenological studies varies from as few as 6 to 8 participants and to as many as 15-20 participants, and in some rare cases, this may reach to 50 participants (Holloway and Wheeler, 2010). For instance, in cases where the topic under study does not provide the researcher with insightful data that can shed light on the topic under study and the researcher can include and analyse more data (Holloway and Wheeler, 2010).

The literature asserts that specifically in interpretive phenomenology an experienced and skilled researcher can gain rich data even with five interviews, but in cases of more inexperienced researchers it is better to use a larger number of participants (Dahlberg, 2011). Also, complex phenomena have to be approached slowly, openly and flexibly, and when necessary, the researcher may follow up with more interviews (Dahlberg, 2011). The current study initially commenced with two pilot interviews to check the appropriateness of the interview schedule (Appendix V), and after a few minor amendments, the researcher conducted the interviews. The current study commenced with an initial sample size of a total of twelve participants. This number was appropriate because the researcher was not highly experienced and felt that she needed more than a single-digit number of participants. Also, the sample was not so big to invalidate the outcomes due to the heterogeneity of the sample impeding theme development. Also, the researcher was attentive to the possibility of study requiring additional participants to achieve data saturation and the researcher assessed this after the collection of the twelve planned interviews. With the completion of the twelve in-depth interviews data already fell in already developed themes, and categories, and no new information or data appeared, hence there was no need to collect any new data and recruit more participants. Therefore the sample size of the current size is twelve participants

4.5.2. Sampling strategy

According to the literature, the sampling strategy aims to provide the researcher with the best information and produce science using the available resources (Gerrish and Lacey, 2010). The literature asserts that the context of the study and the research design affects sampling strategies (Gerrish and Lacey, 2010). The sampling strategy must be appropriate for recruiting participants that best represent the study population or have adequate knowledge on the topic under study (Morse et al., 2002). According to Parahoo (2014), there are different is a variety of sampling strategy, namely; convenient sampling, snowball sampling and purposive sampling.

In accordance to the hermeneutic phenomenological approach neither convenient nor snowballing sampling strategies are appropriate as they lack specificity and are ineffective in acquiring in-depth understandings (Lindsay, 2007; Noy, 2008; Robinson, 2014). The most appropriate sampling strategy for interpretive phenomenological studies as this one is the purposive sampling strategy whereby the researcher deliberately selects the participants because of their specific characteristics, knowledge and lived experiences, and because these experiences are relevant to the topic under investigation (Lindsay, 2007; Petty et al., 2012). In purposive sampling strategies, the researchers ensure that they recruit a particular category of individuals with specific characteristics and knowledge capable to best reply to the study aim and objectives (Robinson, 2014). Therefore, the most appropriate sampling strategy for the current study is purposive sampling whereby the researcher deliberately selects the participants because of their specific characteristics, knowledge and experiences that are relevant to the topic under investigation (Lindsay, 2007; Petty et al., 2012).

4.5.3. The setting of the study

The setting of the current study was the UK's diabetes support groups. The researcher approached and conducted interviews in five different support groups in the North of England. For the researcher to introduce herself and the project, the researcher arranged a first meeting with the managers of the diabetes support groups. During that meeting, the researcher provided the manager with the information sheet (Appendix VI) and with a poster (Appendix VII) regarding the project. The manager provided that information to the members of the groups. Then the researcher introduced herself and her project. In the end, the participants that were interested in joining the study provided the researcher with their contact number or e-mail and their availability.

The venue where the interviews took place was either the places that the charity groups normally have their meetings or were done in private rooms in the libraries of each city or at the University of Leeds premises. Although the researcher tried to conduct all the interviews in the environment where diabetes support group meetings normally occur, this was not always possible because the group leader could only provide the venue for a limited time due support group meeting dates and terms and conditions. Also, using the venue outside the stipulated meeting dates included additional costs for hiring the room. This posed financial implications that the researcher could not afford. Thus the researcher considered that the library was a good common ground area for interviewing since the data collection took place in different cities in the North of England and the participants did not wish to travel to university premises. Moreover, the private library rooms not only assured a quiet venue for interviewing participants but also were secure for the researcher since the venues were public with private rooms and protected by security where the researcher could seek help if needed.

In addition to the recruitment of participants through the diabetes support groups was intentional. Firstly, the researcher considered recruiting people through the NHS; therefore, approached relevant gatekeepers with an invitation letter so that they would allow her to approach participants. Although the researcher thought they would grant access as colleagues and health professionals sharing the same interests of supporting and caring for patients, nevertheless their support in this project was not positive. The health professionals informed the researcher that wards and clinical areas could become extremely busy, and they were unable to spend extra time to assist with the introduction and recruitment process. Although some diabetes specialists responded positively to the request, nevertheless they informed the researcher that they could not guarantee persistent help and support because of high workload demands and busyness.

The most important reason for opting to recruit from the diabetes support groups was the positive attitude and empowering communication skills of the group leaders of these support groups. The group leaders created a supportive environment and reached out compassionately to people with T2D, to their friends and family members and other health scientists and researchers. The researcher's first encounter with each of the groups included members sharing their experiences and explaining how they worked together to promote a better life for managing diabetes and coping with the challenges involved such as altering alcohol patterns and changing lifestyles. According to Turner (2010), it is essential that participants feel comfortable with the researcher to provide insightful information. Thus the diabetes support groups were more appropriate for the current study because before conducting the study, the researcher created rapport with the members of the group and potential participants.

4.5.4 Interviews

Interviews are the primary method of collecting data in most qualitative studies. In qualitative methods, and specific in phenomenology, the researcher uses specific ways to facilitate data collection such as in-depth interviews (Munhall, 2007). The types of interviews range from very structured to total unstructured interviews. The literature categorises the interviews as structured, semi-structured and unstructured (Doody and Noonan, 2013; Gerrish and Lacey, 2010; Holloway and Wheeler, 2010).

Although structured interviews allow the researcher the potential to stay focused on the topic and ask all the essential questions to reveal new knowledge around the topic under study, nevertheless, using structured interviews the researcher is not able to interact or follow-up replies with prompting questions to reveal more information (Gerrish and Lacey, 2010; Holloway and Wheeler, 2010). Thus, structured interviews were not appropriate to gain an in-depth understanding of individuals with T2D who consume alcohol since the researcher is not allowed to include new questions that are a result of the participant's information from the initial interviews.

While unstructured interviews may be deemed to be more appropriate, than structured interviews for this particular study, nevertheless, there was a risk that individuals with T2D who consume alcohol might stray towards describing their experiences with regards to T2D without realising the links between T2D, lifestyle changes and well-being. Thus following unstructured interviews might have left some questions with regards to lifestyle changes, healthcare support and adaptability unanswered. Also, another reason why the researcher has not chosen unstructured interviews is because of the researcher's relevant inexperience in conducting such interviewing. Although the researcher undertook qualitative research training and modules on qualitative interviewing techniques and felt supported by the supervisors, nevertheless the researcher being a relative novice in interviewing decided not to proceed with an unstructured interview format.

Lastly, the best interview format for novice researchers is semi-structured interviews, where the researcher can use an interview guide to avoid missing any important detail. Also, the current study followed an interpretive phenomenological approach which allowed flexibility between the researcher and the participant and as such semi-structured interviews were considered most appropriate and eventually used in the current study (Gerrish and Lacey, 2010; Doody and Noonan, 2013).

4.5.5. Audio recording

The usual data collecting tool for interpretive phenomenological studies is one-to-one interviews to enable the researcher to interact with the participant and via this interaction to gain insights and make sense of the phenomena (Parahoo, 2014). The current study conducted a total of 12 semi-structured one-to-one interviews to gain an in-depth understanding of the participants' experiences living with T2D and initiating or sustaining the required lifestyle alterations (see table 4.5.5.a.). The duration of the interviews ranged from 30 to 70 minutes for each interview. The interviews were audio-recorded. According to Zeng et al. (2009), audio recording methods during interviews can detect subtle non-verbal cues such as pitch, tone, volume and paralanguage that might shed light on feeling, state of mind or defensive behaviour that enable the researcher to analyse and interpret the data collected. The researcher developed an interview schedule with a broad but pertinent set of topics for exploration with the participants was developed. The literature findings from chapter two, along with the researcher's pre-understandings, influenced the development of the interview schedule. Before the commencements of the data collection, the researcher pilot tested the interview schedule and completed any required amendments.

Participants	**Gender**	**Age**	**Location**
1	Male	55	Wakefield
2	Male	54	Leeds
3	Female	50	York
4	Male	67	Leeds
5	Female	75	Halifax
6	Male	58	Leeds
7	Male	60	Sheffield
8	Male	64	Sheffield
9	Female	67	Wakefield
10	Female	71	Halifax
11	Male	51	Manchester
12	Male	50	Halifax

Table 4.4.5.a. - created by the Author

4.5.6 Pilot study: Developing an interview schedule

Before commencing the study, the researcher piloted the data collection and data analysis methods to test the feasibility of the proposed study and potential interview questions. A pilot study is a small scale methodological test conducted before the main study. The rationale for conducting a pilot study is to ensure that the research methods work in practice (Sampson, 2004; Arain et al., 2010). The pilot study provides the researcher with the opportunity to make adjustments and revisions before undertaking the main study and is useful in assessing and preparing the interview topic guide and techniques. Moreover, it can be used to familiarise the qualitative researcher with the interview process and to enhance the credibility of qualitative studies by revealing potential methodological limitations that may otherwise remain hidden (Lancaster et al., 2004; Beebe, 2007; Doody and Doody, 2015).

The aim of undertaking the current pilot study has a twofold aim, namely; 1) to identify potential issues and barriers relating to participant recruitment and 2) to evaluate the appropriateness of the interview schedule and guide and to modify any questions if required. Accordingly, the early development and pretesting of the interview schedule involved presenting the interview questions to a selected number of individuals with T2D who consume alcohol and in specific two participants to review and identify any potential problems of the interview schedule and if the interview schedule was able to acquire the information expected. The researcher conducted semi-structured interviews following verbal and written consent from the two participants. The researcher completed the two interviews at the venue of the diabetes support groups.

4.5.6.1. Pilot study: Lessons learned and implications for the Main study

The first issue identified by the researcher after the piloting of the study was the recruitment challenges posed because some participants refused to participate in the study. The main reasons for refusing participation were the respondents' discomfort in sharing personal experiences with the researcher, and their unfamiliarity with the notion of scientific research. Also, the unfavourable attitude of the manager (in this case, the secretary of the group) posed a barrier to recruitment. According to Marshall and Rossman (2006), the success of qualitative studies depends on the interpersonal skills of the researcher.

At this point, the researcher felt the need to present the aims and processes of the study in a much more concise and clear manner avoiding as much as possible scientific or research terminology, and simultaneously becoming more persuasive to potential participants about the value of taking part in the study. The literature asserts that persuading participants to take part in a study involves respecting the interests and values of the participants and also to be willing to engage in a bidirectional exchange of information and experiences (James and Busher, 2012; Reicherzer et al., 2013; Islam, 2019). The researcher in the initial encounter with potential participants became more open about her own personal and professional motivations for studying this topic, why this topic was personally important to the researcher and how it will impact on the researcher's professional future role. This sharing of information from the researcher created a sense of trust and rapport with the potential participants, and an initial willingness from the potential participants to reciprocate and share as well their own experiences.

Also, the researcher invited potential participants to spend one day at the University of Leeds, where the researcher at the time was based on carrying out the current study. During this visit at the University of Leeds, the participants visited the library and familiarised themselves not only with the idea of the research processes but also allowed the researcher to provide information about her background to enable better communication flows between researcher and participant. These communicative strategies enabled the researcher to establish further a relationship of trust, rapport and common interest in the topic, thus significantly improving the recruitment process.

Also, the researcher contacted the diabetes group managers of the targeted groups, before their monthly meetings and provided them with information about the study, and arranged a separate meeting for questions or queries before the monthly meeting with service-users. It became clear to the researcher that when the manager was reluctant and distant to the researcher, the number of willing individuals to participate in the study was smaller as the groups tend to trust each other and this affected their willingness to take part in the research. After gaining the trust and developing interpersonal relationships with the managers, the researcher pinned posters of the study in the group's bulletin board and agreed with the managers to e-mail participants the invitation letter and information sheet. Although this was helpful, some of the participants did not own an e-mail address thus the researcher needed to attend the meetings of the groups to provide them with the cover letter and clarify potential questions that might arise (see table 4.5.6.1.a).

Participant recruitment method before the pilot study:	Participant recruitment method after the pilot study:
The researcher contacted the manager (secretary of the group) and attended the next meeting of the group to inform and recruit participants for the study.	**The researcher contacted the manager, arranged a meeting with the manager to develop an interpersonal relationship, provided the manager with information sheets, posters and the personal details of the researcher and after attending at least one group meeting started contacting the members of the group to recruit them in the study.**

Table 4.5.6.1.a. - created by the Author

The second issue that the researcher identified was the methodological approach of the study. According to Hill (2006), self-reflection enables the researcher in qualitative studies to recognise how the researcher will present one's self to the participants and how this affects and shapes the research process. The interpretive phenomenological approach stresses the centrality of reflexivity in gaining in-depth knowledge and analysis of phenomena (Dahlberg, 2011; Glasper and Rees, 2013). Before conducting the pilot interviews and the study, the researcher had knowledge and experiences on the topic under study. She brought her hypothetical ideas and expectations supported by the literature on the influences that T2D may have on participants' experiences and well-being. Thus the researcher developed her idea of what their experiences might be through the literature review, her personal experiences and her professional background.

After the first interview, the researcher immediately devoted some time to writing thoughts, feelings and reflections with regards to the interview process. Later, during the transcription of the interview, the researcher discovered that the field notes and the reflective diary were useful tools during the data analysis of the interviews. Hence decided to keep field notes during the data collection phase of the main study and allocate time after each interview to log notes in the reflective diary. One of the insights gained after the first interview was that once the researcher relaxed and felt comfortable with the interview process, the interviewees appeared to displayed good eye contact and engaging gestures. After the end of the first interview, the researcher attempted to build rapport and connect with the next participant before the scheduled research interview began.

The third and final issue identified in the current pilot study was the modification of the interview questions. The researcher designed the research questions of the pilot in a manner that allowed for exploring and understanding the experiences of individuals diagnosed with T2D who consume alcohol (see Appendix V). Although during the first two interviews the participants did not ask for any clarification and participants responded to the questions without exhibiting any signs of difficulty in understanding the questions, nevertheless, the pilot study allowed the researcher to identify the need to merge questions, e.g. questions1a and 1b, as they both referred to daily routines and the two participants in the pilot study by answering question 1a disclosed raw data that also answered question 1b. Furthermore, question 1b of the knowledge section required to precede question 4 and 4a of the action section because after interviewing the first participant if the participant consumed a small amount of alcohol there may be no influence on participants well-being from modifying alcohol consumption. Thus it became apparent to the researcher that questions 4 and 4a are necessary only if there is a positive response to question 1b (see table 4.5.6.1.b). Based on the experiences of the two pilot interviews, the interview questions for the main study were modified (see Appendix VIII) to enable the researcher to elicit potentially rich data.

Interview questions before modification		**Interview questions after modification**
Action Questions: 1a) How have you fitted type 2 diabetes condition with your daily life routine? 1b) What is this routine for you? – Could you please give me an example?	⇨	**Action Questions:** 1a) How have you fitted type 2 diabetes condition with your daily life routine? – Could you please give me an example?
4) How has type 2 diabetes affected the levels of alcohol intake for you? – Give me an example. 4a) Can you tell me if you feel that modifying your alcohol patterns affected your social life? And in what ways?	⇨	4) How many units or glasses of alcohol did you drink per day, and how many do you drink now? 4a) How has type 2 diabetes affected the levels of alcohol intake for you? – Give me an example. 4b) Can you tell me if you feel that modifying your alcohol patterns affected your social life? And in what ways?
Knowledge Questions: 1b) How many units or glasses of alcohol did you drink per day and how many do you drink now?	⇨	**Knowledge Questions:** 1b) Was deleted from this section

Table 4.5.6.1.b. - created by the Author

Following the above refinement of the pilot study, the researcher developed the final version of the interview guide. Finalising the interview guide is a complex process, and the researcher took into consideration the theoretical framework that guided the study, the methodology of interpretive phenomenology implemented and the semi-structured nature of the interviews.

Central to the interview guide are two key concepts that are integral to the Humanising Framework of Care that theoretically underpins the current study, namely; 1) dwelling (coming to terms or feeling at home with life conditions) and 2) mobility (moving on or developing and growing) (Galvin and Todres, 2013). Furthermore, the greater the unity of dwelling and mobility, the greater the sense of well-being for an individual (Galvin and Todres, 2013). Therefore the interview guide includes questions that focus on what are the participants' current experiences of being diagnosed with T2D? What is their current knowledge of T2D and alcohol consumption? How has T2D affected their alcohol consumption? How do they currently feel with the lifestyle changes they are doing or are required to do?

Also, the methodology of interpretive phenomenology requires that interview questions seek out the meaning in the participants' experiences (Creswell, 2007). Phenomenological interviews need to obtain descriptions of the life world of the interviewees including the context of where they live their lives and with the major task of interpreting these descriptions rendering them meaningful and understandable (Seidman, 2006; Brinkmann, 2013). Therefore, the interview guide for the current study incorporates questions that allow interviewees to describe their experiences and the context of their experiences. Also, the interview questions provide the space to interviewees to interpret their life experiences concerning T2D and alcohol consumption by reflecting on how it feels to be diagnosed with T2D and what sense they make of their need to alter their lifestyles due to T2D including alterations in alcohol consumption.

Finally, the literature considers the manner by which the interview process commences, and the ordering and sequencing of the questions as important elements of a successful semi-structured interview (Price, 2002; Creswell, 2007; Rubin and Rubin, 2012). Good semi-structured interviews commence with an open-ended, non-directional and broad question that the literature defines as "grand touring" question (Creswell, 2007; Rubin and Rubin, 2012). The reasons for commencing the interview with a broad question is twofold. Firstly to avoid creating a "tunnel vision" reply to the interviewee that would consequently narrow replies to the following questions and constrain the interviewee's potential in moving through the rest of the interview (Agee 2009). Secondly, to assist the interviewee in settling in the interview process without creating feelings of invasiveness that would as a knock-on effect elicit defensive responses to the interview process (Price, 2002). Both, Creswell (2007) and Rubin and Rubin (2012) state that the "grand tour" opening question of the interview ought to start with the phrase "tell me about ..." your experience. Following this suggestion, the current study also used a "grand tour" opening question for the interview schedule commencing with the phrase "tell me about your experiences with T2D".

Concerning the ordering and sequencing of the interview questions, the relevant literature asserts that this should develop by demonstrating clear connections between each question and facilitate the easing of the interviewee in the interview process (Price, 2002; Seidmann, 2008). Price (2002) defines this process as the "laddering" of questions whereby the interview commences with the least invasive questions and proceeds to more invasive ones. The least invasive questions are those that relate to describing actions, i.e. what the interviewee does or how the interviewee does it and not why, allowing the interviewee to easily recall this information and the same time enable the interviewee to provide the historical and contextual background of actions (Price, 2002; Seidmann, 2008). Following this format, the current interview guide created a set of action questions to gain an understanding of each interviewee's contextual background and their history with T2D and alcohol consumption, and at the same time to ease the interview process as to proceed to more invasive and in-depth questions.

Following the action questions, the literature suggests that the interview progresses to knowledge questions that are more invasive and focus on not merely what the interviewee is doing or what their opinion is, but probes the interviewee to provide details of their experiences and the reasons behind their actions (Price, 2002; Seidmann, 2008). Knowledge questions usually take the form of "what do you know?" or "what do you think" (Price, 2002). Following this format, the current interview guide created a set of knowledge questions to gain in greater detail the reasons behind the interviewees' actions relating to T2D and alcohol consumption, and what they think of their lived experiences with T2D, their encounter with the healthcare system and the expected lifestyle changes.

Following the knowledge questions, the literature suggests that the interview progresses to even more invasive questions that probe the interviewee to provide meaning to their experiences allowing them to present their beliefs, values and personal philosophy (Price, 2002; Seidmann, 2008). Personal philosophy questions focus on how the experience feels, what sense the interviewee makes of the experience and how the present experiences links with the past and the future experiences (Price, 2002; Seidmann, 2008). Following this format, the current interview guide created a set of personal philosophy questions to gain an in-depth understanding of the interviewees' personal feelings and beliefs about their lifestyle, and what sense they make of potential future lifestyle changes due to T2D.

Therefore, the interview guide used in the current study is an amalgam emerging from the Humanising Framework of Care, the interpretive phenomenological methodology used, the proposed structuring of qualitative questions as defined by the relevant literature and the piloting of the study. The finalisation of the interview guide occurred by linking each question to answering or achieving one or more objectives of the study (see table 4.5.6.1.c.)

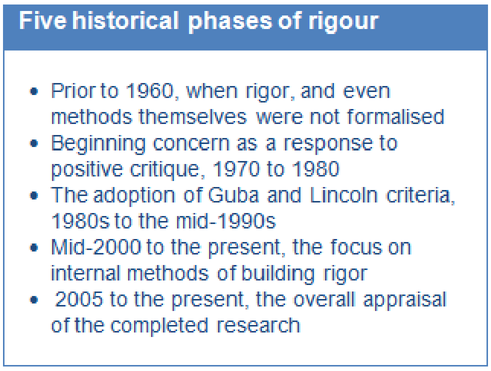
Interview Guide	Study Objectives Addressed
ACTION QUESTIONS	
1) Tell me about your experiences with type 2 diabetes? *a) Can you tell me how you deal with type 2 diabetes?* *b) How have you fitted type 2 diabetes condition with your daily life routine?* c) *What is this routine for you? – Could you please give me an example?*	Study objective 2 and 3 addressed
2) What were you required to do to deal with type 2 diabetes *a) How would you describe the support received in dealing with type 2 diabetes?*	Study objective 1 and 3 addressed
3) What would say has changed in your lifestyle after the diagnosis with type 2 diabetes? – Give me an example.	Study objective 2 and 4 addressed
4) How has type 2 diabetes affected the levels of alcohol intake for you? – Give me an example. *a) Can you tell me if you feel that modifying your alcohol patterns affected your social life? And in what ways?*	Study objective 1, 4 and 5 addressed
5) What kinds of support and resources have been most helpful to you in managing lifestyle modifications?	Study objective 4 and 5 addressed
6) How is the relationship between you and the health professionals developed since the diagnosis and onwards?	Study objective 2 and 3 addressed
7) How is your relationship with colleagues, friends, family, and neighbours?	Study objective 2 and 5 addressed
KNOWLEDGE QUESTIONS	
1) What do you know about type 2 diabetes and alcohol use? *a) Can you expand (prompting)* *b) How many units or glasses of alcohol did you drink per day and how many do you drink now (prompting)*	Study objective 1 and 2 addressed
2) What kinds of support and resources have been most helpful to you in managing lifestyle modifications?	Study objective 3, 4 and 5 addressed
3) What do you think of the healthcare support you received in managing lifestyle changes for: *a) type 2 diabetes* *b) moderate alcohol consumption*	Study objective 3 and 5 addressed
4) What challenges have you experienced with the changes with regards to the lifestyle? / What do you think are the possible solutions to these challenges?	Study objective 4
PERSONAL PHILOSOPHY QUESTIONS	
1) Do you think that type 2 diabetes has changed you as a person *a) If yes, in what ways (prompting question / example)*	Study objective 2 and 4
2) To what degree (extent) do you feel that you have come to terms with the lifestyle changes required from type 2 diabetes	Study objective 4 and 5
3) How do you feel with your current lifestyle	Study objective 2 and 4
4) What are your plans for the future? How do you believe that lifestyle changes will affect these plans?	Study objective 4 and 5

Table 4.5.6.1.c. - created by the Author

4.5.7. The rigour of the study

The rigorousness of a study is a pre-requisite for all research projects because it ensures that the study findings are plausible, are of value, are scientific and have usefulness (Bailie, 2015; Morse, 2015). Quantitative studies establish rigorousness by objectifying and generalising the findings (Morse et al., 2002; Baxter and Jack, 2011). In contrast, qualitative studies do not allow the researcher to produce objective statements or to establish generalisable relationships (Morse et al., 2002; Baxter and Jack, 2011). Qualitative studies have rigorousness built in the research process (Houghton et al., 2013; Bailie, 2015).

Morse (2018), conducted a historical overview of the various approaches on rigour in qualitative research and identified five historical phases (see table 4.5.7.a.). Morse (2018) concludes that currently, we accept that the rigour of qualitative studies is not simple, and validity and reliability are central components of the rigorousness of any qualitative study. Furthermore, Morse (2015) asserts that the reliability and validity criteria intend to make qualitative research rigour. For Morse (2015), the term rigour of qualitative studies is synonymous, and extension of trustworthiness and the terms of validity and reliability for qualitative studies are a replacement of the traditional qualitative terms of dependability and credibility.



Five historical phases of rigour

- Prior to 1960, when rigor, and even methods themselves were not formalised
- Beginning concern as a response to positive critique, 1970 to 1980
- The adoption of Guba and Lincoln criteria, 1980s to the mid-1990s
- Mid-2000 to the present, the focus on internal methods of building rigor
- 2005 to the present, the overall appraisal of the completed research

Table 4.5.7.a. - adapted from Morse 2018

Cohen and Crabtree (2008) in a comprehensive literature review of published articles on the criteria for rigour in qualitative research, identified three perspectives on the evaluative criteria for assessing and defending rigorousness in qualitative studies, namely; 1) validity and reliability criteria as argued by Morse, 2) alternative criteria for qualitative research as those developed by Guba and Lincoln, and 3) no specific criteria but recognition of the uniqueness of each study. Cohen and Crabtree (2008) conclude that two latter evaluative criteria of rigour are vulnerable to criticism. In the case of alternative criteria, it is not possible to apply them in a formulaic manner. There is no certainty that such alternative criteria lead to high-quality studies. In the case of no specific criteria, the number of individuals that can assess a qualitative study is very limited since this would require an in-depth understanding of the theoretical foundations of the specific methodology (Cohen and Crabtree, 2008).

A similar argument regarding the criticism of alternative criteria is put forward by Barbour (2001), who considers that reducing qualitative research to a list of technical procedures can be over-prescriptive and does not eventually confer rigorousness to the study. Instead, Barbour (2001) argues for embedding processes of rigour throughout the design and analysis of a qualitative study. Baile (2015) raises similar concerns about the alternative criteria developed by Guba and Lincoln suggesting that these criteria have essentially the same meaning as traditional criteria and that a single set of criteria applied as a checklist cannot adequately assess the rigour of the variety of qualitative methodologies.

Morse (2015) asserts that the alternative criteria of rigour developed by Guba and Lincoln in the mid-'80s remain the same until today. However, the strategies for attaining these criteria are constantly changing because there is no explicit way how each qualitative study can meet them and there is no evidence to date that these alternative criteria do make a difference or if they indeed secure the rigorousness of qualitative studies. Morse (2015; 2018) makes a case for abandoning alternative criteria of rigour for the sake of returning to mainstream criteria of validity and reliability and stresses the fact that all qualitative studies do not produce the same kind of data or use the same data collecting methods. The qualitative data takes various forms of presentation; for instance, studies may produce "HARD data" that relate more to factual data or "SOFT data" that relate more to experiential data. Also, qualitative data may differ in terms of description and interpretation, e.g. descriptive data and interpretive data (Morse, 2018). Similarly, data collection methods of qualitative studies differ in structure and technique, for instance, data may occur using semi-structured data collecting methods that differ from unstructured data collection methods, and interview techniques differ from observational techniques (Morse, 2018). Hence Mores's argument for safeguarding rigour in qualitative studies is that we need to develop a set of recommended strategies for establishing validity and reliability of qualitative work, but avoid these being highly specific and prescriptive, and allow for flexibility that can account for the variety of data and data collecting methods (Morse, 2015).

The current study agrees with Morse's above suggestions that criteria of rigour need to take into account the variations of data production and data collection techniques in qualitative studies, and that there is not a one-size fit all method for assessing rigour of all varieties of qualitative data. Furthermore, the current study adapts Morse's (2015) assertion of using mainstream terminology of validity and reliability as a means for securing rigorousness in qualitative studies. Because the alternative terminology essentially has very similar, if not the same, meaning as this traditional terminology, but at the same time bears the burden of negative criticism of being too rigid and formulaic. Long and Johnson (2000) reinforce the current study's decision to use traditional terminology of criteria for assessing rigorousness as they as well assert that these have the same essential meaning with alternative criteria and that "...nothing is to be gained from clouding the issue with alternative labels for what have been argued to be identical concepts" (p. 31).

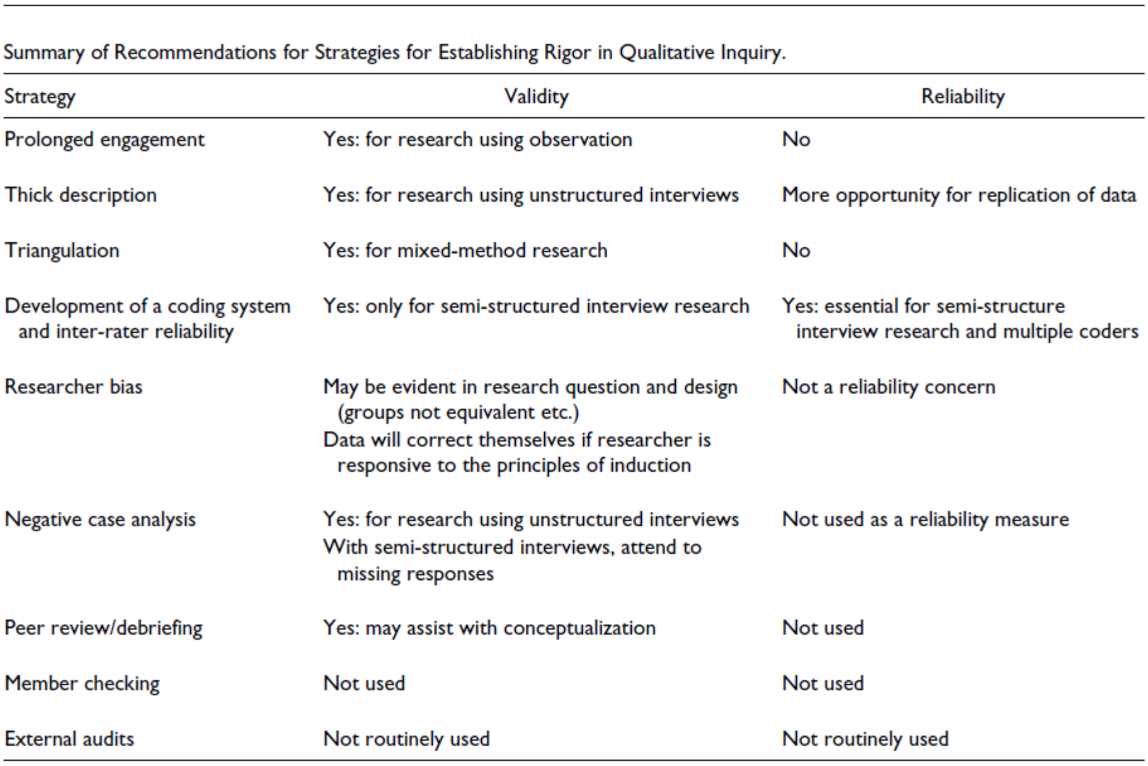
Validity in research generally refers to the potential of the research instrument to measure what it actual purports or intends to measure, and in more specific for qualitative studies validity refers to the persuasiveness of the study and potential to convince about the claims of a statement or position made by the qualitative study (Long and Johnson, 2000). Morse (2015) states that validity for qualitative studies is the degree to which an inference is well-founded and represents the actual phenomenon of study if there is a resemblance of the descriptions of the phenomenon with its essence and if the phenomenon is recognisable by others and has a logical expression in the writings. In a nutshell, validity refers to the logical coherence, persuasiveness and relatedness of the qualitative study's claims.

Reliability in research generally refers to the consistency or the degree of consistency of a research measuring instrument, and in more specific for qualitative studies credibility refers to the degree of consistency of assigning instances to a category (Long and Johnson, 2000). Morse (2015) states that reliability for qualitative studies is the consistency of collecting, interpreting and analysing qualitative data. In a nutshell, reliability refers to the consistency of collecting and analysing the data.

4.5.7.1. *The validity and reliability of the study*

Morse (2015) developed a set of strategies for establishing validity and reliability in qualitative research (see table 4.5.7.1.b.) and took extra care to accommodate for the variations of the types of data, of the structure of the data collection process and the degree of interpretation.

The current study uses the strategies of table 4.5.7.1.a. to establish its validity and reliability, and eventual rigorousness. The first strategy for securing validity and reliability includes prolonged engagement and persistent observations to produce thick descriptions of the context and therefore convince about the resemblance of the context with that described in the study. However, Morse (2015) considers prolonged engagement is appropriate for research using observational methods of collecting data and not necessary for interview research. The current study collected data solely through semi-structured interviews. It did not collect any observational data. Hence the strategy of prolonged engagement and persistent observations is not relevant for securing validity for the current study.



Summary of Recommendations for Strategies for Establishing Rigor in Qualitative Inquiry.

Strategy	Validity	Reliability
Prolonged engagement	Yes: for research using observation	No
Thick description	Yes: for research using unstructured interviews	More opportunity for replication of data
Triangulation	Yes: for mixed-method research	No
Development of a coding system and inter-rater reliability	Yes: only for semi-structured interview research	Yes: essential for semi-structure interview research and multiple coders
Researcher bias	May be evident in research question and design (groups not equivalent etc.) Data will correct themselves if researcher is responsive to the principles of induction	Not a reliability concern
Negative case analysis	Yes: for research using unstructured interviews With semi-structured interviews, attend to missing responses	Not used as a reliability measure
Peer review/debriefing	Yes: may assist with conceptualization	Not used
Member checking	Not used	Not used
External audits	Not routinely used	Not routinely used

Table 4.5.7.1.a. - adapted from Morse, 2015

The second strategy for securing validity and reliability includes obtaining thick descriptions and rich data, and this refers to both the quantity of data (the adequacy of the data) and the appropriateness of the data. While Morse (2015) considers this strategy necessary for unstructured interviews, nevertheless contends that studies doing semi-structured interviews would benefit from considering this strategy and will enhance their rigour. The first main point regarding the thickness and richness of the data is the adequacy of the data, and this has to do with the sample size (Morse, 2015). In other words, an adequate sample size provides sufficient variation and depth of the collected data to represent the phenomenon under study adequately. For semi-structured interviews, the adequacy of the data refers to the concept of data saturation that occurs when the collected data is enough to replicate the data sort within each category (Morse, 2018). The sample size of twelve participants was adequate for the current study. This sample size provided sufficient data to suggest data saturation was reached, with each category having at least 10 codes extracted from the data and no new codes and categories emerged by the end of the interviews.

Also, the appropriateness of the data ensures that the sample criteria are explicit to make sure that data are not inadvertently too scattered with significant variations between participants (Morse, 2018). The current study explicitly defines the criteria for participation and included geography, e.g. the North of England, included condition, e.g. to be diagnosed with T2D for at least six months, to have low to high levels of alcohol consumption patterns, but not alcohol dependency, and to require some lifestyle change as a result of the T2D diagnosis. This defined criteria allowed the acquisition of appropriate data.

The third strategy for securing validity and reliability includes the triangulation of methods, and the assumption here is that multiple methods of collecting data will expand understanding. However, this assumption is not fully justified as it is not always explicit why one method or methodology is not sufficient and also there is the danger that methodological contradictions of the used methods or methodologies may weaken the validity rather than strengthen it (Lincoln et al. 2018; Morse 2018). In any case, Morse (2015) suggests that triangulation refers to mixed-method studies and the current study is not a mixed-method study and as such, did not include this strategy in securing validity and reliability.

The fourth strategy for securing validity and reliability includes the development of a coding system. Morse (2015) considers the development of a coding system a necessary element for securing validity and reliability in studies with semi-structured interviews as this ensures that the extrapolating meanings from analysis remain the same between codes. The current study used semi-structured interviews and therefore took extra care to decide upon and use throughout an explicit coding system. As described in detail in section 4.8. the current study uses in-vivo coding system that includes two cycles of coding, whereby in the first cycle the text was read line-by-line to identify salient attributes, significant meanings and distinctive language, and consequently extrapolating significant prases without altering the interviewee's words (Saldana, 2015). Following this to interpret these significant phrases from the first cycle of coding, I posed the questions such as what is this phrase about or what does it mean or what is happening or what are the assumptions? (Saldana, 2015). In this manner, the current study uses a specific coding system throughout the analysis of all data to secure validity and reliability.

The fifth strategy for securing validity and reliability includes the identification and clarification of the researcher's bias. The qualitative literature agrees that the researcher is the main instrument of data collection in qualitative studies and as such is susceptible of finding in the data what was originally anticipated by the researcher or selecting a non-equivalent sample and therefore not have data with dissimilar types of experiences (Bailie, 2015; Morse, 2015). Identifying and clarifying bias was important for the current qualitative study. Hence before commencing the design of the study, the researcher reflected on her experiences of T2D and alcohol consumption and wrote down these reflections. Consequently, the researcher incorporated these written reflections in the current study as the researcher was continuously aware of these experiences during the design and completion of the study. Also, during the data analysis phase memos were kept with the researcher's thoughts to make personal preconception visible and conscious and try to verify (or not) these reflections when conducting the next interview. Finally, with the completion of the study, the researcher reflected on the experiences of the research process, of her learning from the process and in what ways her views shifted or changed from the initial reflection before the commencement of the study. In this manner, the current study identified and clarified bias, thus securing the validity and reliability of the study.

The sixth strategy for securing validity and reliability includes identifying negative or atypical cases. Morse (2015) considers that negative or atypical cases as those cases that deviate from expectations or what appears as commonly re-occurring in the findings. Such cases in qualitative research should not be ignored or discounted and discarded. On the contrary, qualitative researchers should use these negative or atypical cases to make comparisons with more commonly reoccurring cases to reveal important differences and develop an understanding of these differences and construct the qualitative argument (Tuckett, 2005; Morse, 2015). The current study incorporated this strategy, for example, when one participant demonstrated to have good internet skills and had educated himself on T2D and alcohol consumption through the internet and online social fora this was atypical for most participants as most participants identified limitations in using the internet. However, the researcher did not discard this atypical data but used it to understand better why this person had developed such skills, what inhibited others developing such skills and what effect such skills had. In this manner, the current study used negative or atypical cases to strengthen the validity and reliability of the study.

The seventh strategy for securing validity and reliability includes peer-reviewing or debriefing. Peer-reviewing entails the presentations of the findings or parts of the findings and the developed conceptualisations of the findings to peers for feedback. Peer-reviewing involves what the literature defines as the "objective other" that attends to, listens and questions the presented findings (Tuckett, 2005; Morse. 2015). Peer-reviewing provides the opportunity for the researcher, on the one hand, to listen to one's self in presenting the data and the arguments emerging from the data, and on the other hand to have others ask questions and in this way to refine and sharpen ideas and arguments in the data. The current study incorporates this strategy as the researcher presented the findings and emerging concepts of the study to her supervisors and acquired constructive oral and written reviews that allowed further re-work and refinement of the data (see Appendix IX).

Initially, the researcher shared the coding of the raw data with the supervisors, and the supervisors provided feedback, comments and suggestions for re-working.

Consequently, the researcher shared the re-worked coding of the raw data, along with the developed categories with the supervisors and the supervisors provided further suggestions and comments on the categories. The researcher taking into consideration the supervisors' comments on the categories, clarified issues relating to the categories. Such clarifications included to better link each code within the category, to make the categories more coherent, to reduce the length of the category's name and to provide interpretative summaries for each category. Finally, the researcher shared the themes and the tentative framework of the findings with her supervisors. The supervisors provided further feedback on the need to clarify concepts in the themes and simplify the tentative framework. The researcher proceeded to clarify and simplify the writing of the findings until the supervisors of the thesis were satisfied. Finally, the researcher shared the discussion section and the final draft of the thesis with the supervisors to which the supervisors provided as well feedback and commentary. The researcher used this feedback and comments to finalise the thesis.

Also, the researcher gave an oral presentation of the study's findings in a peer-reviewed conference (see Appendix II, number 1). While the researcher did not present the raw data, nevertheless presenting the findings of the study and the tentative framework to peers provided the opportunity for them to ask clarifying questions on the findings and to provide useful comments. These served as feedback allowing the researcher to develop greater lucidity of the analysis and develop the finding as to make more coherent arguments. All these individuals acted for the researcher as peer-reviewers and provided the opportunity to the researcher to refine and develop arguments. In this manner, the current study used peer-reviewing to strengthen the validity and reliability of the study.

The <u>eighth and ninth strategies</u> for securing validity and reliability includes member checking and external auditing. Morse (2015; 2018) considers both member checking and external auditing as not appropriate for semi-structured interpretative studies and therefore are not recommended to researchers to use them in safeguarding these study's validity. Returning to the members or participants of the study to check if the interpretations are appropriate is problematic at various levels; firstly, participants may not recall the details of their initial interview; secondly, participants may not appreciate the theoretical development of the study and persistently try to find their own data in the presentations; thirdly, the text of interpretative studies is abstracted and analysed interpretatively hence the data no more exist in the form provided by participants and therefore may not be directly recognisable (Morse, 2015; 2018). Similarly, the researcher cannot incorporate external auditing in the study during the research process, such external auditing can only occur after the study finishes, and this occurs in rare cases where there are great suspicions about the data, e.g. from funding agencies. For qualitative studies, this is very rare (Morse 2015). Therefore, member checking and external auditing were not part of the validity strategies of the current study.

In summation, the current study ensures rigour, and it enhances credibility by providing truthfully and with consistency a set of strategies incorporated during the research design and the implementation phase of the research methods (Noble and Smith, 2015). These strategies are summarised and presented below (also see table 4.5.7.1.b.).

The selection of the sample and the justification of sample size followed the expectations of qualitative studies and ensued the key concepts of appropriateness and adequacy. The appropriateness of the sample is grounded in the explicit sample criteria used to include participants in the study, and the adequacy of the sample size is rooted in the richness of the collected data that led to data saturation with codes replicating their meaning within each category.

The current chapter describes and justifies the in-vivo coding system used for analysing all the collected data and provides examples as to how the researcher used the in-vivo coding system to create codes from raw data with further and extended examples in the appendices section (see Appendix X). Also, the researcher used reflexivity and reflections from the commencement and up to the completion of the study. The researcher commenced the study by reflecting on issues of T2D and alcohol consumption acknowledging personal views, taken for granted assumptions and highlighting why this topic is important. Also, during the data collection phase, the researcher maintained throughout reflective memos of the interviews making again conscious any potential interpretive bias that consequently, the researcher tested for verification in the subsequent interviews. The study concludes with the researcher 's reflections on processes and the knowledge developed from the research process. In this manner, the study provides an explicit audit trail of processes and underlying factors that informed throughout the researcher's decision-making.

Also, the researcher takes extra care to includes in the analyses atypical cases rather than discard them as misfits, hence avoiding imposing on the data pre-defined assumptions. Finally, the researchers shared and discussed all the steps and processes of coding, categorisation and thematisation of the data with her supervisors. The supervisors provided both feedback and challenged the researcher throughout the analysis and writing phase of the results, thus contributing to clarifying and refining arguments. Lastly, the researcher gave an oral presentation on the study's findings and the emerging tentative framework from the study to peers in a peer-reviewed conference and used the feedback to develop further and clarify arguments.

Strategies for ensuring rigour

1. Appropriateness of sample (based on pre-defined and explicated criteria) and adequacy of the sample (based on data saturation and replication of codes within categories)
2. Clearly described coding system used (in-vivo coding) and consistently used for all data with examples provided in the thesis and extended examples provided in the appendices
3. Use of reflection and reflexivity before, during and after the conclusion of the data collection and analysis providing an audit trail of actions and factors that informed the researcher's decisions
4. The inclusion of atypical cases in the analysis to avoid imposing on the data an artificial consistency that did not emerge from the data
5. Peer review and feedback from supervisors in the coding, categorisation and thematisation process with examples of how this peer feedback led to alterations in the analysis and discussion of findings
6. Peer feedback from oral presentation in a national conference of the findings, discussion and conclusions of the study that further enabled clarification of ideas and development of greater consistency in data

Table 4.5.7.1.b. - created by the Author

4.6. Ethics

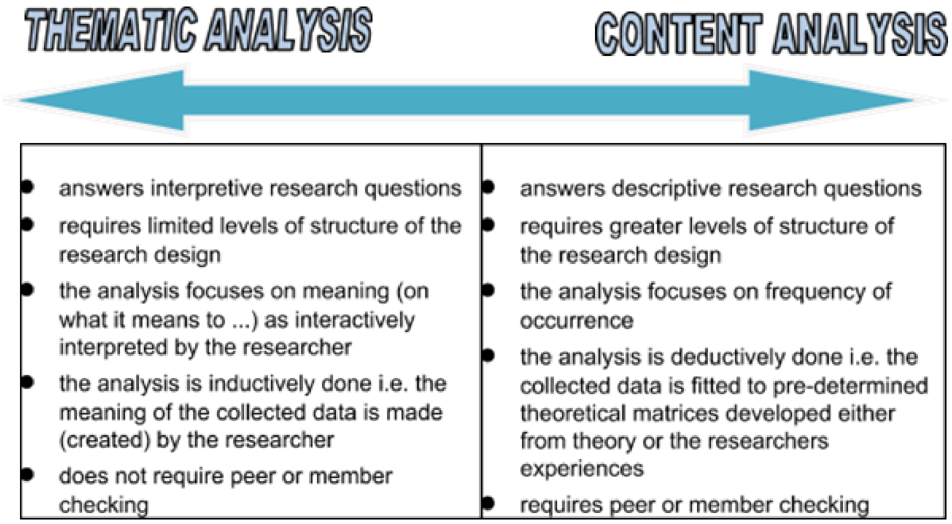
The diabetes support groups after an initial contact agreed to grant access to the researcher before the monthly group meeting to present the aims and intentions of the study and allow potential data collection after the acquisition of relevant ethical approval from the University. Ethical approval was obtained from the University of Leeds Ethics Committee (SHREC) (Ethics Reference: SHREC/RP/527) (see Appendix XI) recognising the requirements for safe and secure data. Before the commencement of data collection, the researcher provided to potential participants the information sheet and invitation letter. The researcher provided further clarifications to all participants that expressed willingness to participate in the study. All collected data are anonymised, participants' details remained confidential at all times, and the data is stored in a password-protected computer at the University of Leeds.

Furthermore, participation in the study has been voluntary, and in case any participant wished to withdraw from the study was able to do so at any stage without any consequences. As stated earlier, the study focused on adults with T2D, and there was no involvement with anyone under the age of 18. Lastly, the study was considered to have low-risk consequences for the researcher and the participants; none of the questions was intended to create stress or increase anxiety among participants.

4.7. Qualitative Data Analysis

In this section, the study presents, discuss and justifies the data analysis processes. The analysis process for any project is a crucial and essential element that enables the researcher and the readers of the research to make sense of the data, to structure the data and to give meaning to the findings (Parahoo, 2014). The research data do not in and of themselves speak or answer the research questions, but need to be processed and analysed in some systematic fashion so that trends and patterns of relationships can be detected (Polit and Beck, 2012). The analytical process in qualitative studies is a transformational process of breaking down the text into relatively small units of content to physically and intellectually order, control and manage the data (Van Manen, 1997; Richards and Morse, 2013).

The qualitative literature identifies a variety of data analysis methods, and the selection of qualitative analysis method depends upon on the research question, the level of structure of the qualitative project and the philosophical modality of the study (Moule and Goodman, 2009; Richards and Morse, 2013; Vaismoradi et al., 2013). The qualitative literature in broad strokes identifies a spectrum of data analysis method and techniques (see table 4.7.a), and while all aim at abstracting the collected data, nevertheless the processes for linking ideas and data, and the significance attributed to various chunks of data, differs (Morse, 2008). On one side of the spectrum of qualitative data analysis is content analysis. Content analysis includes an analytical process that answers to descriptive research questions. It is associated with studies that implement greater levels of structure to sort data based on the frequency of occurrence (how many times a phenomenon occurred) and on already pre-determined theoretical matrices (deductive analysis) (Joffe, 2012; Vaismoradi et al., 2013; Elo et al., 2014). In content analysis, the researcher reviews the content of all the data content and tries to correspond the data to some pre-existing theory or categorisation schema (Joffe, 2012; Vaismoradi et al., 2013; Elo et al., 2014). On the other side of the spectrum of qualitative data analysis is thematic analysis. Thematic analysis includes an analytical process that answers to interpretive research questions and is associated with unstructured or semi-structured methods of collecting and sorting data (Braun and Clarke, 2006; Richards and Morse, 2013; Vaismoradi et al., 2013). In thematic analysis, the researcher reviews all data for meaning and nuances that the researcher interprets and creates the findings, the process is data-driven (emerges from the data) and based inductive analysis (Braun and Clarke, 2006; Richards and Morse, 2013; Vaismoradi et al., 2013).



THEMATIC ANALYSIS	CONTENT ANALYSIS
answers interpretive research questions	answers descriptive research questions
requires limited levels of structure of the research design	requires greater levels of structure of the research design
the analysis focuses on meaning (on what it means to ...) as interactively interpreted by the researcher	the analysis focuses on frequency of occurrence
the analysis is inductively done i.e. the meaning of the collected data is made (created) by the researcher	the analysis is deductively done i.e. the collected data is fitted to pre-determined theoretical matrices developed either from theory or the researchers experiences
does not require peer or member checking	requires peer or member checking

Table 4.7.a. - created by the Author

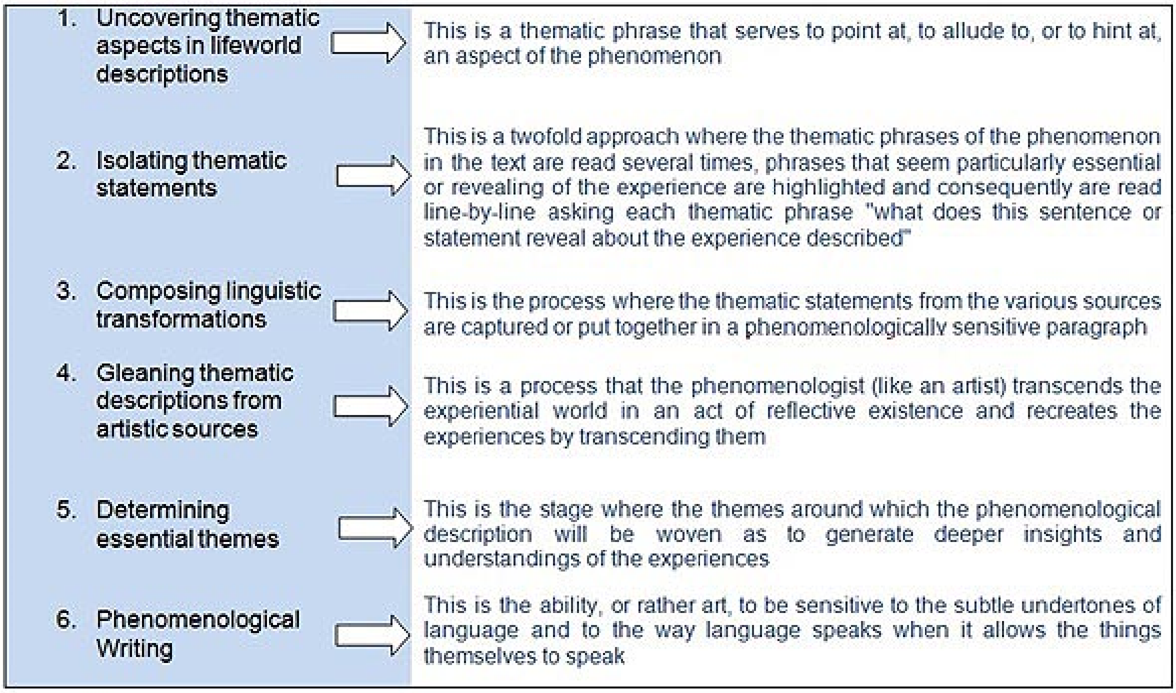
The above broad spectrum of qualitative analysis methods and the associated characteristics of each side of the spectrum is a useful initial guide for defining the data analysis method of the current study. The current study is an interpretive study based on interpretive phenomenology intending to acquire an in-depth understanding of participants' experiences in coming to terms with T2D and alteration of alcohol consumption patterns. Furthermore, the researcher of the current study has pre-assumptions emerging from her experiences and from the theory she has read, which have been reflected upon and presented to demonstrate how these pre-assumptions have influenced the meaning-making of the lived experiences of the study participants. In other words, the research question, the level of structure and the philosophical modality of the current study all point to an analysis that is within the thematic analysis spectrum.

However, the literature on qualitative analysis concedes that even if the genre of analysis is decided, for instance, thematic analysis there are still further ambiguities for the researcher to clarify as each genre of analysis has a variety of features (Miles et al., 2014). Therefore, the thematic analysis used in this study is further clarified. Firstly, the above-presented spectrum is not as straightforward as presented in all the qualitative related literature. Some literature blur the boundaries between content analysis and thematic analysis, and present an overlap of activities suggesting qualitative research is both descriptive and interpretive, or that analysis is both deductive and inductive (Burnard et al., 2008; Vaismoradi et al., 2013; Joffe, 2014). Secondly, there are multiple and various approaches of qualitative data analysis with no standardised procedures or explicit rules making the process complicated, laborious and not straightforward in the justification of choices (Clarke and Braun, 2013; Elo et al., 2014). Lastly, for both content analysis and thematic analysis, the literature developed variations that have a confusing effect for researchers and readers, as it is not clear what is the suggested way of conducting the analysis. The literature becomes further confusing by the assumption in some cases that content analysis and thematic analysis can be treated either as a methodology or linked to a methodology or as a stand-alone analytic method (Clarke and Braun, 2013; Elo et al., 2014).

Like all other aspects of the current study, the researcher intends to link all the steps of the research process logically. The current study implements an interpretive epistemology, subjectivist ontology and interpretive phenomenology. This acknowledgement provides an initially useful starting for justifying the data analysis choice. However, this alone is insufficient in fully answering what is the appropriate method of analysis as phenomenology (and its variations) is viewed in the literature to be both a philosophy and a methodology. The literature considers that the first generation of phenomenologists (Husserl, Heidegger, Marleau-Ponty and Gadamer) understood phenomenology more as a method for doing philosophy, rather than research (Dowling 2007; Munhall, 2007; Sloan and Bowe, 2014). Therefore, clarifying that the current study implements interpretive (Heideggerian) phenomenology is useful but limited in justifying the data analysis choices. Since Heidegger, like the rest of the first generation phenomenologists, was writing philosophically, rather than methodologically offering little in terms of a method of analysing phenomenological data.

Munhall (2007) argues that the second generation of phenomenologists (Giorgi, Colaizzi, Van Kaam and Van Manen) move phenomenology from philosophy to a method of inquiry and, as such, they all propose guidelines for analysing phenomenological data. Giorgi, Colaizzi and Van Kaam all propose guidance of analysis of phenomenological data that develop descriptive accounts intended to represent the structures of the phenomena in these accounts accurately and revealing to the researcher (rather than creating) the nature of phenomena, once previous experiences and prejudices of the researcher are bracketed out (Whiting 2002; Priest, 2003; Munhall, 2007). Van Manen is the only one of the second generation of phenomenologists that the literature links to the interpretation of experiences (Munhall, 2007). Van Manen (1984, 2014) asserts that the phenomenological analysis ought to construct a possible interpretation of human experiences mediated by the thoughtfulness and reflection of the researcher. The literature acknowledges that Van Manen develops Heidegger’s phenomenology from philosophy to a method of inquiry and the proposed method of analysis by Van Manen materialises the interpretive, reflective and constructive nature of phenomena that hermeneutic phenomenology seeks to create (Dowling 2007; Munhall, 2007; Sloan and Bowe, 2014).

As already discussed, the epistemological and methodological choices were those of interpretive epistemology and interpretive phenomenology. Therefore, Van Manen's methods approach of data analysis is the most suitable as it enables the creative analysis of data mediated by a thoughtful and interpretive process with the intent of (re)constructing the participants understanding of their lived experiences. Van Manen (1984) suggests a series of processes for doing the thematic analysis of phenomenological data (see table 4.7.b):

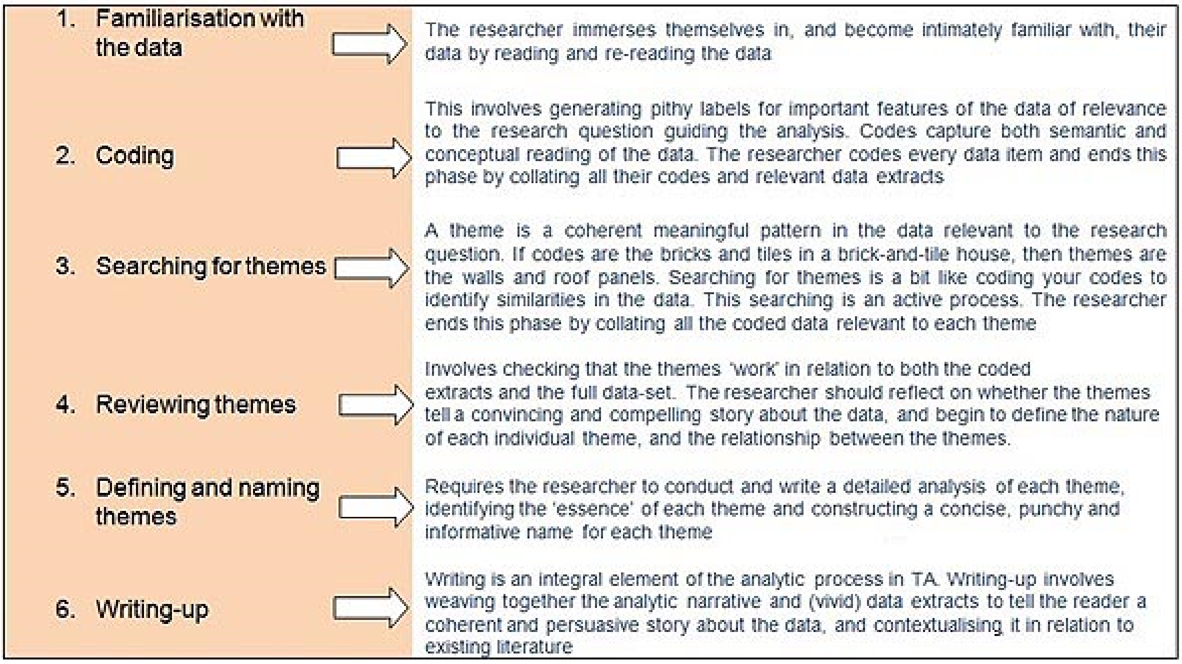


1. Uncovering thematic aspects in lifeworld descriptions	This is a thematic phrase that serves to point at, to allude to, or to hint at, an aspect of the phenomenon
2. Isolating thematic statements	This is a twofold approach where the thematic phrases of the phenomenon in the text are read several times, phrases that seem particularly essential or revealing of the experience are highlighted and consequently are read line-by-line asking each thematic phrase "what does this sentence or statement reveal about the experience described"
3. Composing linguistic transformations	This is the process where the thematic statements from the various sources are captured or put together in a phenomenologically sensitive paragraph
4. Gleaning thematic descriptions from artistic sources	This is a process that the phenomenologist (like an artist) transcends the experiential world in an act of reflective existence and recreates the experiences by transcending them
5. Determining essential themes	This is the stage where the themes around which the phenomenological description will be woven as to generate deeper insights and understandings of the experiences
6. Phenomenological Writing	This is the ability, or rather art, to be sensitive to the subtle undertones of language and to the way language speaks when it allows the things themselves to speak

Table 4.7.b. - created by the Author

While Van Manen contributed in moving phenomenology from philosophy towards a method of inquiry and provides a guide to analysis, nevertheless this guide serves more as a theoretical and heuristic guide, rather than a set of rules or steps to follow (Spaten et al., 2012). The above processes are useful and relevant for linking hermeneutic phenomenology to a theoretical and heuristic guide of theme development but lacks the specificity of a step-by-step process that is useful for researchers in the analytical phase. Furthermore, as already demonstrated, the research question of the current study, the level of structure of the qualitative project and the philosophical modality of the current research require thematic analysis to be carried out. Moreover, the literature considers that the philosophy of interpretive phenomenology, Van Manen's phenomenological method of inquiry and the thematic analysis method are all link and interrelate. For instance, Dowling (2005) presents a series of studies in her review that utilised Heidegger's hermeneutic phenomenology and were informed by Van Manen's method of analysis to explore and interpret the lived experiences of participants. Furthermore, Van Manen (2014) asserts that for interpretive phenomenology, thematic analysis is a popular interpretive strategy for identifying themes in transcribed interviews. Joffe (2011) and Clarke and Braun (2013) share the notion of characterising thematic analysis as an interpretive phenomenological method of analysis.

Hence, the current study supplements Van Manen's heuristic guide (see table 4.7.b) with the thematic analysis framework that provides greater guidance in terms of practical application. Clarke and Braun (2013) provide a six-step thematic analysis framework (see table 4.7.c):



1. Familiarisation with the data ⇨	The researcher immerses themselves in, and become intimately familiar with, their data by reading and re-reading the data
2. Coding ⇨	This involves generating pithy labels for important features of the data of relevance to the research question guiding the analysis. Codes capture both semantic and conceptual reading of the data. The researcher codes every data item and ends this phase by collating all their codes and relevant data extracts
3. Searching for themes ⇨	A theme is a coherent meaningful pattern in the data relevant to the research question. If codes are the bricks and tiles in a brick-and-tile house, then themes are the walls and roof panels. Searching for themes is a bit like coding your codes to identify similarities in the data. This searching is an active process. The researcher ends this phase by collating all the coded data relevant to each theme
4. Reviewing themes ⇨	Involves checking that the themes 'work' in relation to both the coded extracts and the full data-set. The researcher should reflect on whether the themes tell a convincing and compelling story about the data, and begin to define the nature of each individual theme, and the relationship between the themes.
5. Defining and naming themes ⇨	Requires the researcher to conduct and write a detailed analysis of each theme, identifying the 'essence' of each theme and constructing a concise, punchy and informative name for each theme
6. Writing-up ⇨	Writing is an integral element of the analytic process in TA. Writing-up involves weaving together the analytic narrative and (vivid) data extracts to tell the reader a coherent and persuasive story about the data, and contextualising it in relation to existing literature

Table 4.7.c. - created by the Author

Van Manen's heuristic guide and Clarke and Braun's thematic analysis framework act in a supplementary and an explicatory manner to each other of the data analysis processes for studies as the current one that utilises interpretive phenomenology. In the following table (see table 4.7.d) Van Manen's heuristic guide and Clarke and Braun's thematic analysis framework are juxtaposed to identify aspects that supplement each other and clarify each other:

Van Manen's heuristic guide	Clarke & Braun's thematic analysis framework
	Familiarisation with the data: reading and re-reading the data
Uncovering thematic aspects in lifeworld descriptions: thematic phrase pointing at an aspect of the phenomenon	Coding: generating pithy labels for important features of the data of relevance to the research question guiding the analysis
Isolating thematic statements: read line-by-line asking each thematic phrase "what does this sentence or statement reveal about the experience described"	
Composing linguistic transformations: thematic statements from the various sources are captured or put together	Searching for themes: Searching for themes is a bit like coding your codes to identify similarities in the data
Gleaning thematic descriptions from artistic sources: in the act of reflective existence the researcher recreates the experiences by transcending them	Reviewing themes: The researcher should reflect on whether the themes tell a convincing and compelling story about the data, and begin to define the nature of each individual theme, and the relationship between the themes
Determining essential themes: themes generate deeper insights and understandings of the experiences	Defining and naming themes: identifying the 'essence' of each theme and constructing a concise, punchy and informative name for each theme
Phenomenological Writing: writing in sensitive and subtle undertones of language and allowing the written language to speak for the experience	Writing-up: involves weaving together the analytic narrative and (vivid) data extracts to tell the reader a coherent and persuasive story about the data, and contextualising it in relation to the existing literature

Table 4.7.d. - created by the Author

The above table that merges Van Manen's heuristic guide, and Clarke and Braun's thematic analysis framework is both useful and relevant to the current study. However, there was still some level of confusion in actually doing the process of analysis and a few practical issues that the above table does not fully answer or explicate. For instance, the qualitative literature asserts that there is a confusion between the concepts of "code", "category" and "theme", with some authors using them almost interchangeably and others using the same language to define both the terms "codes" and "categories" or "categories" and "themes" (Smith and Firth 2011; Morse, 2008). Furthermore, a more explicit manual of how the raw data were developed into meaningful themes enabling interpretation while preserving context would be useful, as this transformational phase seemed up to a point mystic or under-developed in a lot of the qualitative literature (Dowling 2007; Richards and

Morse, 2013; Saldana, 2015). Gale et al. (2013) in a recent paper attempt to provide some clarification by developing a glossary on "codes", "categories” and "themes". Gale et al. (2013) conceptualise 1) **codes** as descriptive or conceptual labels assigned to excerpts of raw data, 2) **categories** as the analysis process whereby codes are clustered around similar and interrelated ideas or concepts and while categories are closely linked to the raw data, developing categories is a way to start the process of abstraction of the data, and 3) **themes** as interpretive concepts that explain aspects of the data, which are the final output of the analysis of the whole dataset and are articulated and developed through comparison between and within cases.

Similarly, Morse (2008) and Richards and Morse (2013) consider that the major difference between "codes", "categories” and "themes" is the level of abstraction with codes being the least abstract and themes being the most abstract, and also in terms of representation of text with codes representing very small chunks of text and themes representing the whole part of the text. Richards and Morse (2013) understand the coding process at its simplest form to be a descriptive label about a sentence or phrase. Saldana’s (2015) manual for coding refers to this simple form of coding as the first cycle for in vivo coding, whereby the code is a label that refers to a word or short phrase from the actual language found in the raw data that is of significance. Consequently, Richards and Morse (2013) assert that once the researcher assigns a label to a phrase or sentence, then the researcher starts to think analytically. This analytical thinking is what Saldana (2015) defines as the second cycle for in vivo coding, where the researcher teases out the meaning from the raw data in a phrase and provides interpretations for the raw data.

Once the researcher codes all the transcribed text using the descriptive and analytical cycles, then this text is left aside, and the codes henceforth represent the text with the raw data. These codes are read and re-read to identify similarities between codes or codes that share common characteristics. Consequently, the analysis process proceeds by clustering together codes that share characteristics and have similarities to allow for the emergence of patterns (Gale et al., 2013; Saldana, 2015). The emerging patterns of the clustered codes create categories that are more abstract than codes and demonstrate relationships between codes (Richards and Morse, 2013).

Finally, once the researcher develops all the possible codes into categories, then the codes are left aside and the researcher reviews the categories that now represent the data. The researcher compares each category with other categories to identify relationships between categories, e.g. complementary or antithetical relationships etc. The researcher groups together the categories that share some form of relationship creating in this manner themes. A theme is a much more abstract piece of text that encloses a meaningful essence that runs through the data and interprets the meaning and essence of the participants' lived experiences (Morse, 2008; Richards and Morse, 2013). The coding, categorising and thematising process is not a linear one, but a reiterative one (see table 4.7.e).

In Vivo Coding - 1st cycle	A label that refers to a word or short from the actual language found in the raw data that was deemed to be of significance
In Vivo Coding - 2nd cycle	Researcher interprets the code from the 1st cycle by asking the initial code what does it mean or what is happening or what are the assumptions
Categories	In a reflective and creative effort, the researcher reads and re-reads the codes to identify similarities between codes or codes that share characteristics to cluster them together, to identify patterns and develop taxonomies to determine *what* is in the data
Themes	Categories are reviewed and compared to identify relationships between categories. A theme is a much more abstract piece of text that encloses a meaningful essence that runs through the data and interprets the meaning and essence of the lived experience

Table 4.7.e. - created by the Author

The above clarification of glossary and steps further clarified Van Manen’s heuristic guide and Clarke and Braun’s thematic analysis framework concerning the practical aspects of actually doing the analysis. Table 4.7.f merges Van Manen’s heuristic guide, Clarke and Braun’s thematic analysis framework and the coding/categorising and thematising steps that informed the current study.

Van Manen's heuristic guide	**Clarke & Braun's thematic analysis framework**	**Coding/ categorising and thematizing steps**
	Familiarisation with the data: reading and re-reading the data	
Uncovering thematic aspects in lifeworld descriptions: thematic phrase pointing at an aspect of the phenomenon	Coding; generating pithy labels for important features of the data of relevance to the research question guiding the analysis	In Vivo Coding- 1st cycle: a label that refers to a word or short from the actual language found in the raw data
Isolating thematic statements: read line-by-line asking each thematic phrase "what does this sentence or statement reveal about the experience described"		In Vivo Coding - 2nd cycle: interpretation of codes from the 1st cycle by asking the initial code what does it mean or what is happening or what are the assumptions
Composing linguistic transformations: thematic statements from the various sources are captured or put together	Searching for themes: Searching for themes is a bit like coding your codes to identify similarities in the data	Categories: reflectively and creatively reads and re-read the codes to identify similarities between codes or codes that share characteristics and cluster them together to identify patterns and develop taxonomies to determine *what* is in the data
Gleaning thematic descriptions from artistic sources: in an act of reflective existence the researcher recreates the experiences by transcending them	Reviewing themes: The researcher should reflect on whether the themes tell a convincing and compelling story about the data, and begin to define the nature of each individual theme, and the relationship between the themes	
Determining essential themes: themes generate deeper insights and understandings of the experiences	Defining and naming themes: identifying the 'essence' of each theme and constructing a concise, punchy and informative name for each theme	Themes: categories are compared to identify relationships between categories and develop highly abstract and meaningful essences that run through the data that interprets and understands the meaning and essence of the lived experience
Phenomenological Writing: writing in sensitive and subtle undertones of language and allowing the written language to speak for the experience	Writing-up: involves weaving together the analytic narrative and (vivid) data extracts to tell the reader a coherent and persuasive story about the data, and contextualising it in relation to existing literature	

Table 4.7.f. - created by the Author

Table 4.7.f links Van Manen's heuristic guide, Clarke and Braun's thematic analysis framework and the coding/categorising and thematising steps. The following table describes the eventual framework that informed the analysis process of the current study (see table 4.7.g).

STEPS	PROCESSES	
Step 1	Familiarisation with the data	reading and re-reading the data
Step 2	In Vivo Coding (1st cycle) - Uncovering thematic aspects in lifeworld descriptions	Generating a label or phrase from the actual language found in the raw data that points to an important features or aspect of the phenomenon
Step 3	In Vivo Coding (2nd cycle) - Isolating thematic statements	read line-by-line each code and ask the initial code what does it mean or what is happening or what are the assumptions or what does this statement reveal to provide analysis and interpretation of codes
Step 4	Categories - linguistic transformation of codes and searching for themes	reflectively read codes to identify similarities between codes and re-create an abstract and transcending pattern or taxonomy that begins to define the nature of experience each individual felt and the relationship between these lived experiences
Step 5	Defining essential themes	categories are compared to identify relationships that can generate deep, meaningful and informative essences of the lived experiences that run throughout the data
Step 6	Phenomenological Writing-up	weaving together the analytic narrative and (vivid) data extracts to tell the reader a coherent, sensitive and persuasive story about the experience, and contextualising it in relation to the existing literature

Table 4.7.g. - created by the Author

4.8. Data Analysis Process

Immediately after the completion of each interview, the data analysis process commenced by coding the data. Reading the transcripts and the developing codes of the first interviews allowed for greater levels of focus in the consequent interviews on issues that emerged as eminent concepts in the transcripts or the codes. Also, this analysis process allowed for a cyclical back and forth between existing data and the collection of new data and in this manner avoid any blind spots in the collected data and avoid making the analysis process an overwhelming activity left for the end (Miles et al., 2014; Giles et al., 2016). The audio recorded data from each interview was transcribed in a Word document. The data analysis commenced with listening to the recorded data, and reading and re-reading the transcribed audio recordings to obtain a broad overview of what was said by the participants and for me to become familiar with the totality of the data (Greenwood et al., 2017; Hackett & Strickland, 2019).

Also, during this initial immersion in the collected data and before the commencement of the coding process, I developed a system of managing and organising the data to make the mass of collected data manageable and easily retrievable (Miles et al., 2014; Creswell and Poth, 2017). Initially, I created a matrix template with rows and columns (Creswell and Poth, 2017). The three developed columns of the matrix from left to right corresponded to "*raw text*", "*Coding I - 1st cycle coding*" and " *Coding II - 2nd cycle coding*", and the rows corresponded to a full reply from the participant to a question posed (see table 4.8.a.). Also, I developed a data accounting log with keys that allowed the correlation of the raw data to each code created to enable the code to be retrieved if required. Each Interviewee was labelled alphabetically, i.e. the first interviewee was labelled "Interviewee A", the second interviewee as "Interviewee B" etc. and to make it briefer "Interviewee A" became "InA", "Interviewee B" became "InB" etc. Also, I counted the lines in the matrix and the number of codes developed in each line. Hence the key "InCL6C1" referred to raw data from Interviewee three, line six of the matrix and corresponded to code one.

Text	**Coding 1** 1st cycle coding	**Coding 2** 2nd cycle coding

Table 4.8.a. - created by the Author

Consequently, using in-vivo coding, I commenced the first cycle of coding by reading line-by-line each participant's replies to a posed question to identify salient attributes, significant meanings, distinctive language and to attune myself with the interviewee's replies (Saldana, 2015). At this phase, the use of colours to identify significant phrases and change of meaning within the interviewee's reply was important. Then, I transferred each coloured phrase to the second column of my matrix and numbered it without altering the interviewee's words to honour interviewee's voice and to avoid imposing too quickly my interpretations on the data (Saldana, 2015). After completing the first cycle of coding, I proceeded to commence the second cycle of coding. The second cycle of coding included interpretation and condensation of the codes from the first cycle but made sure to retain the meaningfulness and parsimoniousness of the content (see table 4.8.b) (Miles et al., 2014; Darcy, 2019).

Text	**Coding 1** **1st cycle coding**	**Coding 2** **2nd cycle coding** *What is this about?* *What does it mean?* *What is happening?* *What are the assumptions?* *(make abstract-touch test)*
I guess the most useful thing has been the Diabetic nurse referring me to the Good to Go online course because obviously, they do mention...well there's a big focus on diet, and they do mention alcohol and that was useful to remind me about the amount and the measures of alcohol because it's very easy to have a big wine glass isn't it so I guess I'm a little bit more conscious about not filling the wine glass quite as much but the other resource I think was obviously the Heal project and obviously going to...being a member of the Diabetes UK. I get their magazine Balance every month, and that's got lots of useful information in it and lots of good recipes on their website which I've been using.	1) the most useful thing has been ... referring me to the Good to Go online course... 2) there's a big focus on diet and they do mention alcohol, and that was useful to remind me about the amount and the measures of alcohol because it's very easy to have a big wine glass ... so I guess I'm a little bit more conscious about not filling the wine glass quite as much... 3) ...the other resource I think was obviously the Heal project and obviously going to...being a member of the Diabetes UK. I get their magazine Balance every month, and that's got lots of useful information in it and lots of good recipes on their website which I've been using.	Internet and volunteer support groups support in altering alcohol and dietary habits (InCL6C1)

Table 4.8.b. - created by the Author

To interpret the codes from the first cycle of coding, I posed questions such as what is this phrase about or what does it mean or what is happening or what are the assumptions? This process is what the literature defines as the "touch test" (Saldana, 2015), whereby in the first cycle of coding includes more tangible codes (you can almost touch them), for instance in the provided example in table 4.8.b the websites or the glass of wine is something tangible, whereas in the second cycle of coding this becomes much more abstract (they are not tangible anymore). In the example, the websites become the internet, and the glass becomes wine alcohol habit.

Also, the literature identifies at this stage, the stick coding issue where the researcher does not feel confident about the relevance of some data and needs to decide whether to exclude or not such data (Rosenblatt and Wieling, 2019). Similar issues emerged in the current study; for example, one of the participants of the current study strayed into sharing his view that diabetes had side-effects of sexual impotence and that this was putting a strain on his marriage. For the current study, I processed all phrases from the first cycle of coding and included them in the second cycle of coding. I did this even for phrases that appeared not directly relevant as I considered that I might be able to use these codes as deviant cases in the categorisation phase (Rosenblatt and Wieling, 2019). At this point of the coding process, I kept memos noting the potential need for modifying codes in the future or the need to collect more and new data on the issue that a code referred to or merely providing commentary as a reminder of what was happening in the code (Castellanos, 2019).

The completion of the coding process was not a linear as described in this text, there was a continuous back and forth in the second cycle of coding as more data was collected and there was a continuous refinement of codes based on greater levels of data understanding. Once completing the second cycle of coding and achieving a level of abstraction and condensation of data, the focus of attention shifted away from the raw data to the developed codes (Richard and Morse, 2013). I assembled all created codes in one Word document to be able to read and re-read the developed codes, to make comparisons between codes and to identify emerging patterns (Richard and Morse, 2013). I focused on identifying relationships between codes, initially identifying similarities and/or differences and consequently identifying frequencies, correspondences and causations moving from the data to greater levels of abstraction and creating a composite collection of distinct but interrelated concepts (Averill, 2015; Ganapathy, 2016). In the above coding example, the code "*Internet and volunteer support groups support in altering alcohol and dietary habits (InCL6C1)*" was grouped with other similar or corresponding codes (see table 4.8.c) to create a single category.

CATEGORY: The internet input in (mis)shaping identities
CODES • Mass media provide mixed messages to support consumption rather healthy lifestyles (InBL3C4) • The temptations as expressed in current consumerist society impede healthy lifestyles and changes for individuals with type 2 diabetes (InBL18C1) • Social media and volunteer support groups provide partial support in altering alcohol and dietary habits (InCL6C1) • Greater social awareness of type2 diabetes would enable a more conducive environment for alcohol reduction in individuals with type 2 diabetes (InDL3C1) • The use of social media as a means for sharing information (InHL18C1) • Self-educated about diabetes from the internet (InJL10C2) • Complimentary to support groups are online social forums that provide extensive and immediate information (InLL4C1) • Friends, internet and support groups are the major sources of information (InJL1C3)

Table 4.8.c. - created by the Author

Once completing the categorisation phase of the analysis and creating relationships between codes, the focus of attention shifted away from codes to the developed categories (Richard and Morse, 2013). I developed a total of eleven categories, and these categories were read and re-read to collate them, to examine relationships between categories, to develop theoretical concepts from the categories and to sort together categories that best answered my research questions (Richard and Morse, 2013). The grouping of categories together created more abstract conceptual ideas and explanations that were running throughout the data. These constructs are the themes of the study. In the above example, the category "*The internet input in (mis)shaping identities*" was grouped with other conceptually similar categories (see table 4.8.d) to create a single theme.

THEME: Collective determinants influence on lifestyle changes
CATEGORIES • Group membership and identity construction • Marketing practices of the consumer industry • Collective determinants influence on lifestyle changes

Table 4.8.d. - created by the Author

The current study developed a total of four themes that provided the conceptual abstractions and understandings that enables the theorisation of key ideas and in this way to answer the research questions of the study.

CHAPTER 5:
DATA ANALYSIS

5.1. Introduction to the analysis

Data analysis is a transformative process whereby the researcher breaks down the collected data into small and simplified conceptual parts with the eventual purpose of grouping these parts into manageable clusters based on their similarity and potential to answer the research questions (Moule & Goodman, 2009; Parahoo, 2014). The qualitative research language defines this process as the coding, categorising and thematising of the data, and the researcher completes this process in a systematic and non-linear manner with the overall intent of making sense of the data, providing explanations and developing interpretations (Moule & Goodman, 2009; Richards & Morse, 2013; Parahoo, 2014). Importantly, the qualitative literature argues that thematic analysis is neither the mere collection of extracts or quotations nor is the simple paraphrasing of participants or researchers narratives (Braun and Clarke (2006). The thematic analysis incorporates and illustrates "the analytical points the researcher makes about the data and should be used to illustrate/support an analysis that goes beyond their specific content, to make sense of the data, and tell the reader what it does or might mean" (Braun and Clarke, 2006, p.94). Therefore, this section will break down the data into categories and cluster these into themes and in the process, provide explanations, interpretations and sense-making of the collected data.

The data analysis of the current study has three distinct and inter-related sub-headings; namely: Sub-heading 5.2, 5.3 and 5.4. Sub-headings 5.2 includes the themes of the study and their constituting categories. Sub-heading 5.2 presents the categories that constitute each theme with direct quotations from the interviewed participants with T2D who have a current or previous inclination of consuming alcohol along with the researcher' description and analysis of the quotes. Each category concludes with the researcher's interpretative summaries of the category content, extrapolating concepts and meanings from the participants' descriptions. Also, each theme concludes with the aggregation and integration of the summaries of all the theme's categories to create the final summary of the theme. Sub-heading 5.3 further analyses, interprets and presents each theme to identify the variety of existing layers and to highlight the emerging links between themes leading to the development of a multi-layered and inter-linked framework entitled the "Framework of Well-being withT2D". Finally, Sub-heading 5.4 presents each stage of the multi-layered and inter-linked conceptual Framework of Well-being and in this manner (re)frames the phenomenon of living well for individuals living with T2D who consume alcohol.

5.2. Theme Presentation - Section 1

This section includes the presentation of direct participant quotations and their formation into categories. Consequently, comparisons and contrasts of the constituting categories lead to the developing of themes. The categories are organised and patterned in a complementary, explanatory and contrasting manner, and presented under each developed theme. The study has four themes; namely: 1) *Influences of collective determinants on lifestyle changes*, 2) *Contextual and cultural framing of lifestyle changes*, 3) *Embodiment of intersubjective interactions* and 4) *Being and well-being withT2D*.

*5.2.1. Influences of collective determinants on lifestyle changes (**Theme 1**)*

Theme 1 entitled "**Influences of collective determinants on lifestyle changes**" consists of three categories, namely: 1) *Group membership and identity construction*, 2) *Marketing practices of the consumer industry* and 3) *Health literacy and lifestyle changes*. The theme focuses on social systems such as social group memberships, food/alcohol culture, weight loss and pharmaceutical industries, and online media, and their impact on the lifeworld of individuals living with T2D and consume alcohol.

The theme further explores the enabling or resisting forces exerted by these social systems in achieving or not lifestyle changes in food and alcohol consumption.

5.2.1.1. Category 1: Group memberships and identity construction

The current Category entitled "*Group memberships and identity construction*" focuses on influences that food and alcohol have as symbolic representations in gaining and maintaining membership to various social groups and consequently in constructing personal, professional and social identities. The Category considers these constructed identities under the prism of T2D diagnosis and the need for lifestyle modifications concerning food and alcohol consumption. Finally, the Category examines the role of social groups and networks in either delimiting or enabling the (re)construction of a new social identity for individuals with T2D and in achieving permanent lifestyle modifications concerning food and alcohol consumption.

In the following quotation, participant F explains that the context and environment of the pub are conducive to alcohol consumption. Furthermore, the situational and social practices in public drinking environments, such as pubs, increased his alcohol consumption levels because of his need to take part in drinking rounds and drinking games. Participant F was able to significantly reduce the levels of alcohol consumption only when ceased going to the pub and avoided socialising with the groups of people in the pub environment. Similarly, participant E indicates that food consumption is part of socialisation, and food preparation and acts of commensality reflect the norms of social gatherings and with friends and community members that unavoidably increases the amounts of food consumed.

> I was a pub person; I used to go to the pub almost every night. I preferred it from staying home watching telly. I knew the owner of the pub. I mean I knew most of the people in there ... [and] I like whiskey, so I used to have at least one [glass] whiskey every night, maybe two or three if others joined and started buying rounds or doing "shouts" that you have to keep up with. Now I have one [glass of] whiskey once a week either on Friday night or on Saturday night. But I have it alone; I do not go to the pub. I have not been to the pub now for 7 or 8 months .... and I have massively cut down on my drinking - over a seventh ... If I go to the pub I will be back drinking 8 or 9 [glasses of] of whiskey; it is the environment there, you cannot resist it *(participant F)*

> You see when you live alone sometimes, you cannot be bothered and you do not feel like eating. But when my husband was alive, and we had friends and his colleagues come over I would cook meals and also I would make cakes, I used to be a good cook, everyone said so, and everyone ate. I would eat much more than I do now. I took great pleasure cooking for others *(participant E)*

Participant C in the following direct quotation appeared to be cognisant that the diagnosis of T2D required changes of both pace and prioritisations in her working life. She is aware that there would be a disruption to what she considered as expected rules of reciprocity between employer and employee, as she would be asking for a different type of employment. For instance, she would be asking for a different type of treatment that includes having time off for midweek gym activities. Similarly, participant A implied a disruption of daily reality, but in his case, this referred to his constructed social and personal identity whereby a disruption and alteration of self-imagery occurs as he no longer can consume alcohol affecting his social interactions and his ability to make decisions autonomously.

> ... I want just to drop another afternoon [from work]. I don't know if work will let me do that yet, but that's what I've requested; actually to support me going to the gym mid-week *(participant C)*

> The only thing I did at one event I went to was to ask for a bottle of Baileys. And she (nurse) says no that's a no go area. But I used to like drinking Baileys... mix it with my coffee. I'll be getting one [bottle] bought this Christmas... unfortunately, I will not drink it because once you've opened it you've only got three months life in it apparently and I am not allowed to drink it... I cannot make any more decisions about what and when to drink *(participant A)*

Participant A in the following direct quotation constructs new meanings for sugary foods that family and friends gift him as part of the social norm of gift exchange. Instead of eating these sugary foods, he alters their role and makes them into prizes for a bingo game. In this way, he positively transits from one social identity to another and in the process opens up the possibility of new group membership with those people participating in the bingo game, while at the same time maintaining his previous group membership in the social network of family and friends. On the other hand, participant L in the following direct quotation affirmed that she manages to eat healthy when on her own at home. However, to maintain her membership in her social groups, she feels compelled to eat out as well, where she feels to have no control of what she is eating, thus creating a discrepancy between the perceptions of what she needs to do for controlling T2D and the eating and drinking norms that affirms her group membership.

> It's my birthday in a fortnight anyway so I'll be 82 at Christmas so that's another thing and I get stuff bought for me for Christmas which really I shouldn't. I think people get stuck what to buy me... we'll get probably a box of Cadburys …so what I'm going to do with that....and I'm coming back here next Monday because I'm organising a few games and bingo and I'm going tip these sweets out and put them in little polythene bags and put them on there, and that'll be the prizes for the bingo *(participant A)*

> I know on occasion when we are out for a meal, and I don’t know what they are putting, I don’t know what I am eating so I am in shock after eating healthy at home, and it might go up to 15 (glucose level)... I feel that I need to stay home to control what I eat [but] I miss the days before [my diagnosis with diabetes] that I could join family and friends for a meal or drink *(participant L)*

Participant B, in the following quotation, identified the social consequences of losing contact with friends once diagnosed with T2D. Furthermore, participants D illustrates the undesired differentiation that T2D has for them within their social groups and the breach of group unity and reciprocity of going out and taking part in alcohol drinking. The Participants of the current study to deal with their potential disapproval of the group developed a set of coping strategies, such as secrecy relating to T2D or covertly alter their eating and drinking habits. However, these coping strategies limit their group membership compounding their stress as they are unable to change their social identity and become part of new groups. They cannot anymore neatly fit into their existing social groups.

> I did lose touch with one friend, and I always wondered if it was turning to Diabetes or not, I don't know *(participant B)*

> Since being diagnosed I've now come down to no more than one pint per night...it was very difficult because you go around with friends who you know are going to drink 3 pints or so, and I would have a half and make that last for a long time and then have another half, so I'd keep it going to one pint a night ...it is difficult to go out and not have a pint *(participant D)*

When the researcher queried how participants dealt with the limitations posed to them in taking part in group activities that were normally accompanied by alcohol and food consumption, most participants replied that they substituted these groups with other social groups. For instance participant B, in the following quotation, states that he actively sought new groups to socialise. Similarly, participant A joined groups that included tea and coffee drinking and game playing. Both participants indicate that these new group memberships forged a new identity for them that excluded alcohol and food consumption, focusing more on walking, dancing and game playing.

> Because of an article in the Yorkshire Evening Post about this rambling group that said they were going to have some trial walks in the Leeds area. So I thought it might be interesting, not from a diabetes point of view just from an exercise and a social life point of view. So I went along, I did two [walks] and thoroughly enjoyed it. So then ... [name of the group] they meet every Thursday, and they do country dancing and one or two other things, and so I joined the B group. They were a very sociable crowd *(participant D)*

> The groups I go to now they are having a Christmas party next week, next Monday a week today ... [Also] tomorrow night, Wednesday night ... it is a Christmas party at the youth club, there are only four of us, and all the children will get a present. I am coming back here next Monday because I am organising a few games and bingo ... [we will be] making tea and coffee and participating in the games, we play carpet bowls, bingo and stuff like that *(participant A)*

Interpretive Summary of Category: The current category illustrates that food and alcohol consumption to a large extent, acquires symbolic meanings, and regulates individuals’ membership in social groups and networks. Such social memberships to a degree forge individuals’ social, personal and professional identity, and define their social behaviour. The diagnosis of T2D and the requirement of alterations in food and alcohol consumption confuses individuals’ explanatory frameworks of everyday normality, disrupts their social, personal and professional identities, and disturbs their internalised and embodied norms of group reciprocity putting at risk their membership to their social groups. Individuals with T2D who worked towards creating or becoming part of new social groups or figure ways of maintaining membership in existing social groups are in a better position to achieve permanent changes in food and alcohol consumption successfully. Individuals with T2D that consume alcohol have membership in social groups that consume only alcohol and social groups that combine alcohol and food consumption, and social groups that consume only food. For these individuals, lifestyle alterations would imply risking membership in all three social groups i.e. alcohol drinking social groups, food consuming social groups, and alcohol drinking and food consuming social groups. The more memberships in social groups an individual put at risk; the more disruptive lifestyle changes become and the greater the barriers these individuals need to bypass in achieving lifestyle modifications. Therefore, lifestyle modifications for individuals with T2D that consume alcohol are more difficult than for individuals with T2D who do not consume alcohol due to the greater number of memberships in social groups that are putting at risk. In conclusion, the development of multiple group memberships can ease the (re)construction of a new social identity for individuals with T2D who consume alcohol and contribute to their successful modification of food and alcohol consumption.

5.2.1.2. *Category 2:* Marketing practices of the consumer industry

The current Category entitled "*Marketing practices of the consumer industry*" focuses on the role of food and alcohol industry, weight loss industry and pharmaceutical industry, and how these industries affect and influence individuals with T2D who consume alcohol in achieving lifestyle changes.

Participant A in the first two direct quotations suggests that an effective labelling system concerning the nutritional information and value of foods and drinks is either lacking or is incomprehensible to be of any real usefulness for individuals with T2D who consume alcohol. Furthermore, participant A in the final quotation suggests that the colour-coding scheme denoting the nutritional value of food and drinks is useful. Nonetheless in the same quotation, the participant appears unable to comprehend the colouring scheme applied on some foods fully, and more importantly, the colouring-coding scheme was currently applied to a small range of foods and drinks, and at a voluntary basis.

> They don't have labels on them, stuff like different types of bread that can make a big difference and cakes can make a difference *(participant A)*
>
> But I do feel that these food manufacturers can help a lot more... they put a list, not colours, just a list of your daily allowance and it's over the top unless you're in the profession you wouldn't understand it *(participant A)*
>
> This traffic light system, I feel that rather than being voluntary it should be compulsory... all the reds are no good for you, and it surprises some foods I get it's not an éclair, it's probably a doughnut, but it's filled with custard filling, but there are no reds on it *(participant A)*

Participant B in the following direct quotation felt that weight reduction programmes failed to match him to a group of other individuals with a similar dietary profile, gender and interests, thus limiting his interaction with others in the group and restricting his potential of developing reciprocal relations within the group, eventually limiting the efficacy of the weight loss programme. Furthermore, participant B appeared to link the costs of participating in the weight loss programme to the benefits of weight reduction. The more obvious the association between the costs of taking part in the weight reduction programme and the outcomes of the participation, the more effective such programmes are in keeping individuals with T2D engaged.

> I tried joining Weight Watchers. There were about 50 women and three blokes, so you felt totally swamped by all of the people that you do not know and have nothing in common... so if you sign up, it's not at all balanced. And so every week you'd pay £5, and they weigh you, and if it's good, they will say well done, but if it's not good nothing happens ... and they've got this general scheme on how to lose weight, but did not work for me *(participant B)*

Finally, participant L, in the following quotation, highlights the role of pharmaceutical companies in self-managing T2D. This process appears to enable self-monitoring and self-management of T2D. Also, the reported financial reimbursement of expenses for supplies from pharmaceutical companies, insurances or third-party payers according to the following participant has a significant role in improving glycaemic control. However, participant G suggest that while medication may contribute to controlling blood glucose levels, nevertheless easy prescription or over-prescription of medication can act as a deterrent for individuals with T2D who consume alcohol to strive for lifestyle changes and over-rely on medication for controlling their T2D condition.

> They have got the support from some major pharmacy companies that will help you with diet and blood testing and that way. I got my blood meter and my test stripes. It cost me £99 for 12 months. Which considering the actual test stripes are £15 for 50 it is quite cheap. My GP prescribed sometimes with some free test stripes but they are very limited, so I don’t get many *(participant L)*

> I originally started on a diet, but moved on to tablets and now probably about a year after my diagnosis, and I've been on tablets ever since, gradually increasing the number of now tablets. Well, I try and exercise. I don't do enough, so take my tablets *(participant G)*

Interpretive Summary of Category: The current category narrates the experiences of individuals with T2D who consume alcohol of the food and alcohol industry, the weight loss industry and the pharmaceutical industry. These experiences concern the persuading or dissuading influence these industries have on lifestyle changes for individuals with T2D who consume alcohol. The lack of systematic and comprehensible labelling procedures by the food and alcohol industry, the inattentiveness to group dynamics and the vagueness between the cost demands and weight outcomes by the weight loss industry, and the over-prescription of medications and financial inconsideration by the pharmaceutical industry all contribute to limiting individuals' living with T2D potential in altering their lifestyle.

5.2.1.3. *Category 3*: Health literacy and lifestyle changes

The current Category entitled "*Health literacy and lifestyle changes*" focuses on the experiences of individuals with T2D who consume alcohol and the access and use of available online information. Furthermore, the category scrutinises the usefulness of this information in empowering or disempowering these individuals in achieving lifestyle changes. The category concludes with the tentative presentation of the preconditions for making the internet sources a liberating and productive resource for lifestyle changes.

Participants, J and H in the following direct quotations point out that the internet was an easy and accessible source, since can do this in the familiar setting of their home or local library or local centres, and they consider the online material as important information sources. They continue asserting that acquiring information online is both satisfying and empowering as it creates better understandings of their T2D condition and enables greater involvement in the decision-making and caring processes. However, the first direct quotation places emphasis on the personal initiative in retrieving online information, thus making internet usage a personal and individual endeavour, not included in the treatment package provided by health professionals. The online experience of participant B demonstrates that internet information can expose individuals with T2D who consume alcohol to reading unreliable, misleading and inaccurate source or lead them misconstruing these sources and drawing premature conclusions making the online search a potentially horrifying experience.

> ... find out about diabetes and what else it can cause. I found all the information by myself on the internet. I went on the internet and found a lot of things out... [one of] the best thing I did... finding out about diabetes online and what else it can cause. I found all that information by myself on the internet. *(participant J)*

> ...Yeah I mean it [*internet site*] does work people asking it is like a local centre an internet library, everyone walk and everyone has access to that, so people can read them and share them. So that is my future goal to keep working on that *(participant H)*

> Going to the internet and finding information was a grim experience because you read about amputations, blindness, kidney disease all the horrors you can get from it, and in one of the wards this woman was laying on a bed with the sheet going flat off the end of her legs and connected the dots *(participant B)*

Participant C in the following quotation identifies various online fora that provide not only useful information about T2D but create a sense of belongingness and a feeling of membership to a group with other individuals that are struggling with dietary and alcohol modifications as a result of T2D. This process appears to promote the sharing of experiences and feelings with a sense of reassurance and empowerment that they are on the right tracks with lifestyle changes. Moreover, participant L went on to suggest that online social networks are his preferred source of information and that these sources have a greater impact on his lifestyle changes than health professionals. The reason they have a greater impact is their immediacy, “real- life” practical advice and the sense of parity in sharing information.

> I guess the most useful thing has been the Diabetic nurse referring me to the Good to Go course (online course)... there's a big focus on diets. They do mention alcohol, and that was useful to remind me about the amount and the measures of alcohol because it's very easy to have a big wine glass, isn't it. So I guess now I'm a little bit more conscious about not filling the wine glass quite as much... the other resource I think was the Heal project and... being a member of the Diabetes UK. I get their magazine Balance every month, and that's got lots of useful information in it and lots of good recipes on their website which I've been using *(participant C)*

> By far the biggest impact was when I went on the internet, and I joined a site that is more online than places like this it is called dibetes.co.uk it is not a charity, and it is a really good site because it is full of information with a chat room questions and instant answers, there is a lot of people online *(participant L)*

Participant B in the following direct quotation experience of online information is fraught with difficulties as she is unable to discern the source and authorship of the information. She points out that the multiplicity and contradictory nature of this information creates more confusion and greater difficulties in comprehending the information on T2D and lifestyle changes, and heightens the sense of uncertainty of the retrieved information.

> Then if you compare it with what's in the media and what's coming out from some online sources, it's sometimes difficult to be clear what is the best way because fats and saturated fats have had a very bad press until recently *(participant B)*

Interpretive Summary of Category: The current category presents a variety of experiences concerning the role and significance of available online information and internet fora. Those who felt at ease with using the internet conceptualised the available online information as valid, genuine and applicable knowledge that was empowering for making decisions and achieving lifestyle changes. In contrast, others who did not feel at ease with using the internet assumed a more cautious stance, as the online information appeared to them to be contradictory, confusing and incomprehensible. Also, the fact that there is no formal education from health professionals on internet sources and online information concerning T2D and lifestyle changes as part of the treatment package further delimits the usefulness of online information or makes such information counterproductive to lifestyle changes. Finally, the participants of the current study while selected on the dual criteria of being diagnosed with T2D and of consuming alcohol, none of the participants used the internet to acquire information about alcohol consumption or lifestyle changes relating to alcohol consumption and their focus was solely on T2D. The participants did not conceive alcohol consumption as an issue that may have an influence on lifestyle changes and therefore, did not seek related information.

SUMMARY OF THEME 1

Theme 1 entitled “**Influence of collective determinants on lifestyle changes**” presents the experiences of individuals with T2D who consume alcohol in forging an identity that either enables or resists lifestyle changes based on the broader temporal and spatial context of the multidimensional cultural system within which they exist. The tripartite of social groups, industries and online media have a normative effect on forging individual identities and lifestyles.

The symbolic meanings society attributes to food and alcohol constructs the explanatory frameworks of everyday normality and conveys the norms of group membership that, to a large extent, shape individuals' identities. Furthermore, lifestyle modifications for individuals with T2D that consume alcohol are more difficult than for individuals with T2D who do not consume alcohol due to the greater number of memberships in social groups that are put at risk. Multiple group membership can ease the construction of new social identities for individuals with T2D who consume alcohol and can promote permanent changes in food and alcohol consumption. Also, the systematic and comprehensible labelling of the food and alcohol industry, the explicitness of the cost demands and weight outcomes relations by the weight loss industry, and the cooperative and financially sensitiveness of the pharmaceutical industry all can contribute to enabling individuals with T2D in altering their lifestyle.

Finally, experienced internet users that attain valid, genuine and applicable information and knowledge from the internet and online fora empowers them to modify their lifestyles. However, individuals with T2D who consume alcohol did not conceive alcohol consumption as an issue that may have an influence on lifestyle changes and therefore, did not seek related online information. Finally, individuals with T2D that lack the aptitude for developing membership to new social groups, that do not understand the labelling of the food/alcohol industry, the cost/outcomes of the weight-loss industry and the influences exerted by the pharmaceutical industry may resist lifestyle changes. Similarly, the lack the experience in using the internet and searching online information for alcohol consumption can as well contribute to creating additional barriers for achieving lifestyle changes.

*5.2.2. Contextual and cultural framing of lifestyle changes (**Theme 2**)*

Theme 2 entitled "**Contextual and cultural framing of lifestyle changes**" consists of three categories, namely: 1) *Impersonal approach of the NHS*, 2) *The interactional nature of support groups* and 3) *The professional and organisational culture of the NHS*. The current theme focuses on the organisational structure of the healthcare system, on the cultural characteristics of health professionals and the interactions developed between individuals with T2D who consume alcohol, and the NHS organisation, health professionals and support groups. Furthermore, this intersubjective relationships can frame positively or negatively the experiences of individuals with T2D who consume alcohol, and further ease or hamper their aim and attempts to alter their lifestyles.

5.2.2.1. *Category 1:* Impersonal approach of the NHS

The current Category entitled "*Interpersonal approach of the NHS*" focuses on the relationships between NHS healthcare professionals and individuals with T2D who consume alcohol, and the influence and impact this has in achieving or not lifestyle changes.

For participant J, states that in his experience of interacting with an NHS nurse the most memorable event is the formulaic manner with which she reports his weight targets without any attempt to elicit the reasons the for gaining weight or for being unable to lose weight. Furthermore, the participant felt that the impersonal interaction strips their interaction of any meaningful output. Similarly, participant K interactions with health professionals are expert-led interactions and unidirectional. The health professionals provide information without clarifying if the individual is able or can understand this information depersonalising the provided care and support.

> I have no problems with them (healthcare professionals), but no, they didn't provide any information about alcohol or lifestyle. They just didn't... The only thing they were worried about was my weight. I used to see the nurse, and the only thing she was worried about was my weight. The only thing she will say, was you have to take your weight down, but not nothing on how I can do that *(participant J)*

> My GP is now retired and replaced of two years ago with a Scots woman, and she is not as approachable, and as I said there with one of the nurses, I feel I cannot ask her any question. At first, I wasn't sure what to do …they didn't explain how to take prescriptions, and I was confused …simple things like that. So I didn't know anything about booking appointments for the GP, prescriptions, everything *(participant K)*

Participant J felt that there was a limited and one-way flow of information provided to him by health professionals curtailing his potential in making any decisions relating to his treatment. Participant K professed that she had no involvement in the deliberations about the treatment options. Instead, the health professionals gave her a list of things to do concerning dietary consumption. Furthermore, Participant K did not receive any information relating to alcohol consumption or how alcohol consumption may affect lifestyle changes. Finally, participant B affirmed that he as well did not have any decisional input in the practical implementation of the treatment, but was merely told what to eat or not to eat by health professionals.

> But the doctors and the nurse didn't give me enough information. I went to the hospital at (name of the city), and they just gave me this about diet, and I thought what is this? What do I do? *(participant J)*

> They gave me a list of what I should eat and what I shouldn't eat, and some of the things on the list I was doing anyway. But there was no more discussion, and for some things, I should eat I was not clear, and there was no information on drinking *(participant K)*

> The only person I've seen is this nurse recently, and they just come out with the healthy plate, it is like a pie chart of the different stuff you've got to eat, and she said don't have too many calories and balance it with what's on the healthy plate and keep off biscuits, keep off the chocolate and keep off the ice cream and cakes *(participant B)*

Participant B describes that the communication between him and the health professionals was minimal lacking compassionate and empathetic interaction and that health professional provided descriptive details for the T2D in a sterile and insensitive manner creating more anxiety, insecurity and hopelessness. Interviewee J describes the perfunctory interaction he had with the health professionals and portrays how this lack of emotional bonding and the absence of human engagement between him and health professionals created sentiments of uneasiness, frustration, and distrust towards health professionals. These sentiments created doubts with regards to the health professional's competencies and therefore limiting the impact of the health professional's role in supporting participant J in initiating lifestyle changes.

> The first the doctor saw of me was the day of the diagnosis, so the first thing he gives you is a thing saying... so you fill the form in and get free prescriptions and then you get the NHS booklet which crushes all hope. You read that, and you think right life's over... I was reading the booklet thinking - "I'll become a monk and just give up". And you think this is awful; this is it. Life's over. The doctor said you'll have to take these drugs (diabetes medication) for the rest of your life because you can't control this with diet and so I ended up having a very rough time with the drugs a rough time and this booklet from the NHS which destroys all hope *(participant B)*

> I don't get annoyed easily, but I said there is more to it, and I know the weight I need to lose, but how? I went to the hospital, and the only thing that they gave me were leaflets about what to eat and not to eat. I am not stupid. I know what you have got to eat if you have diabetes. Some people don't know, but I do, I am not silly. So I didn't seem to get any support... I had the leaflets when diagnosed, I just got the tablets, and then I went to see them, and they said no potatoes, no pasta, no bread for six weeks and that's it. Then I went to see the nurse, and she was useless *(participant J)*

Participant H describes his interactions with the diabetic nurse as merely one based on fact aggregation, whereby the nurse assumed a generic approach and avoided interacting at a personal level. The nurse's impersonal approach disrupted the potential to develop a sense of rapport with the participant, instead further agitated the participant leading to a sense of fragmentation in care provision. Similarly, participant B perceives the routinisation of the care provision processes as upsetting and coercive for his identity obscuring individual needs and health professionals reduce their input in routinely prescribing medication for the T2D condition.

> So I have a relationship with her you know the Diabetic Nurse, you know I just feel that they pass on to her after the GPs. She's just there to fill the gap. That's how I feel. I don't think it is enough you know because you know she was made to be the expert of Diabetes and I do not get answers, and she does not know me (regarding T2D condition) *(participant H)*

> So all routes lead to your doctor, and your doctor is just saying oh well you'll get used to these pills... they've got their routine they're going to hit you with drugs because that's the cheapest for NICE and if the drugs really upset you ... then try some more anti-depressant drugs if you're still getting anxious *(participant B)*

Participant D shares his experience of the effects that the financial cutbacks in the NHS have for T2D condition. The participant states that the absence of policies for prevention, early diagnosis and equity in treatment leads to more individuals developing T2D and also to subtly pass on the responsibility to individuals to do scanning tests, rather than these be part of the NHS prevention policies. Participant I expresses similar concerns for the changing nature of the NHS and emphasises on the shifting nature and reforming structures of the NHS as an organisation, and the need for individuals to seek care outside the NHS structures.

> I just feel at times with the cutbacks in the NHS, and everywhere else you keep on seeing these statistics...but they ought to emphasise more the problems that you're going to get with undiagnosed diabetes... somewhere there ought to be a system of every couple of years pulling people in for a health check, and then they can say yeah you're fine, your blood sugars are fine, your eyes are fine, everything else is fine go away for a couple of years and be happy, but I think if they've got them in there would be a lot more people they could catch... the little testing strips, people with Diabetes type 1 get those as normal, people with type 2 usually get them initially, but now they don't get them at all *(participant D)*
>
> I have never really had much support from the NHS apart from my GP; otherwise, I have not any other support … because I am diabetic, I am only going to the hospital for that, and hospitals have changed, haven't they? if you are not something urged they do not pay much attention to you *(participant I)*

Interpretive Summary of Category: This category at its core highlights a contradiction in philosophy concerning the relationship between health professionals and individuals with T2D who consume alcohol. On the one hand, the NHS culture over-emphasises the somatic manifestations of T2D and appears to overlook the complexities of the social contexts and personal experiences of individuals with T2D, and in the process depersonalises their interactions and ruptures relationships between health professionals and individuals with T2D who consume alcohol. On the other hand organisational demands, standardisation of care and the cost-cutting efforts of the NHS to a large extent regulate the caring process and as a byproduct place responsibility for the T2D condition on the person to self-manage but without any support in developing any self-managing skills. Also, for individuals with T2D who consume alcohol, health professionals do not provide information on the impact of alcohol consumption in T2D, and they do not provide any support concerning the alteration of alcohol drinking patterns.

Hence, responsibility for lifestyle alterations became a personal issue for the individuals with T2D who consume alcohol to deal with at an individual level, while treating and caring for the symptoms of T2D was done in a routine and impersonal manner by the NHS organisation. The contradiction of approach concerning symptoms and lifestyle changes for individuals with T2D who consume alcohol creates feelings of anxiety, distrust, a sense of discrimination and a notion of fragmentation in the provision of care to these individuals that essentially hampers their efforts in achieving lifestyle changes.

5.2.2.2. *Category 2:* The interactional nature of support groups

The current Category entitled "*The interactional nature of support groups*" focuses on the space, context and culture developed in support groups that enable interaction to take place, and on the role that such interaction has in developing and consolidating formal and informal types of knowledge concerning T2D and lifestyle changes.

Participant E perceives support groups as open, voluntary and interactive fora that enable the development of affiliative relations, comradeship and safe environments for disclosing personal information, sharing experiences and developing collective wisdom. Furthermore, participant I describes her conceptualisation of support groups for T2D as collective buffers for individual emotional distresses emerging from the adaptive expectations to T2D and the pragmatic realisation of the diabetes progression. Finally, participant F conceives support groups as the place where individuals with T2D gain a sense of control in accessing information, resources and support independent of established and authoritative professionals.

> I was on my first year of care when Diabetes UK set up this, and they set up this to have this new approach to diabetes and let everybody have the same treatment which they don't get, that was the whole idea of our group (diabetes support group) you know. …and then when I got transferred to the hospital and they wanted to look after my diabetes I'd regular back up with them (diabetes support group) *(participant E)*
>
> The only place I have learned about diet is here (diabetes support group). And this group helped me, it is good. And it helps me in other aspects because most of them are on insulin and I know about that, and I am avoiding going into that as can see the effect this has in their lives *(participant I)*
>
> I've only been coming to this group (diabetes support group) for about two years or a bit more than two years, so I have found out a right lot while I have been coming here... Probably coming to this group and then going… to conferences or day events... I think I have learnt a lot from coming here *(participant F)*

Participants A and G in the following direct quotations demonstrate how support groups create a sense of belongingness, foster intimacy and develop bonds amongst its members. Also, support groups provide the context for sharing not only personal stories but also allows space for creating new stories based on the interactions within the group. The support groups became for these individuals not only a forum for transmitting values and beliefs or sharing feelings and experiences concerning T2D and alcohol consumption, but also the context where they could unashamedly admit their vulnerabilities or feeling of isolation.

> I think if we can have a good Christmas party next week, we meet once a month and we have had a lot of new people just hoping that we can keep them there is a social side of the group, and this helps, well in my experience it does help, and people look forward to coming here. Here I know I am not alone and I know others, like me, feel not sure what the future has in for us *(participant A)*

> Oh yeah, that's all part of the social job of the group…the only time we have cake is when it's somebody's birthday otherwise it's a biscuit… I will have to make a birthday cake, although it's not my birthday. I think it’s a little bit like that with diabetes, but we're trying to get... at least I'm hoping to get a more social thing *(participant G)*

Finally, participants I and K acknowledge the salient role that nurses have within these support groups as they find nursing participation and input in these groups useful, helpful and necessary. The nursing input in the support group context takes on the form of providing information and assisting individuals with T2D who consume alcohol to integrate formal professional knowledge provided by GPs or nurses in the traditional healthcare contexts with informal peer knowledge available in the support groups. Importantly, participant K points out that the nursing role in the support groups differs from the nursing role in traditional healthcare contexts with the main difference being the lack of formality in approach and considers this nursing role in the support group as useful and helpful.

> I think they support me pretty well here. One of the diabetes UK nurses used to come here back in the days and used to talk, and she was brilliant. She was brilliant. She helped educate me and help me understand what to do *(participant I)*

> Again what they do here in the diabetes UK you know learning about different things it is variable from what I get from my GP. But I think the best support for changes would be the diabetes UK. I normally speak with the nurse that happens to be here, they have three nurses, and the especially two of them are very approachable and is to understand, they are very helpful *(participant K)*

Interpretive Summary of Category: The focal point of this category is the voluntary and affiliative nature of support groups and the emerging benefits these have for individuals with T2D who consume alcohol. Such groups become the trusting environments for sharing feelings, admitting vulnerabilities and developing insights from the variety of experiential understandings of other group members. Also, these social support groups provide the space for nurses to interact with individuals with T2D who consume alcohol, but within a more informal manner and as equals, thus contributing in consolidating knowledge imparted in traditional settings with experiential knowledge imparted in the social group setting.

5.2.2.3. *Category 3:* The professional and organisational culture of the NHS

The current Category entitled "*The professional and organisational culture of the NHS*" focuses on health professionals' cultural attitudes and the organisational structures of the health system, and the effect this has on empowering or disempowering individuals with T2D who consume alcohol in achieving lifestyle changes.

Participant J, in the following direct quotation, describes how the T2D condition affects and limits his capacities to make decisions and how it creates a sense of powerlessness to control his diet. For Individuals with T2D who have not adapted to their new lifestyles the dietary and drinking alterations feel as limitations in self-determination. Transgressions of the diabetes diet, as participant J states, also indicate limitations of confidence in self-controlling or making positive lifestyle shifts. Furthermore, participant B highlights the disempowering effect that contradictory messages form health professionals have on individuals with T2D who consume alcohol.

> And I have had quiches and pies and bread that is my downfall it is bread. But I am trying to keep off the bread at the minute. It is portion sizes, so instead of having one piece of chicken, I will have two. I have got a good appetite. For example, today at my lunch I had pasta I don't have this every day or every week, or I will have a jacket potato. I know they said to avoid pasta, but the last nurse told me that I could have it *(participant J)*

> Years of going in one direction seem to be changing, appear to be changing on what you are allowed to eat or drink, dieticians appear to be changing direction a little bit. When I first got diagnosed, I went on that expert course... and there was a lot of dietary stuff involved; A dietician came, and she was going on about everything being up in the air. That they have been told about four new diets and digging their heels in and not clear of the evidence and all this kind of things. In the end, I was more confused *(participant B)*

Participants F and B identify the limited interaction they had with healthcare professionals and how this created the preconditions for being labelled by health professionals as a challenging and uncooperative patient. This labelling further curtails individuals with T2D who consume alcohol potential to gain sufficient information, vent emotions, rationalise the need for change and develop a narrative of hope for the future. On the contrary, participant C describes a much more optimistic projection of adapting to required changes which she links with the opportunity to spend time with health professionals and interact with them. She was able to exchange information, to communicate with the specialist and to create a sense of hope for the future by re-focusing her life narrative.

> To be fair, we have a specialist in diabetes doctor at my practice, but I have never seen them. I have never seen them, and I've been there now about I would say four or five years, maybe even six years. I've never seen them. I see the doctor for no more than 4 minutes! Last time I went in February, the doctor said to me you'll have to go now *(participant F)*

> I had a lot of concerns about my medication. He (doctor) eventually disappeared... either he didn't know, or he didn't care to answer me... because that summer I think I must have been the 'most wanted' poster up in surgery because I went back every 5 minutes saying I don't like this (diabetes medication)... they didn't really like me, I was Mr Side Effect after a bit *(participant B)*

> He (doctor) was very helpful because the first thing he said to me was it's not your fault and I think that was so important and we had a very general discussion about life-style, about portion sizes and watching what I ate… I'm very pleased with the Health Professionals, and I see a GP at the (name of medical centre), and again he was very supportive in terms of giving me the diagnosis and reassuring me and putting it in a different view *(participant C)*

The following direct quotations attest to the highly structured and hierarchical nature of the healthcare system in both staff allocation and appointment booking. This hierarchical structure of the healthcare system significantly limits individual with T2D who consume alcohol to develop a relationship with health professionals that eventually limited individuals with T2D autonomy and created a sense of helplessness and dwindling motivation for change.

> She said you have got diabetes you have now got to eat carefully and look after yourself, and she gave me a copy of a diabetes magazine; and after that, it was like... go away and be good. At the time I thought this was awful but... went on for a year then they got a Diabetes Nurse into the practice and so now... well I used to see her every six months, I'm not sure why but it's about every year, I suspect it's money, we've got to save money so now it's once a year. The last time I went, it was a different nurse, and she probably has Diabetic Nursing experience, but I just felt it was more like a box-ticking exercise than being able to talk freely between each other. Have you, yes, tick the box, have you, yes, tick the box *(participant D)*

> At first, I wasn't sure they didn't explain how to take prescriptions, and I was confused. Simple things like this. Because it was the first time, I have been to that GP because I have been healthy all my life. So I didn't know anything about booking appointments for the GP, prescriptions everything *(participant K)*

In contrast to the above participants, the following quotation from Participant C denotes a different experience of her interactions with health professionals. Participant C conceived the interactions with health professionals to be considerate of her values, understood her capacities to change, shared decision-making responsibilities, and encouraged her to make decisions. In this way, the health professional was empowering the participant to be more confident in initiating lifestyle changes.

> It was important to have regular checks with the diabetes nurse, and she was very good because she was very encouraging. I felt that both my GP and the nurse had the right approach with me because they didn't try and tell me what to do. After all, that wouldn't have worked. They made suggestions, and because at the end of the day I know what's good to eat or drink, so it's no good telling me what I already know that. It's I guess just encouraging me to keep going, and also they were very practical both my GP and my nurse saying we don't expect you not to have any treats, so that was very good, and then I did lose quite a bit of weight, and every time I went to see the nurse, and I'd lost more she was encouraging, and one of the things she said was I'm so proud of you, and that did boost my confidence...and as I say they know how to approach me without being bossy *(participant C)*

Interpretive Summary of Category: This category highlights the expressed shock and devastation of some individuals with T2D who consume alcohol felt when they became aware of their diagnosis. The contradictory messages transmitted by some health professionals concerning their current status and future trajectory of their condition further exacerbated their shocking sensation. Also, the manner health professionals approached these individuals had a significant impact on their potential to initiate and sustain lifestyle changes. Distant, and formulaic health professionals that were easy on labelling individuals as non-compliant and detached had a negative effect and limited participants' levels of autonomy, creating further sentiments of helplessness and dwindling motivation for change. In cases that health professionals provided adequate time and space, allowed for individual's personal preferences, assessed responsiveness to change and shared knowledge, then this had an empowering effect on individuals with T2D who consume alcohol in successfully initiating lifestyle changes. Finally, the organisational structure of the healthcare system contributed to limiting their interaction with health professionals, delimited their decision-making capacities, and eventually disempowered individuals with T2D who consume alcohol in successfully achieving lifestyle changes.

SUMMARY OF THEME 2

Theme 2 entitled “**Contextual and cultural framing of lifestyle changes** "presents the intersubjective relationships of individuals with T2D who consume alcohol within the formal NHS organisation and the informal diabetes support groups. The culture of the NHS organisation appears to emphasise the hierarchical structure in its' interactions with individuals with T2D who consume alcohol. Hence, creating philosophical and practical contradiction, whereby responsibility for lifestyle alterations is a personal issue for the individual with T2D who consume alcohol to deal at an individual level, while treating and caring for the symptoms of T2D is done in a routine and impersonal manner, and is the responsibility of the NHS organisation. Furthermore, the NHS organisational structure and professional culture of health providers create an impersonal, detached and time-limited environment that disempowers individuals with T2D in achieving lifestyle changes. Also, health professionals do not correlate the role of alcohol consumption as the contextual and cultural framing that may deter lifestyle changes in T2D and do not provide any information or support with regards to alcohol consumption. On the contrary, the culture of support groups seemed to have at the epicentre the creation of space and time for individuals with T2D and nurses to interact, and consolidate theoretical, technical and experiential knowledge, thus easing lifestyle changes.

*5.2.3. The embodiment of intersubjective interactions (**Theme 3**)*

Theme 3 entitled “**The embodiment of intersubjective interactions**” consists of three categories, namely: 1) *The impact of individuals' networks on lifestyle changes*, 2) *External and internal factors impacting on lifestyle changes* and 3) *The embodied significance of food and alcohol consumption*. The theme focuses on the interactions of individuals with T2D who consume alcohol and their immediate environment of family and friends, and how individuals with T2D embody these relationships in facilitating or not the meaning-making for lifestyle changes and decision-making process for initiating and sustaining any lifestyle change.

5.2.3.1. *Category 1*: The impact of individuals’ networks on lifestyle changes

The current Category entitled “*The impact of individuals' networks on lifestyle changes*” focuses on the influences that structured networks such as family and friends have on individuals with T2D who consume alcohol in their potential altering lifestyles.

Participant K, in the following quotation, illustrates the influencing effect that a caring and an involved spouse has in supporting the individual with T2D who consume alcohol to learn about T2D and in committing to participate in networks that enable lifestyle changes. Participant G similarly refers to being accepted by friends as an individual with T2D diagnosis, and that this acceptance appears to have a cumulative impact on creating the supportive socio-physical milieu of feeling at ease with T2D and a sense of well-being that encourages the initiation of lifestyle changes.

> My wife’s major reaction was to get on the computer and research it. She used to be a librarian and do research all the time for people, so she did a lot of research. It was very useful, and she found diabetes UK (support group). She suggested the group,

> and she comes along with me to the meetings she doesn't have diabetes *(participant K)*

> I don't hide the fact that I'm diabetic, but I don't go around advertising it either. I think my friends know, certainly my close friends know. People at work may or may not know. I do have mood swings every now and again. I don't know if that's linked to diabetes or not or if it's just the way I am *(participant G)*

Participant G refers to the collectiveness of the family in lifestyle modification, whereby the entire family participates in changing their dietary habits. This family involvement creates both a symbolic value for the individual with T2D who he is not alone in the change process and simultaneously, develops a genuine and practical supportive interpersonal relationship with family members that sequentially reinforces the commitment to change. Similarly, participant L highlights the importance of being able to have meals as a family and all eating the same things. In the case of this participant, the family all changed their eating habits, and this became both a trigger and an indicator of family cohesion, making the lifestyle changes a family effort, rather than an individual issue.

> Being a diabetic, I think the diet I should be following is basically a healthy one. It's good for anybody. It's just a case of being sensible. If we go out for a meal, I don't go for the sweet tops and don't go for the fatty options that sort of thing really. It probably is my diet to be fair. You know I've cut down on food like chips and that sort of stuff. We've done it as a family really rather than just me as an individual *(participant G)*

> At first, it was a bit difficult because all of us as a family I have two teenage boys and college and things and they want something that I can't have that wasn't for very long though. After all, I gradually but slowly got them in my way of; sort of thinking, and now they enjoy some of the food I eat and things like stews with vegetables you can have a good meal and still be full *(participant L)*

Participant D expresses the lack of behavioural leverage points offered from family members in promoting changes towards salutary eating habits because family members were not only unwilling to alter their diet to support the individual with T2D. On the contrary, the family members exhibited unsupportive behavioural reactions by mocking participant 's D new dietary requirements. Likewise, participant E felt that family traditions and misconceptions of family members concerning diabetes were unhelpful in promoting behavioural change, as the tradition of gifting wines when returning from trips directly conflicted the intentions of the son to support the change process. These family members unintentionally and contrary to their wishes, did not create a conducive environment concerning alcohol consumption to promote lifestyle changes for T2D who consume alcohol.

> We go for a meal out I'll choose probably a salad option or something else while they (family members) will pile in with the big meal and the big chips and everything else and would say, oh you're eating rabbit food again aren't you *(participant D)*
>
> I don't drink much now... I have, my son bring me, he has a house in France, and he brings me wine boxes. So my friend she lives opposite and what we'll do, I'll say the bar's open and she comes across, and we have a glass of wine with our meal *(participant E)*

Participant A implies that the family norms that emerge from family members' interactions and other social actors with which the individual with T2D who consume alcohol interact can impede lifestyle changes for these individuals. The following participant highlights both how his wife and peers in his club retain what they conceive as normal or usual behaviours and how these became a temptation for the individual to not give up his old eating habits, despite his educational awareness of the need to change. The participant feels concerned deviating from what family and his social environment conceives as mainstream. The consequence of this is to weaken his resisting capacities to the temptation of reverting to previous lifestyle behaviours, thus making any attempted lifestyle change unsustainable.

> No, it's been a gradual thing, and as I've gone to various lectures and talks and what not and read various illustrations I feel that I do understand the changes I need to do, I've grasped it now. My wife still buys this stuff you know… and sweet stuff, I go to a youth club every Wednesday, and two ladies always bring some food; they always finish off with sweets. But I do feel guilty if I see a little chocolate roll, we've got some at home, these little chocolates they are like marshmallows and I like them *(participant A)*

Interpretive Summary of Category: This category highlights the role family and friends or peers have in creating norms and narratives of interaction and how these norms and narratives influence the lifestyle change potentials of individuals with T2D who consume alcohol. In cases that family and friends understand the need of individuals with T2D for a lifestyle change, they can re-frame the social milieu in which they interact and make the lifestyle change a collective process, thus enhancing family cohesion and reinforcing commitment to change. Contrastingly, in cases where family and friends either misconstrue the change process, or prioritise family tradition over change, then, and despite their intentions, they exacerbate the preconditions that limit the potential of individuals with T2D who consume alcohol to self-control. Moreover, it appears that family members are unaware of the role that alcohol consumption has in inhibiting lifestyle changes and unintentionally family members by encouraging alcohol drinking may inadvertently further discourage lifestyle changes in individuals with T2D who consume alcohol.

5.2.3.2. *Category 2:* External and internal factors impacting on lifestyle changes

The current Category entitled "*External and internal factors impacting on lifestyle changes*" focuses on the interaction of external and internal influences that shaped the personality of individuals with T2D who consume alcohol and how these affect their potential in achieving lifestyle changes.

Participant B in the first quotation, illustratively denotes how his waning coping power has shaped his capacities to resist eating sugar products and to consume alcohol. Furthermore, participant B viewed the sustainability of lifestyle change as a challenge and struggle that requires ongoing commitment and strong will power. Participants F and L similarly view lifestyle changes as a challenge, but finding meaning in the change process and relying on previous experiences of successfully dealing with health issues create an embodied memory and a sense of self-fulfilment emerging from the change process. These memories and experiences enabled them to confront and deal with the demands of lifestyle change concerning T2D.

> I'm trying to diet down, so I can get rid of this weight. I'm just trying to get as much exercise as I can and get rid of this weight. I got my weight right down to 16 stone, but it's crept back, so I've got to creep it off again... I drink a lot less now than I used to drink before I got diagnosed, but I think it's still a bit too much. It's crept up again with the weight *(participant B)*

> I have changed physically, and I've changed my mind about food, I've changed food, obviously yes. I haven't missed not eating a lot of food, and I never have, I've not missed not having a drink every night. I just did it, and that's it. I just decided to have it once a week and enjoy it once a week, and that is it *(participant F)*

> I like reading things, I have had to because with my other problem my neuromuscular disease. So from experience, I have had for learning about that condition I think it set me up quite nicely to pick up on what was good with diabetes and what wasn't good with diabetes *(participant L)*

Furthermore, the following direct quotations from participants F and B demonstrate that lifestyle changes do not occur incidentally or that it is an easy process. On the contrary, it is an act of will that requires conscious and effortful actions on behalf of the individual with T2D who consume alcohol. The participants' descriptions of these conscious lifestyle change processes include phrases as "I *keep plodding on*" or "it is *on-going wrestle*" or "it is *laborious*". These phrases signify that while lifestyle changes are a conscious process, nevertheless they are potentially difficult and unpleasant to materialise requiring significant mental stamina and cognitive effort on the part of individuals with T2D who consume alcohol. Furthermore, both participants appear cognizant that lifestyle changes are not only an intentional and conscious process but also this process that needs to integrate with other life events, such as professional life. It needs to become embedded in routine ways of doing or thinking to become automatic and habitual, and eventually become sustainable.

> I'm 3 pounds of my ideal weight of 15 stone, it took me eight and a half years, but you've got to keep plodding on you see. I'm a great believer that plodders are better. I have very low blood pressure, always have had low blood pressure because I never let things bother me; I just don't... I do believe that, and there is a bit of a religious aspect to it I think *(participant F)*

> From one week to the next I went down 7 lbs, and I thought crikey that's fantastic so I made another appointment and she said to keep a food diary. You keep a food diary for a bit, but after a bit, you think it's a bit more laborious trying to remember every single thing you've had, and the weight creeps up…Well, it is an on-going wrestle to get rid of this weight and find some kind of work or employment or thing to do so that I can live and... get some kind of job, software development or anything else. I might do other things like film extra or...I do photography, as well ... *(participant B)*

Participant L underscores the deterring effects that intense emotions have on her internal motivation to initiate lifestyle changes suggesting that when she underwent significant emotional turmoil, she increased the levels of alcohol consumption. Interestingly participant L highlights that the triggering of alcohol consumption may not relate to issues of T2D, but be a result of other unrelated emotionally intense life events. Participant J demonstrates that even in cases that intense emotions are not present, this does not necessarily imply that the individual with T2D who consumes alcohol can easily achieve the desired lifestyle changes. Participant J indicates that the mere sense of urgency for a fast and efficient process of lifestyle change with the potential of failure in achieving the expected lifestyle changes at the level and pace required may lead to self-blaming behaviours. Such self-blaming behaviours consequently may have an overall negative effect on the lifestyle change process. Participant C also identified the need to consolidate internal and external motivators for change. However, participant C goes a step further and implies that successful lifestyle changes rest upon having choices, setting goals, initiating one’s actions for change, and accurately evaluating one’s capacity to change. In contrast, the lack of choices or the lack of the ability to set goals can create feelings that lifestyle changes are very difficult endeavour.

> One thing that has changed ...you see when my husband was alive, we used to go out with few others...that few months that he lived - he died from cancer - we went out ...I was drinking more than I was drinking normally. So I was bringing a lot of sugar in my system *(participant I)*
>
> I cheat on my diet I have been naughty with my diet I have put some weight on, and it comes round here (belly) and my arms, but I know that I have been cheating, I know... and January I have done some tests, and everything was fine ... and you need to be careful, and I know that, but I cheat. Mary (wife) has been to an expert, we have been before we went again for six weeks and it really gave us that kick start again. But I have just been cheating *(participant J)*
>
> So that's been positive, it's just sometimes when you've got a busy weekend and do not have the time to go to the gym I feel oh no I haven't done what I should have done. That's the hardest thing, the time *(participant C)*

Finally, participant G reports an unwillingness to accept the chronicity of T2D out of fear of discrediting his identity as a healthy individual and disrupting what he considers as a healthy life. Participants I and B revealingly outline how T2D diagnosis (re)constructed aspects of their personality that directly affect or not their potential to achieve lifestyle changes. They suggest that either others did not believe that they had a health issue as there was no immediate sign of diabetes, or that others considered that they had a moral responsibility for being a weak character and therefore developed diabetes.

> Certainly when diagnosed and I now when I went onto medication first time around I found that quite depressing because being what I thought to be a quite fit person all of a sudden you go on medication for life. I did find it hard coping. When first

> diagnosed, and when they first said oh we need to put you on medication I did fight against it because I don't know if I thought it was a sign of weakness or what really but I found that hard to cope. I found this change over quite hard *(participant G)*
>
> You know they know, and I tell them [*about diabetes and limitations of alcohol*]…it is just one member of my family just now that is not listening to anybody…They know they understand and I think if I start doing things wrong they are concerned I think they probably tell me *(participant I)*
>
> Yes, I told them (friends) about it (T2D) a few of them decided to become the food police for me so people were handing out biscuits in the office they were saying you can't have any biscuits. So a lot of people decided they'd help me with my dieting so if they saw me eating anything they'd tell me off, or if they were handing something out like cakes I wouldn't get a piece of cake... I'm not sure if some people actually thinking well it's his fault he's been overweight for so long he's now got his rewards *(participant B)*

Interpretive Summary of Category: This category focuses on the interplay between external and internal influences that impact on individuals with T2D who consume alcohol in achieving and sustaining lifestyle changes. External locus of events and internal locus of motivators are key in influencing behaviours of individuals with T2D who consume alcohol. The external locus of events includes family and friends' moral judgements and potential blame for developingT2D, the disruption of one's sense of healthiness, the inability to set achievable goals due to environmental or contextual aspects and the potential to integrate lifestyle changes in existing habitual routines. The internal locus of motivators includes personal histories of the individual in successfully achieving changes in the past, the ability to attribute meaning to lifestyle changes, the regulation of intense emotions and have the cognitive and mental capacities to focus on the lifestyle changes. Also, for individuals with T2D who consume alcohol, while the triggering of increased alcohol consumption may be unrelated to T2D, nevertheless this can negatively impact on the external and internal influences that affect achieving and sustaining lifestyle changes concerning T2D.

5.2.3.3. *Category 3*: The embodied significance of food and alcohol consumption

The current Category entitled "*The embodied significance of food and alcohol consumption*" draws attention to the under-recognised impact of the appearances and images of food and alcohol consumption, and the unconscious meaning these conveyed for inter-subjective relations and subjective gratifications.

Participants B and J both highlight that food reflects their mood and transmits information about their feelings at specific times. In this sense, food consumption takes on the role of discrete signs that convey meaning about the emotional worlds of individuals and constitutes a way for them to communicate their sentiments. Moreover, participant J states that food and eating is also an expression of collectiveness. It involves more than merely isolated choices, and it signifies routinised configurations of relationships developed with other people, such as her husband.

> I think a lot of eating is comfort eating. I think there is a lot of truth in comfort eating and if you are directing yourself at something else then you forget about eating because you are engrossed in something else... it's not too bad keeping off the biscuits and chocolate as long as you get some exercise because the exercise is a key thing as well *(participant B)*

> I felt abandoned really this was 26 years ago, sometimes it comes over me... I didn't have diabetes back then, and I think over the years I was comfort eating when Paul (husband) died plus drinking a little bit while I shouldn't be drinking, but I don't do that now you just come to terms with it you know *(participant J)*

Participant D underscores the centrality that alcohol consumption has for him in developing a sense of belonging within a group and for constructing a social identity through the common interaction of alcohol consumption with other social players such as friends, peers and colleagues. Participant B went on to identify alcohol consumption as a mechanism of relaxation, of overcoming personal tensions and of attaining personal gratification. Furthermore, and despite efforts to reduce alcohol consumption, he felt that he missed drinking alcohol and that he needed to recommence alcohol consumption to relax and unwind. Participant B highlights the added effect that alcohol consumption has for individuals with T2D linking alcohol consumption to stress relaxation and potentially using it as an adaptive response to other life events.

> We do 10 miles, and one of the things to look forward to was always that first pint when you went to the pub because we always went for a meal afterwards. That first pint virtually went straight down straight away, and then you get another one to go with the meal... that first one was just like nectar going straight down, and now it's the half-pint, and instead of putting it straight down it's sipping it slowly and then have another half with the meal *(participant D)*

> Before I got diagnosed, I drank more. Then when I got diagnosed, it went right down to next to virtually nothing. I think that helped. That got rid of the weight. Since I've been out of work, it's crept up a bit, being out of work. You're so cheesed off being out of work; being out of work doesn't help. It helps in one way that you can get exercise rather than sit at a desk all day, so it's good for that. On the other hand, it's stressful thinking when I am going to find a job and alcohol helps me relax and not think all this *(participant B)*

Participant J reveals that he feels that he does not have sufficient information on the linkage between T2D and alcohol consumption, and also feels unable to conceptualise the connections between excess consumption of alcohol and food consumption. At the same time, he suspects that alcohol drinking alcohol may be the reason he also gained weight. Furthermore, participant D indicates a possible misunderstanding of how T2D treatment works and suggests misconstruing medication intake as the means for maintaining previous lifestyles of food and alcohol consumption.

> Well, I don’t know (the relationship between T2Dand alcohol). No, I have never had that information... Before my diagnosis obviously, I went out to drink, whether that was the reason I put the weight on and I got diabetes I don’t know. I wasn’t an alcoholic, but I used to drink a lot of wine before my diagnosis, so maybe when you look back I think I got it for a while (diabetes) before my diagnosis *(participant J)*

> One of the things there that shocked me at times was people who are on medication of one kind or another would say oh we went out for a binge the other night, you know they had a massive meal and a lot of alcohol, so I just took some extra tablets for that *(participant D)*

Interpretive Summary of Category: This category highlights the significance that food and alcohol consumption has for individuals with T2D who consume alcohol and develops linkages between food and alcohol consumption, and their emotional states and relationships with others in the context of their daily lives. Also, excessiveness in the consumption of either food or alcohol feeds into each other, leading in this way to excesses consumption of both. Food and alcohol (over)consumption took the form of habitual behaviour and an unconscious mechanism for potentially developing relationships and for achieving personal gratification. Furthermore, alcohol consumption takes the form of an adaptive and coping response to other life events. In contrast, non-alcohol consuming individuals with T2D have learned or developed other, not related to alcohol consumption, adaptive or coping responses to deal with the stresses of life events. This habitual and unconscious manner of consuming food and alcohol allows for its effects to be under-recognised and largely unarticulated.

SUMMARY OF THEME 3

Theme 3 entitled "**The embodiment of intersubjective interactions**" presents the personal intersubjective interactions developed between individuals with T2D who consume alcohol and other individuals within the context of their everyday existence. The embodied personal histories, the mental capacity to consciously make choices, and the ability to provide meaning to changes in food and alcohol consumption by individuals with T2D who consume alcohol are influenced by and from their immediate daily interaction with family, friends and other social networks.

Individuals with T2D that consume alcohol are open to the influences of their environment. When this immediate environment is ready to make their lifestyle change a collective process, this eases the process and reinforces the change. In contrast, in cases that the change does not make sense to the immediate environment, this impedes and hinders the lifestyle change. Moreover, family members are largely unaware of the deterring role that alcohol consumption has for lifestyle changes, ergo unintentionally encouraging alcohol drinking and inadvertently discouraging lifestyle changes in individuals with T2D who consume alcohol. Also, a relationship emerges between excessiveness in consumption of food and alcohol with excess in either one leading to an excess in the other. These interactions and regularities of relationships amongst individuals with T2D that consume alcohol and their immediate environment of family and friends are instrumental in understanding the choices made between alternative lifestyles. Furthermore, for individuals with T2D who consume alcohol, alcohol consumption can take the form of a coping response to other, unrelated to T2D, life events increasing the overall alcohol consumption of these individuals. Hence, adding an extra barrier to the process of lifestyle changes for individuals with T2D who consume alcohol in relation to non-alcohol consuming individuals with T2D. Unforeseen and unrelated life events may trigger excessive alcohol consumption in individuals with T2D who consume alcohol and this, in turn, can trigger excessiveness in food consumption.

*5.2.4. Being and well-being with T2D (**Theme 4**)*

Theme 4 entitled “**Being and well-being with T2D**” consists of two categories, namely: 1) *Attunement to lifestyle changes* and 2) *Stabilising lifestyle changes and progressing*. The theme focused on the actualisation of lifestyle changes, the ownership and stabilisation of the changes, and the feelings of wellness and well-being with the materialised changes.

5.2.4.1. *Category 1*: Attunement to lifestyle changes

The current Category entitled “*Attunement to lifestyle changes*” focuses on the elements for actualising lifestyle changes among individuals with T2D who consume alcohol and the anticipated characteristics of the well-being of these individuals, once they are at peace with their altered lifestyles.

Participant G highlights the centrality of owning the lifestyle changes and attributing worthiness to the change without this being an externally imposed outcome or an obvious consequence of the T2D diagnosis. The lifestyle change for this participant is a result of free will and of conscious choice that positively affects a variety of other aspects of his life and does not feel as if imposed by the T2D situation. Thus, enabling him to pursue his life goals and to fulfil of his life potentials. Participant H concedes that his variations of mood and outlook towards life, in general, affect his ownership of the lifestyle change. In return, this affects his ability to realise these lifestyle changes and eventually fulfil his life potentials.

> I have done half marathons and full marathons and stuff. More recently, I have not really done a great deal to be fair, but I do try and go jogging, and I keep myself fairly fit. I try and watch my diet. I think it's being aware of it and trying to do the exercise and consciously trying to do it. I mean it does help with diabetes, but it also helps other things obviously for the body, for stress levels and stuff *(participant G)*

> My biggest challenge is to go to the fitness club and also the diet as well as how to cook and get used to it. I do not feel I have achieved even half of it. Things I used to do I cannot do them because it is difficult. The little bit I have achieved... I try to stay fit, keep a regular weight instead of heavy on weight still, I am struggling with that. I would say psychologically you know I think I was thinking of a psychological achievement because I do not allow it to take me down *(participant H)*

Participant C points out the critical role his interactions with a nurse have in adapting to a new lifestyle. The evolved interpersonal relationship and intersubjective communication between himself and the nurse allowed him to construct a shared meaning, and integrate each one's perspectives into the other's, creating a shared world of common understandings. This participant accepts that there are goals to meet, and the nurse accepts that setting weight targets is not something the participant wishes to do. Thus, acknowledging each other's cognitive and emotional state creates the preconditions for recognising the independent subjectivity of each other. Participant L expands on this notion of shared lifeworlds to depict how shared understandings became the resources for peacefully coming to terms with the T2D lifestyle expectation of altered dietary regime and the need to reduce weight.

> I feel that it is crucial to have the appointment with (*name of the nurse*) because she has seen me at the beginning of the diagnosis. She set us some goals which we did together, and I just feel it is important that you have the same person there that you have set your original goals with and you can see them coming to fruition...She did not set goals in terms of weight loss which I thought was quite good. But every time I was going to see her, she would put the weight down at the side because I asked her to do it so that I could see that I was losing weight *(participant C)*

> I try to eat a bit of porridge with water and a little bit artificial sweet maybe a bit of coconut in it. That will be my breakfast it will take me up to dinner I will have a can of soup, and at the evening meal I usually have a fairly full meal, but I am careful what is in it. Now I do not have as much rice and pasta as I used to. For the first few months of being diagnosed, I was a bit experimental to tell you the truth, and I worked this out with my nurse. After the three months discussions with my nurse I got

> my head around the eating regime I got a good sense of what I could have and what I could not, and after the first three months I have got my weight down *(participant L)*

Finally, participant G describes his sense of rhythm and familiarity with his new and now altered lifestyle and describes how he feels comfortable with the day to day activities and is at ease with the new patterns and routines of life. Respectively, participant F indicates that he is now at a personal state where he feels comfortable with his lifestyle changes concerning alcohol intake. Furthermore, participant F indicates that he has personally grown and this is both the driving force for further reducing alcohol consumption and for assigning meaning to the altered lifestyle.

> I think coming to terms with having the medication day in day out, having to be organised to order repeat prescriptions, pick up the prescription, don't run out, when I go on holiday make sure I've got enough, and you know to plan all those sorts of things *(participant G)*

> Yeah, I mean there's a lot of sugar in alcohol, I have never liked beer really, but as I say I like whiskey, so I know that in spirits there is a lot of sugar...when I had a glass, I used to have a double every night, so I was having quite a lot of sugar, well having a seventh of that must make quite a big difference *(participant F)*

Interpretive Summary of Category: This category highlights that the actualisation of lifestyle changes occurs once the individuals with T2D who consume alcohol are in the mood for and attuned to the change requirements, consider these lifestyle changes worthwhile and attain ownership of them. Furthermore, the empathetic awareness and sharing of reality with others humanises the lifestyle change process and promotes peaceful acceptance of the change when conceived as the result of free will. The coming to terms with the lifestyle changes, feeling comfortable with the altered lifestyle state and developing a vision for the future provides the promise for personal growth for individuals with T2D who consumes alcohol to initiate and sustain such changes.

5.2.4.2. *Category 2*: Stabilising lifestyle changes and progressing

The current Category entitled "*Stabilising lifestyle changes and progressing*" focuses on stabilising lifestyle changes, and creating new, alternative and healthier lifestyles. The stabilisation of the lifestyle changes relates to individuals with T2D who consumes alcohol state of mind and their potential to conceptualise their situation. Also, the sense of the progression of these individuals in their new lifestyle constructs is key in achieving happiness, positiveness and well-being.

One of the forces for stabilising change mentioned by participant D is to treat the diagnosis of T2D as an opportunity and a starting point for bringing to the forefront the unhealthy lifestyles and the desire of directing one’s life to a different place from the one currently living. Participants C and E similarly report feelings of being energised in achieving and maintaining their lifestyle changes and that they find in this motivation a sense of positiveness for life and happiness for their efforts to change. This sense of growth constitutes the inner resources for individuals with T2D who consume alcohol in maintaining, promoting and living well with their altered lifestyles.

> I think I got T2D because when I was working, I was away from home quite a bit, so you have a large English breakfast to start with, sandwiches for lunch, probably white bread. Also, because you are staying at hotels, it is the three-course dinner and a big piece of cake and a couple of pints a night to go with it. Once I got my diagnosis, I said right I've got to do more than this, so I started going to exercise classes. I've also changed my alcohol consumption because before... you know you go out with friends so that you would be walking home from a local hostelry and it would be probably 3 pints regularly, occasionally 4, and then I always used to like whiskey *(participant D)*

> Yeah, I think I have come to terms with them [changes]. So at the moment, it's been quite positive, and I have managed to cope with the lifestyle changes. I think it was really positive effect being diagnosed with type 2 diabetes because it has made me look at what I eat, I have lost a stone and a half, so the health benefits of that hopefully are going to be good for my health *(participant C)*

> Just live a day at a time. I'm glad when I wake up every morning, be with my family... I just keep happy because I am alive and I keep well, that's my main thing, to keep going and keep happy *(participant E)*

Participant B reveals that before his diagnosis, he had a specific mindset about the future and that he took the future for granted considering it to be ordinary, familiar and predictable. It was at the point of his diagnosis with T2D when it occurred to him that the future is not only unpredictable, but it can as well become unsatisfactory, “*crushing all hope*” of living his life as originally envisioned. Therefore, he commences on the venture of developing new horizons and seeks to create new possibilities to find a new place of promise and retain a sense of optimism for the future. Participant G similarly views the diagnosis of T2D as both a destabilising process for his expected life trajectory and a potentially edifying event that allows for the exploration of alternative ways of living. Thus, making the diagnosis of T2D a disturbing event that opened up the possibility to self-understanding and to pushing previously accepted limits of life's horizons. All this consequently allowed space for exploring new places, and to view these new or alternative horizons from a different perspective.

> When I say this booklet crushed all hope, one thing after I read that I started looking myself, going on the internet and looking, finding out what you can then find out what books there are... basically trying to find out information on what T2D is all about. There is a bit in there saying that in some cases, diabetes can disappear. I thought a ray of hope! So I thought the way forward is to find out as much as you can yourself about this *(participant B)*

> I'm very grateful that for being diagnosed and know what I have, that keeps my life going longer than it would do otherwise because without knowing I would have failed to change anything, and so I'm ever so grateful for everything that does happen, and I think I'm aware that I've got to do my bit, the exercise, the diet, reduce the alcohol *(participant G)*

Finally, participants D and K in the following direct quotations explicate why and how they have avoided stagnation in the ordinary and familiar life trajectories. They outline how they have found meaning in their newly developed vision of the future, how they could see and imagine themselves living this future, and eventually that they could progress as individuals and social actors.

> I can see us doing more cruising... so I can see myself going on a cruise but yes getting up every morning and doing that [excercise] and probably doing it later on in the afternoon or at night time... so she's [wife] quite happy to sit with a book in a cafe while I go off for a couple of hours or more and then come back again, so we enjoy ourselves that way *(participant D)*

> I am getting close to a time where I have plans for more working and exercise. I am just gradually adjusting to what and the aims of every day. My father, when he retired, he did not know what to do, and in the end, he actually turned to alcohol… whiskey a bottle a day, so I thought I would last longer than him. Increasing exercise is my main plan. Planning where we are going next year cause everywhere, we are going with the caravan there is plenty of cycling and hiking. I don't think diabetes will affect these plans *(participant K)*

Interpretive Summary of Category: The current Category entitled "*Stabilising change and progressing*" focuses on the stabilisation of lifestyle changes and moving on in life with the changes becoming part of daily normality for individuals with T2D who consume alcohol. While T2D was a disruptive event in all of the participants' lives, nonetheless individuals that successfully adapted to the required lifestyle changes conceptualised T2D as an opportunity for dealing with already unhealthy lifestyles and expressed sentiments of happiness and positiveness for the future. Finally, these individuals felt a sense of progression, growth and development, and exhibited a sense of well-being with their new lifestyle and with their T2D situation. In these cases, individuals lived their life with a sense of wellness despite the T2D and the altered lifestyle or possible because of their T2D diagnosis.

SUMMARY OF THEME 4

Theme 4 entitled "**Being and well-being withT2D**" suggests that the actualisation of lifestyle changes depending on the mood of individuals with T2D who consume alcohol, on their ownership of the lifestyle change and on considering it worthwhile. The development of empathetic relationships, the notion of free will in initiating changes and the construction of a vision and promise for a better future are the preconditions for developing the mood, ownership and worthwhileness of the lifestyle changes. The final step is feeling at ease with the new lifestyle and stabilising the change by making it part of daily life. The notion of progression and growth is pivotal for the participants of the current study in sustaining their new lifestyle. Individuals with T2D who consume alcohol who reached to the point of viewing lifestyle changes as progression and part of their personal growth, also describe a sense of wellness and well-being despite the T2D.

5.3. Tentative Framework - Section 2

This section includes the development and presentation of the Framework of Well-being with T2D (FWT2D) and the analysis of its relevance to the daily reality of individuals with T2D who consume alcohol. The Framework comprises of four constructs that emerge from the themes developed in the previous section, namely:

1. **Influences of collective determinants on lifestyle changes**
2. **Contextual and cultural framing of lifestyle changes**
3. **The Embodiment of intersubjective interactions**
4. **Being and well-being with T2D**

The above themes constitute the components that construct the Framework of Well-being withT2D. This section presents the components in a layered fashion with the first theme/ component constituting the outer layer of the framework, and the fourth theme/component constituting the inner layer of the framework. The underpinning philosophy of the FWT2D is for individuals with T2D who consume alcohol to reach a state of well-being that constitutes the inner layer of the framework it requires first to consider the collective determinants, consequently the contextual and cultural aspects that are necessary for enabling intersubjective interactions to reach a state of well-being. This ordering ultimately led to the achievement of the well-being outcome that is at the heart of the component of the Framework. Each component of the Framework is as well explicated by pictorial representations that develop as the Framework progresses to build the final pictorial representation of the FWT2D. Also, the Framework identifies relationships within and across the four components, and develops these relationships and represents them pictorially to provide comprehensive explications and explanations.

5.3.1. Influences of collective determinants

The ***influences of collective determinants*** focus on societal aspects such as systems of social group membership, industries and online media (see Figure 1) that have a normative effect in reproducing lifestyle values and canonising human behaviour. Individuals are part of various social groups, such as peer groups, recreational gaming groups, extended family and groups of friends and colleagues. These social groups attribute symbolic meanings to food and alcohol, including the type and quantity of consumption. The symbolic meanings attributed to food and alcohol convey information about the norms of the social groups. Transgression of these norms disrupts the normality of these social groups and puts in question individuals' membership to the group. Individuals with T2D who consume alcohol have an additional burden when compared to non-alcohol consuming individuals with T2D because these individuals put at risk more memberships in social groups making lifestyle changes a more disruptive process.

Figure 1.

While the norms of social groups influence individuals with T2D who consume alcohol, and these individuals do not directly influence the social group norms. Membership in multiple social groups makes the potential rejection from one social group less stressful, and individuals more willing to openly transgress the norms of the social group to achieve their lifestyle changes. Maintaining or developing membership in multiple social groups can create the feeling to these individuals that they can afford to lose membership in some of those groups and still maintain a social identity.

The food and alcohol industry, the weight loss industry, and the pharmaceutical industry all appear to influence the lifestyle changes of individuals with T2D who consume alcohol. These industries represent impersonal mechanisms that lack systematic and comprehensible procedures for appropriate labelling of food and alcohol, for matching people in weight-loss programmes, for explicating links between costs for weight loss and weight outcomes, and for timely reimbursing medications and equipment. Individuals with T2D who consume alcohol do not feature high in the priorities of the above industries. However, these industries influence individuals with T2D in their choices and preferences, and consequently, these choices affect the successful implementation or not of lifestyle changes.

Finally, the internet, online information and virtual online fora are useful knowledge sources and network systems that have a positive effect on supporting lifestyle changes for individuals with T2D who consume alcohol. However, the variety of types and significant quantities of online information and online fora suggest that inexperienced individuals with T2D who consume alcohol may find it difficult navigating away from inaccurate and misleading information from the internet. The internet is influential in assisting lifestyle changes for individuals with T2D who consume alcohol, but only if the individuals have sufficient experience in using it or have adequate support in learning how to use it. Also, even in cases that individuals have sufficient navigating knowledge of the internet concerning T2D, alcohol consumption remained a hidden issue. Individuals with T2D who consume alcohol did not seek out information in their internet-based searches and interactions as they did not self-identify as having alcohol issues or did not consider that alcohol drinking influences their lifestyle changes.

5.3.2. Contextual and cultural framing of lifestyle changes

The ***contextual and cultural framing of lifestyle changes*** focuses on the relationships between the care delivery systems and individuals with T2D who consume alcohol and these include; a) Impersonal approach of the NHS, b) the interactional nature of support groups, and c) the professional and organisational culture of the NHS (see Figure 2). The provision of care by the NHS is

Figure 2.

characterised by formality in structure and neutrality in interactions. Also, the care needs of individuals with T2D who consume alcohol do not emerge from their interaction with health professionals. Instead, health professionals conceive the potential care needs and encapsulate them general guidelines or categories.

Also, decision-making is not a shared endeavour, and there is an evident power disequilibrium between professionals employed by the NHS and the individuals with T2D who consume alcohol. NHS professionals are the dominant party in this relationship, and they usually impose their decisions about lifestyles on individuals with T2D without always or fully taking into consideration the experiences and beliefs of these individuals. Health professionals emphasis is on the somatic aspects of individuals with T2D and not on their well-being. Also, the NHS reproduces the norms and values that are essential in sustaining the organisation, such as standardisation of practice, maximal usage of the limited available time and fragmentation of activities. These norms and values further contribute to depersonalising the interactions of NHS health professionals and individuals with T2D who consume alcohol.

In contrast, the context of Support Groups provides both the space and opportunities for greater levels of interaction with individuals with T2D who consume alcohol. Support Groups have a loose structure, lack formality and roles are not strictly defined. This context allows for the expression of individuality and the consolidation of different types of knowledge. The types of knowledge available in Support Groups include primarily personal wisdom and experiential knowledge that, to a degree, lacks the validity and rigorousness of formal or scientific types of knowledge. The formality and highly structured context of the NHS, while providing valid knowledge, nevertheless due to its structure is not usually conducive to supporting lifestyle changes of individuals. The informality and relaxed structure of Support Groups, while more conducive to supporting lifestyle changes, nevertheless provide knowledge with validity limitations.

Finally, in cases that health professionals adapted hastiness in communication, detachment in approach and labelling in terms of compliance as professional attitudes in their interactions with individuals with T2D who consume alcohol lifestyle changes become much more difficult to initiate and sustain. In cases that health professionals allowed adequate time and space for interaction, listened to individual concerns and included in the decision-making the personal preferences of individuals with T2D who consume alcohol lifestyle changes become easier to initiate and sustain. The participants of the current study indicated that the first set of professional attitudes are encountered primarily in NHS structures, and the second set of professional attitudes are encountered primarily in Support Group settings. Also, in both NHS structures and Support Group settings, health professionals are either unaware of the effect of alcohol consumption on the lifestyle changes of individuals with T2D who consume alcohol or consider that alcohol consumption should not be a priority of care.

5.3.3. The embodiment of intersubjective interacting

The ***Embodiment of intersubjective interactions*** focuses on the relationships that individuals with T2D who consume alcohol have with significant others and with their self, and includes: 1) The impact of individual's networks on lifestyle changes, 2) External and internal factors impacting on lifestyle changes and 3) The embodied significance of food and alcohol consumption (see Figure 3). The current study identifies that in cases lifestyle changes a collective issue for the family or group whereby the family members, friends and peers actively commit to altering their food and alcohol patterns this both eases and reinforces the initiation and sustainment of lifestyle change processes. In cases that the lifestyle changes do not make sense to this immediate environment, they deride the

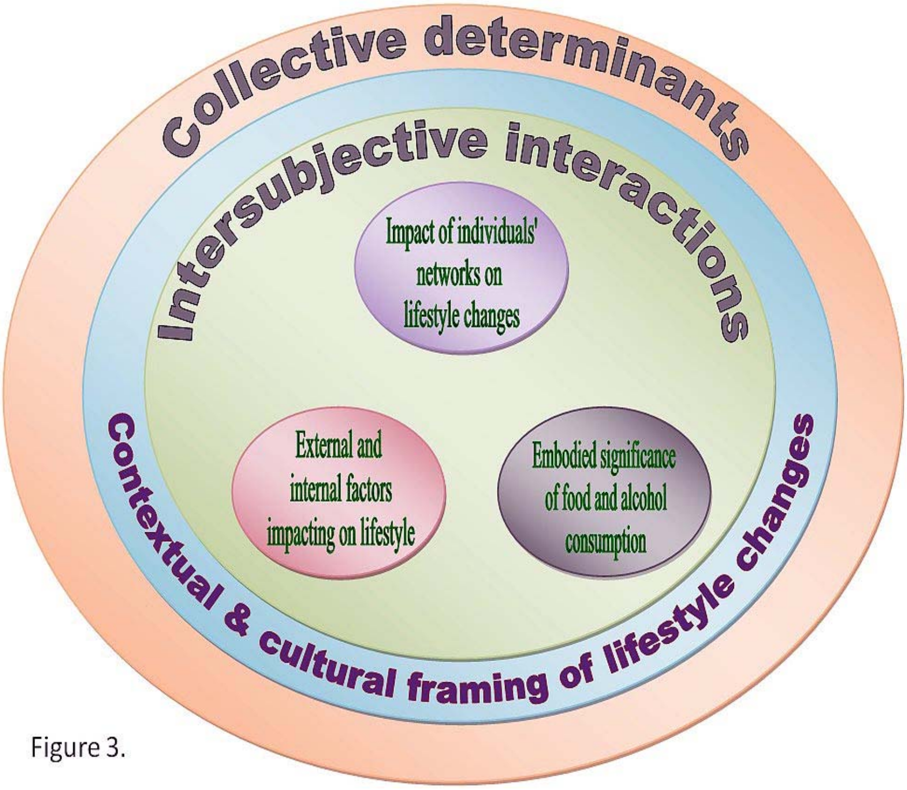


Figure 3.

change process and overemphasise the importance of family traditions or the significance of past lifestyle patterns that hinders the initiation and sustainment of lifestyle changes. Even in cases that the immediate environment is aware of the significance of lifestyle changes for T2D they appear to be unaware of the role that alcohol consumption has in inhibiting lifestyle changes and unintentionally may be encouraging alcohol drinking and inadvertently discouraging lifestyle changes. Also, individuals with T2D who consume alcohol can influence the attitudes that family, friends and peers hold with concerning lifestyles.

A relationship exists between excessive food consumption food and excessive alcohol consumption with excessiveness in the consumption of either food or of alcohol feeding into each other, leading in this way to excesses consumption of both. Also, in the case of individuals with T2D who consume alcohol, the consumption of alcohol can be triggered by unrelated to T2D life events and take the form of coping response that in turn can trigger excessiveness in food consumption. The immediate family environment, as well as friends and peers, can contribute to the construction of narratives that attribute positive meanings to lifestyle changes or can construct narratives that attribute negative meanings to lifestyle changes. Positive lifestyle change narratives provide context and meaning to the proposed lifestyle change and make understandable the need for the lifestyle changes and interpret this change via recognisable explanations to both individuals with T2D who consume alcohol and the individuals in their immediate environment.

5.3.4. Being and well-being

The ***being and well-being of T2D*** focus are the actualisation and stabilisation of lifestyle changes by individuals with T2D who consume alcohol (see Figure 4). The mood of individuals with T2D who consumes alcohol has a significant role in the actualising lifestyle changes. A positive mood for lifestyle changes usually emerges from viewing T2D as an opportunity to deal with existing unhealthy lifestyles and from a sense of free will to initiate the changes, eventually leading to ownership of the change process. Lifestyle changes when forced or felt as such are unsuccessful. On the contrary, when the individual has the central role in designing both the change process and developing a vision and promise for a better future, then the change can actualise.

Furthermore, when individuals with T2D who consume alcohol feel that the altered lifestyle is part of their daily life and feel they can progress and grow as individuals and as part of a collectiveness, then the lifestyle changes can stabilise. The stabilisation of the lifestyle changes for individuals with T2D who consume alcohol signifies their potential to transform what would otherwise be conceived as a pathological condition to a new way of viewing and anticipating health. This altered view of healthiness leads to feelings of wellness and a state of well-being. The attunement to the new lifestyle and the sense of progression and growth in their new lifestyle produce sentiments of well-being for individuals with T2D who consume alcohol and re-narrate their altered lifestyle as their new healthy daily reality.

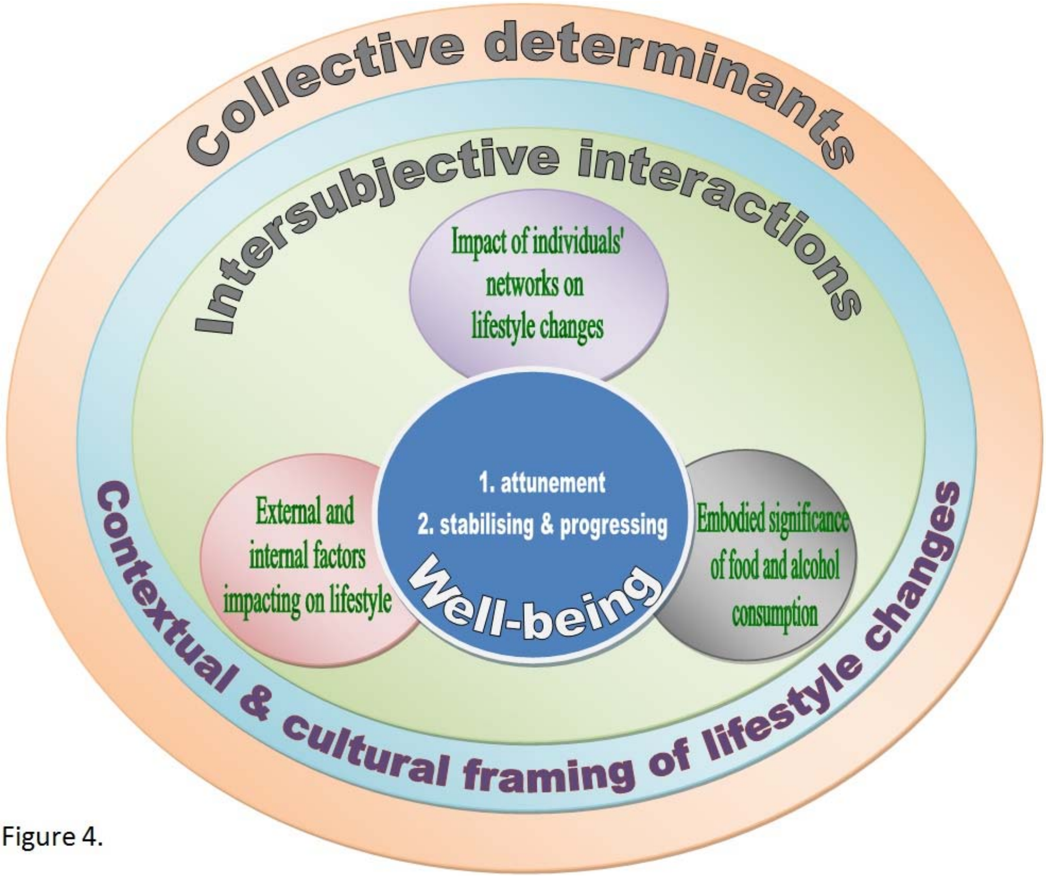


Figure 4.

5.3.5. The framework of well-being with T2D

The remaining of this section focuses on the interrelated connection of above four themes/components that construct the Framework of Well-being with T2D (see figure

5) and identify the relevance to the life and reality of individuals with T2D who consume alcohol. The *collective determinants* as represented by systems of social group membership, food/alcohol, weight loss and pharmaceutical industries and online media influence and constrain all the other components of the inner layers of the FWT2D.

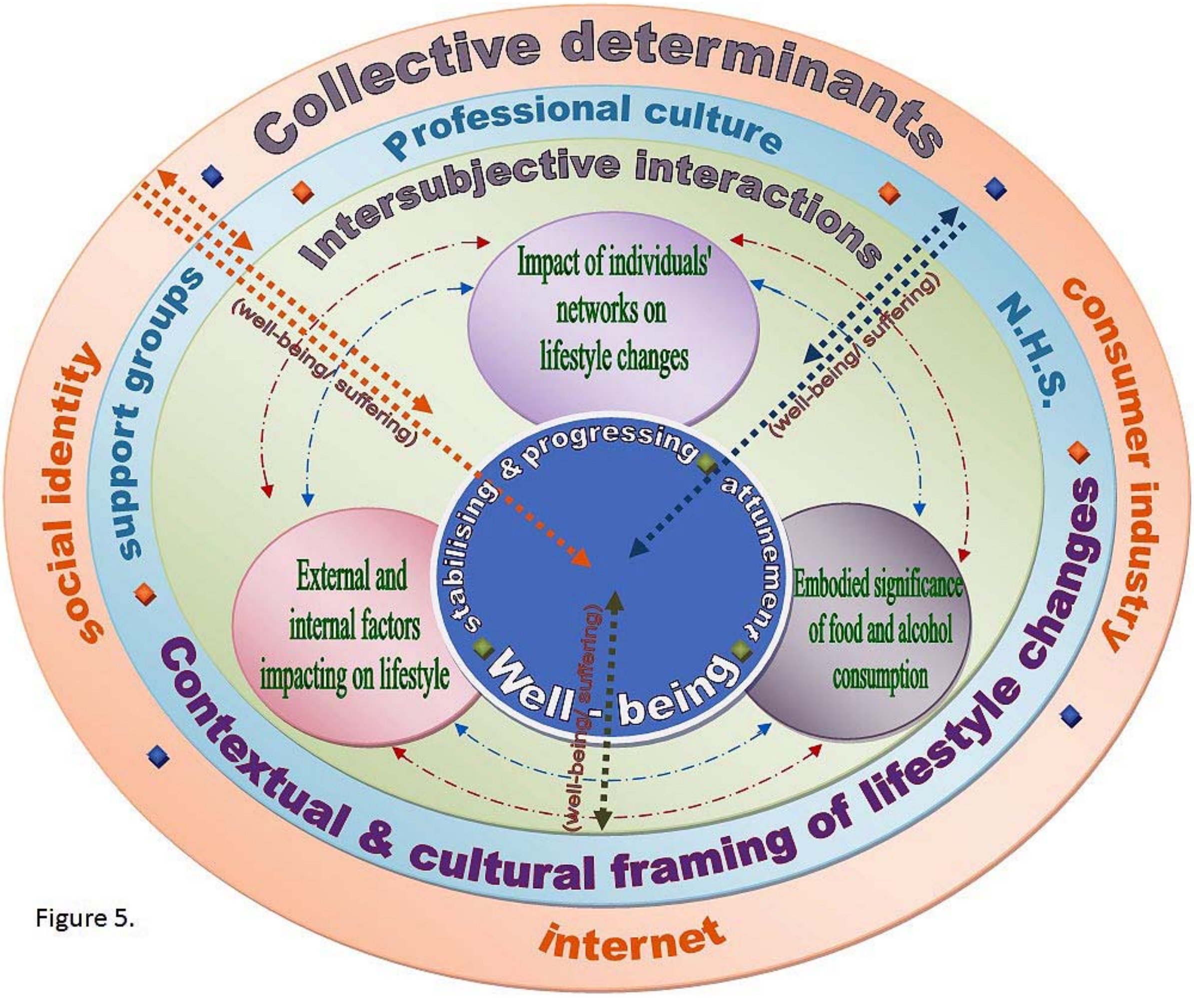


Figure 5.

The context of NHS and Diabetes Support Groups and the professional and organisational culture of care provision is affected by the norms created by the collective determinants. The social identity of individuals with T2D who consume alcohol, the quality and quantity of food and alcohol they consume, their beliefs about weight loss, their compliance to medication and their understandings of diabetes all link to and influenced by the contextual and cultural framing of lifestyle changes.

For example, individuals with T2D who have multiple group memberships use the context of care provided by the NHS and the Support Groups to develop further groups within which they interact. Whereas individuals with few social group memberships, use the NHS and the Support Groups context as a way of figuring out how they could retain membership in their limited number of social groups. Their aim is more of maintaining their previous lifestyle, at least with its main features unchanged and therefore strive to maintain their membership in their existing social groups. Maintaining and developing membership in social groups creates a sense of belongingness and directs the life of individuals with T2D who consume alcohol towards well-being. In contrast, sentiments of loss of belongingness and social displacement directs the life of individuals with T2D who consume alcohol towards a sense of suffering.

The *collective determinants* further influence the third layer of the FWT2D, namely the *intersubjective interactions*. For example, social groups and the symbolic meaning they attribute to food and alcohol can influence the narratives of family, friends and peers that are part of individuals' with T2D who consume alcohol reality. Individuals with T2D who have multiple group memberships have a greater network of interactions that provide them with multiple life narratives. Also, the individual with T2D who consume alcohol can influence of their family, friends and peers as well and the more group memberships they have, the greater this influence is in creating positive narratives of change.

Finally, the *collective determinants* influence the fourth layer of the FWT2D, namely the *well-being* of individuals with T2D who consume alcohol. For example, social groups can impact the mood and free will of individuals with T2D who consume alcohol in making lifestyle changes. Multiple group memberships with the multiplicity and variety of norms contributing in the construction of their social identity can define the mood for change (or not) and the free will (or not) to make lifestyle changes.

The second layer of the FWT2D entitled *Contextual and Cultural Framing of Lifestyle Changes* beyond the influence regarding the well-being or suffering direction it accepts from the *Collective Determinant*, it in itself has a set of influences on the well-being or suffering direction of the *Collective Determinants*. For example, the systematic and comprehensible labelling procedures of the food and alcohol industry or the comprehensiveness and explicitness of the financial costs and weight outcomes of the weight loss industry are (or should be) influenced by the health professionals. Health professionals influence these industries when using the values, preferences and needs that emerge from their interaction with individuals with T2D who consume alcohol.

Moreover, the *Contextual and Cultural Framing of Lifestyle Changes* influences regarding the well-being or suffering direction the *Intersubjective Interactions* of individuals with T2D who consume alcohol. For example, health professionals' empathy, respect for individual values, and sharing of knowledge further affect meaning-making potentials and emotional regulation of individuals with T2D who consume alcohol. Eventually, assisting in creating a sense of readiness for lifestyle changes. Both the process and product of sense-making for food and alcohol consumption and weight-loss directs the life of individuals with T2D who consume alcohol towards well-being.

In contrast, in cases that individuals with T2D who consume alcohol feel that health professionals exhibit limited empathy and respect to their values and are unable or unwilling to share knowledge comprehensibly. Such an approach from health professionals can lead individuals with T2D who consume alcohol to misconstrue the need for any lifestyle changes and feel negative sentiments for any such change. Negative sentiments of loss of meaning with regards to food and alcohol or weight-loss can direct the life of individuals with T2D who consume alcohol towards a sense of suffering. Furthermore, the lack of empathy from health professionals can lead individuals with T2D who consume alcohol to sentiments of objectification and fragmentation of identity further intensifying their sense of suffering.

Finally, the *Context and Culture of Care* influences the overall *Well-being* of individuals with T2D who consume alcohol. For example, health professionals' empathy, respect for individual values, and sharing of knowledge lead individuals with T2D who consume alcohol to consider the suggested lifestyle changes worthwhile and feeling at ease with these changes. In contrast, in cases that individuals with T2D who consume alcohol feel that health professionals exhibit limited empathy and respect to their values and are unable or unwilling to comprehensibly share knowledge, lead them to consider the suggested lifestyle change as unworthy to implement. Furthermore, in such cases, individuals with T2D who consume alcohol conceive lifestyle changes to lead to greater levels of suffering rather than well-being.

The third layer of the FWT2D entitled *Intersubjective Interactions* beyond the influence regarding the well-being or suffering direction it accepts from the *Contextual and Cultural Framing of Lifestyle Changes*, it in itself influences the well-being or suffering direction of the *Intersubjective Interactions* and the *Contextual and Cultural Framing of Lifestyle Changes*. For example, the individuals' habitual behaviours of food and alcohol consumption, and their excessiveness (or not) in consumption of food and alcohol influences the validity of the informal and experiential knowledge shared in the Support Group context.

Also, *Intersubjective Interactions* influence the *Well-being* of individuals with T2D. For example, individuals with T2D with highly habitual and excessive consumption of food and alcohol influence the anticipation of lifestyle changes as destabilising. Current and future choices that do not link with and develop from past choices and interactions with significant others direct the life of individuals with T2D who consume alcohol towards a sense of suffering. In comparison, individuals with T2D who consume alcohol with a limited or low level of habitual and excessive consumption of food and alcohol anticipate lifestyle changes as edifying. Because the individual views the self as an agent of choice that can bring together past and future choices, thus directing the life of individuals with T2D who consume alcohol towards a sense of well-being.

Also, in the third layer of the FWT2D entitled *Intersubjective Interactions* there are influences amongst the categories as well, namely: i) *the impact of individuals' networks on lifestyle changes*, ii) *external and internal factors* and iii) *embodied significance of food and alcohol consumption*. The *individuals' networks* influence regarding the well-being or suffering direction both the *external and internal factors* and *the embodiment of food and alcohol signifiers*.

For example, family, friends and peers that create a conducive environment for lifestyle changes influence the individuals' self-concept concerning their potentials to achieve lifestyle change, and in communicating their emotions primarily by other means, and not via food and alcohol consumption. Meaningful interaction with valued others develops a sense of vitality that creates the energy to direct the life of individuals with T2D who consume alcohol towards achieving change and developing a sense of well-being.

Similarly, the wilful act of using previous successful cases of lifestyle changes as a tool for achieving current meaningful lifestyle changes influences the well-being of family, friends and peers. It also influences the individuals with T2D who consume alcohol in comprehending the negative effect of indiscriminately consuming of food and alcohol onT2D. Using previous experiences and the context of family, friends and peers creates the possibility for successful lifestyle changes and for embarking on a journey of creating new horizons directing the life of individuals with T2D who consume alcohol towards a sense of well-being.

Finally, the ability to find outlets for relaxation and personal gratification beyond alcohol consumption can influence and increase the levels of self-control and the potential to set goals accurately. Achieving such levels of gratification, self-control and goal-setting creates to individuals with T2D who consume alcohol a sense of identity. This identity that emerges from past significant achievements can create a sense of success and achievement directing these individuals towards an overall sense of well-being. Such an approach to identity from individuals with T2D who consume alcohol can as well influence family, friends and peers in averting the creation of guilting narratives for irresponsible patterns of behaviour and reinforces the narration of life stories that promote lifestyle changes.

5.4. Summary of findings

This section includes the summary of key issues of the themes and the multi-layered and interlinked Framework of Well-being with T2D. The intention of the Framework of Well-being withT2D, as developed from the four themes, is to explore and understand how the well-being of individuals with T2D who consume alcohol relates to and influenced by intra-personal, interpersonal and extra-personal factors.

Furthermore, the FWT2D sought to understand how these factors influence the potential of individuals with T2D who consume alcohol to successfully alter their lifestyles and accordingly develop a sense of well-being within their altered lifestyle. The FWT2D does not provide a predictive model or a model that discovers law-like relationships. Instead, the FWT2D is an explanatory framework that explains how collective, contextual, cultural and intersubjective concepts relate to individuals' with T2D who consume alcohol potential to alter (or not) their lifestyles and in what ways these concepts act upon (or not) in creating sentiments of well-being for individuals with T2D who consume alcohol. The FWT2D does not imply that all individuals with T2D who consume alcohol react or are influenced in the same manner by collective, contextual, cultural and intersubjective concepts, or that all enveloped in these concepts function in the same way. For example, when referring to the food and alcohol industry this includes a variety of industries and a variety of products, and some industries are better than others in labelling their products, or some products may have more explicit labelling than others from the same company.

The FWT2D does not aim at depicting which industries or which food and alcohol products are not sufficiently labelled. Instead, the FWT2D aims to provide the linkages between the industries' labelling of food and alcohol products and their effects in achieving and sustaining necessary lifestyle changes of individuals with T2D who consume alcohol. Therefore, the linkages developed and the understandings created by the FWT2D provide a logical sequence of relationships that are transferable to a variety of contexts to understand and explain how the well-being of individuals with T2D who consume is influenced, what issues need to be taken in consideration to promote lifestyle changes and what it is like to live well after altering lifestyles.

The FWT2D commences with the symbolic meanings that food and alcohol have in creating social belongingness and social identity of individuals. Alteration of lifestyles due to T2D put strains on the social belonging and identity of the individual. These strains influence how the individual used the services provided by the NHS, Support Groups and health professionals. Also, it influences their mood, willingness, and the articulation of narratives that these individuals create in commencing, actualising and sustaining lifestyle change. The symbolic meanings of food and alcohol concerning social belongingness and social identity are something that the NHS, Support Groups and health professionals can bring to the forefront of their care, make individuals with T2D who consume alcohol aware of these effects and campaign within society to make explicit the role of social inclusiveness. Moreover, NHS, Support Groups and health professionals can affect family and friends of individuals with T2D who consume alcohol in including them in the process of information giving, knowledge transmission and creating the social milieu that is conducive to lifestyle modifications.

Similarly, systematic comprehensible labelling, sensitivities to individualities, and considerations of financial potentials and monetary worthiness of products created by industry are factors that influence individuals with T2D who consume alcohol and their potential to alter their lifestyles. The behaviour of the industry also influences the NHS, Support Groups and healthcare professionals in over-emphasising the somatic, pharmacological and impersonal aspects of T2D. The transmission of knowledge occurs from health professionals, either within the NHS context or the Social Support Group context. In instances where they may overlook the individual needs and subjective complexities, this usually impedes the meaningful construction of a useful lifestyle change story.

When individuals with T2D who consume alcohol lack the support in constructing meaningful stories as to why they need to change their lifestyle, they are unable to identify with the expected changes. They do not feel that they are at peace with what they need to do, and even if they momentarily change their lifestyle, they are unable to sustain the change and in all probability revert to previous lifestyles. In cases where the NHS, Support Groups and health professionals take into consideration individual values, preferences and needs, and are responsiveness to their capacities for change, then they become an advocate for individuals with T2D who consume alcohol. In their advocate role, they can impact upon the various industries, and voice concerns and make suggestions about public policy issues relating to the labelling of products, to supporting the financing of products and to highlighting the awareness of cost and benefits.

The transmission of valid and comprehensible knowledge and information from online fora or found in internet sources influence individuals with T2D who consume alcohol to change lifestyles. Also, the informality of the Support Group context eases to the transmission of knowledge and information to individuals with T2D who consume alcohol. However, this knowledge is susceptible to oversimplifications, contradictions and inaccuracies promulgated from the online fora within Support Groups.

Health professionals can as well unintentionally promote the incomprehensibility of online knowledge and information by directing individuals with T2D who consume alcohol to these fora leaving the information largely unelaborated. Such oversimplified, contradictory and undigested knowledge and information lead individuals with T2D and their families to become highly stressed by the change process. Thus, rendering them unable to develop linkages between excess consumption of alcohol and food, misconstruing the workings of T2D and constructing stereotypical views of healthiness. In turn, this can affect individuals' with T2D who consume alcohol perception of what the change process signifies. Ergo, leading to conceptualising the change process, not as an opportunity to deal with unhealthy lifestyles, but instead, as a discomforting and dehumanising experience that impedes the sense of happiness and rhythm in the new lifestyle.

Health professionals have a pivotal role within the NHS and Support Groups to identify gaps between the various types of available knowledge, to understand the vulnerabilities of individuals with T2D who consume alcohol, and to deduce the meaningful interpretation. Consequently, through their online writings, evaluation of others' online information and promotion of specific online fora, could influence internet sources.

Furthermore, NHS and professional culture of health professionals affect the autonomy and potentials of individuals with T2D who consume alcohol to alter their lifestyles. The culture workings of the organisational structure of the NHS and the culture of professionalisation permeating health professional both seek respectively to maintain the integrity of the organisational structure and the professionalisation of healthcare workers. Most of the time, this leads to the standardisation of practices, and to the expectation that users of NHS services and recipients of healthcare professionals’ services conform to a proposed set of actions concerning lifestyle changes. Failure to fit the standardised care practices and to conform to proposed lifestyle changes usually interprets as a failure of the individuals with T2D who consumes alcohol. Individuals with T2D who consume alcohol and their families can as well affect the NHS culture and health professional culture by the reflective induced self-assessment of health professionals and other personnel of the NHS concerning their success in empowering (or not) individuals with T2D in changing their lifestyles.

Also, family ties and other relationships of individuals with T2D who consume alcohol, meaning-making of lifestyle changes and self-conceptualisation, emotional states and consumption of food and alcohol by individuals with T2D who consume alcohol, all interact and influence each other. Supportive families that perceive the lifestyle changes as a collective family challenge, rather than an individual one, allows individuals with T2D who consume alcohol to view the change as part of family cohesion and conceptualise the change as a worthwhile activity that accords with the expectations and efforts of the family.

Failure on behalf of an individual with T2D who consumes alcohol to implement and sustain lifestyle changes becomes not only an individual failure but also a collective family failure. Therefore, an Individual with T2D who consume alcohol if they fail to change lifestyle feels that they let down not only one’s self but lets down all the family. This sense of potential collective failure then becomes an even stronger motivator for initiating and sustaining lifestyle changes. Supportive families become outlets for emotions and function as sentimental buffers for individuals with T2D who consume alcohol, thus limiting the signification of food and alcohol as expressions of their emotional states. Also, individuals with character traits and personal histories of previous successful lifestyle changes have the potential to create meaning concerning lifestyle changes. They also can persuade family and friends to make the lifestyle change a collective worthwhile activity.

CHAPTER 6: DISCUSSION

6.1. Discussion of the findings

The discussion section relates the findings of a study to other studies to identify the meaning of the findings, to compare and contrast the findings to the broader literature and to discuss the key issues arising from the results to contextualise them within the broader academic context (Bettany-Saltikov, 2010; Bettany-Saltikov, 2012; Glasper & Rees, 2013). In simpler terms, the discussion section allows the researcher and the reader to understand how the findings fit with the broader literature and how the findings complement, contradict or add to the existing body of knowledge. The current discussion aims to compare and contrast the four themes and the FWT2D tentative model as developed in chapter 5 and collating these to the broader and published literature in order to provide unity and continuity of meaning and to further the debate on the key issues of the lived experiences of individuals with T2D who consume alcohol concerning the existential challenges they face in changing their lifestyles, in the meaning-making processes of their lifeworld and in the perceived caring processes needed to achieve a sense of well-being in their new lifestyles.

6.1.1. The role of food and alcohol in the construction of social identity

The findings of the current study recognise the unconscious effect that food and alcohol have for individuals with T2D who consume alcohol and their relational meanings that others within their social networks attribute to food and alcohol. This relational, internalised and behaviour defining constructs in accordance with Jenkins (2008) are powerful forms of collective identification that forge a social identity. Social identities of individuals derive from their interaction and relations with other individuals of the social groups they wish to be part. These social groups serve as entities in creating values, norms, goals, ways of thinking and doing, and eventually, a sense of self that derives from the membership in these social groups (Jenkins, 2008; Maxwell et al., 2013; Best et al., 2016). The current study identifies that food and alcohol acquire a salient role as representations that construct the internalised norms defining social identities for individuals with T2D who consume alcohol. Group norms in part regulate the types and portions of food and alcohol consumed, and in this manner create a sense of belongingness, of attaining and maintaining group membership, and of making group membership meaningful for these individuals.

The literature recognises the salient role of social identity in developing a shared representation that focuses on similarities between members of a social group and discriminates between the in-group and out-group individuals (Jenkins, 2008; Maxwell et al. 2013). The salient role of signifiers in forming a social identity as a powerful form of identification appears in studies concerning professional membership of nurses within the profession of nursing, of nursing students adaptation to nursing educational programmes, of violent and illegal behaviour, and of parenthood and morality (May, 2008; Maxwell et al. 2013; Willetts and Clarke, 2014). All these studies highlight the salient and powerful role that social identity has for individual behaviours and choices. However, the literature is critical of the fact that most studies focus remains on the individual identity (Maxwell et al. 2013) largely neglecting the role of social identity (Best et al., 2016). Also, a further critique is that these studies may be too context-specific to provide broader understandings (Willetts and Clarke, 2014) or include too many variables resembling laboratory studies and therefore not transferable to the real world (Cruwys et al., 2015).

The current study emphasises the role of social identity and views this as a result of the food and alcohol consumption and relates it to attaining and maintaining membership in social groups. Furthermore, the study introduces the argument that the concept of social identity for individuals with T2D who consume alcohol constitutes the set of influencing norms that up to a point regulate behaviour concerning food and alcohol consumption. Finally, the current study argues that alcohol consumption for individuals with T2D who consume alcohol has a pivotal role in developing and maintaining social identities, and can in comparison to non-alcohol consuming individuals with T2D adversely affect lifestyle changes.

Cruwys et al. (2015) invoke the conformity explanation concerning social identity to suggest that individuals identifying with a group become sensitive to group norms and are more likely to conform to those norms. They are thus suggesting that any lifestyle alteration strains the individual’s relations with the group placing into question the individual's belongingness to the group. The current study findings assert that alterations of lifestyles due to T2D can create great levels of anxiety for these individuals because of the disruption that lifestyle alterations create to their sense of belongingness to social groups in which they are already members.

Furthermore, the consumption of food and alcohol to a great extent influences the lifestyle changes for individuals with T2D who consume alcohol, and any lifestyle change implies alterations in the patterns, types and portions of food and alcohol consumed. Such alterations are distressing concerning the identity of these individuals intensifying their resistance in altering their eating and alcohol consuming habits. The literature as well concedes that the portions and type of food and alcohol individuals consume are to a degree a result of social modelling, conformity to social norms and shaped by social conditions and social relationships (Lindsay, 2010; Cruwys et al., 2015; Higgs, 2015). Higgs (2015) identified a positive correlation between the amount of food consumed by a given individual and the number of his/her eating companions.

Similarly, Lindsay's (2010) work on healthy living contrasts the idealised lifestyle of individualism to the complex reality of the social worlds that individuals inhabit where food and alcohol are central to their social life and key social practice, and to the enactment of their social identities. Lindsay (2010) concludes that the effectiveness of any intervention on individuals' eating and drinking lifestyles rests upon the awareness of how these eating and drinking lifestyles relate to the individuals' social worlds and their sense of social well-being. Finally, Jarvinen et al. (2014) assert that alcohol drinking intentionally (or not) affect the promotion of friendships and the creation of social networks, and refraining from alcohol does usually have social costs.

Furthermore, the literature asserts that eating rituals have a strong link to alcohol consumption and vice-versa, and suggests that individuals are more likely to make unhealthy food choices after consuming alcohol (Scott et al., 2017). Since both food and alcohol consumption is part of the individual's social identity formation, any deviation from group normative prescriptions that define the social identity may risk negative judgements or exclusions from the group (Lo Monaco et al., 2020). Hence, making lifestyle changes even more difficult for individuals with T2D who consume alcohol.

Moreover, individuals with T2D who consume alcohol confront greater challenges in comparison to non-alcohol drinking individuals with T2D because it does not suffice to merely make alterations or deviate from their social identity relating only to food. Alterations or deviations from their social identity will also have to occur concerning alcohol consumption. This may be too much and too challenging to achieve and not merely because of the permeating sense of alienation, but also because the exclusion from social groups does not occur neatly. Lo Monaco et al. (2020) maintain that before a group excludes a member due to transgression of group norms, there is initially intense scrutiny of the individual followed by continuous reminders of the group's norms and reiterating attempts to persuade the individual to follow these norms. Therefore, the pressure for individuals with T2D who consume alcohol to maintain group norms is not a one-off matter. It is a reiterating process where the individuals will need to admit their T2D health issue and will need to have the stamina to resist intense and reiterating attempts from the group to persuade them to fall in line with group norms.

Furthermore, the persuasive efforts of the group to follow group norms relating to alcohol consumption may also include inadequate or misstated information. Saylor and Calamaro (2016) in a rare study on individuals with diabetes who consume alcohol conclude that social groups based on alcohol consumption provide information regarding diabetes and alcohol that is not always accurate in their attempt to persuade individuals to follow the norms of the group. Furthermore, the literature suggests that social identity is not a single construct solely influenced by one social group. Individuals are usually part of multiple social groups and each one of these groups has it's norms (Farrow et al., 2017). Therefore, individuals develop a salient social identity that dominates when competing social norms from various groups co-exist. Alcohol-consuming social groups tend to forge in most cases the salient social identity and are the strongest single predictor of an individual's cognition and intentions (Farrow et al., 2017). Hence, individuals with T2D who consume alcohol have more barriers to overcome and greater social costs when attempting lifestyle changes in comparison to non-alcohol drinking individuals with T2D.

The emerging social costs for individuals with T2D who consume alcohol from altering dietary and alcohol drinking patterns when viewed from the Humanising Framework of Care perspective has a significant impact as this can dehumanise the individual and lead to various forms of suffering. In accordance to the eight dimensions of humanisation of the Humanising Framework of Care disruption of social connections and separation from taken-for-granted feelings of belonging with one's existing social world creates a state of isolation (Galvin and Todres, 2013). Moreover, this state of social isolation can further dis-orientate individuals with T2D consuming alcohol and lead to a sense uneasiness to fit in existing social groups and eventually trigger sentiments of strangeness and social displacement. For the Humanising Framework of Care, the loss of social belonging and the associated loss of comfort, familiarity, continuity and unreflective easiness of group belonging further creates a state of non-physical dislocation, thus intensifying sentiments of suffering (Galvin and Todres, 2013).

The current study demonstrates that fear of social isolation can impede the initiation or sustainment of any alteration of dietary and alcohol drinking patterns for individuals living with T2D who consume alcohol. The key impediment relates to the individual's inability to create new meanings from their proposed altered lifestyles within their existing social groups and to the potential social dislocation that can lead to sentiments of dehumanisation and suffering. Clark and Knight (2017) highlight this downward spiral of initial social isolation and consequent social dislocation of individuals living with joint hypermobility syndrome and define it as the "domino effect", whereby one leads to the other. Further literature concurs with findings of the current study on the notion of belongingness being more than a physical space to include socio-emotional intelligence linked to community co-existence in the construction of identity and shaping of human individuality. The loss of any such commonalities with others can occur from alterations due to illness and may result in individual alienation (Devis-Rozental, 2018; Pound and Jensen, 2018).

When an individual positions one's self in the spectrum of isolation and dislocation dimensions of the Humanising Framework of Care, this unavoidable impacts as well on the individual's inter-subjective domain. Galvin and Todres (2013) assert that suffering in the "inter-subjective" domain can take an existential form and lead to a feeling of being cut off, cast out of meaningful engagement and feel like an unwanted outsider or pariah. Indeed the literature argues that intersubjectivity includes the meeting of two or more subjects whereby they do not lose their subjectivity but share their subjectivity and in doing so relate to each other. Furthermore, they self-reflect and empower each other to develop narrations of experiences and in this way, make sense of their common experiences and in the process achieve personal growth (Burke, 2014; Hasson-Ohayon, 2016).

Disruption of inter-subjective connections delimits the potential to make sense of experiences and create meaningful narratives. The breaking down of intersubjectivity occurs when individuals no more share similar understandings, do not share similar goals, and are not viewed as equals in their relationship with the possible stigmatisation or self-stigmatisation of the subject that detracts from common goals and norms (Hasson-Ohayon, 2016). The findings of the current study suggest that commencing and sustaining of lifestyle changes in terms of food and alcohol consumption may be impeded by the possible disruption of intersubjectivity and the fear of isolation and dislocation.

6.1.2. Group memberships and sense-making of lifestyle changes

There is a link to be drawn between membership to social groups and lifestyle changes with the emerging view from the data suggesting that the fewer group memberships an individual has, the more difficult it is for the individual to commence and sustain lifestyle changes. The increased number of group memberships or the potential to develop new group memberships after the T2D diagnosis increases the likelihood for individuals with T2D to commence and sustain modifications in eating and alcohol drinking lifestyles.

Murata et al. (2006) identified a correlation between the decline of social group membership amongst elderly individuals and their reported sense of confinement, isolation and adverse impact this had on their health and lifestyle changes. Haslam et al.'s (2008) study on the well-being of stroke patients identified positive implications between the well-being of recovering individuals from stroke and multiple group memberships. They suggest an association between the individuals' failure to adapt to their new lifestyles and their inability to maintain membership of groups to which they had belonged before their stroke. Jetten et al. (2017), in their work, explicitly identify group memberships to be an effective support source and a psychological resource for individuals in dealing with and adapting to physical and mental health issues. They go on to cite a series of studies demonstrating the effectiveness of multiple group memberships in increasing life expectancy, adapting to pain and positively reacting to mental and physical problems.

Furthermore, the current study argues that the greater the number of group memberships that an individual has or the potential to develop new group memberships after the T2D diagnosis, the more robust is the social capital to buffer the negative consequences of the diagnosis. Individuals can draw upon the multiplicity of sources from social groups to deal with the stressful aftermath of the diagnosis and possibly maintain at least some of their memberships in these social groups that can function as a psychological resource and existential security mechanism to achieve lifestyle changes (Haslam et al., 2008; Iyer et al., 2009; Jetten et al., 2017). Recognising the role of multiple group memberships and the importance of social groups in underpinning lifestyle modifications and the sense of well-being for individuals with T2D who consume alcohol are significant and unique findings of the current study. This recognition has a set of ramifications for the planning of care and overall care provision.

An initial implication relates to the lack of studies focusing on individuals with T2D who consume alcohol and multiple group memberships, the current study by highlighting the potential significance of multiple group membership in initiating lifestyle changes can act as a catalyst for further research focusing on multiple group membership and lifestyle changes for T2D and alcohol consumption. Another implication is that retaining and developing multiple group memberships does not necessarily and automatically imply a linear connection with successful lifestyle modifications as there are ethological and cultural variables that may limit the value of multiple group membership in lifestyle changes (Dingle et al., 2015; Chang et al., 2016; Jetten et al., 2017). Chang et al. (2016), in a study of multiple group memberships in an Asian population, conclude that culture variations between Asians and Westerners may lead to Asians benefitting less from multiple group memberships.

Furthermore, Jetten et al. (2017) caution on the potential discrimination and stigmatisation that may result from multiple group membership as groups may try to exclude members that do not conform to group norms. Dingle et al. (2015) raise concerns that in some cases, as in substance misuse, maintaining group membership may perpetuate addictive and unsafe behaviours, whereas abandoning group membership can support the development of a new social identity that may be useful in recovering from substance use.

Finally, the current study focuses on individuals living with T2D who consume alcohol. As indicated in the above subsection, the forging of social identity from membership in alcohol drinking social group impedes, rather than supports lifestyle changes relating to T2D. Therefore, membership in alcohol groups or groups typified by risky and disinhibiting behaviours such alcohol-consuming may deter, rather than promote lifestyle changes. The literature concurs with this finding as membership in groups that use psychoactive substances such as alcohol can alter usual behaviours and reduce the perception of risk when consuming alcohol (Cruwys et al., 2020; Moitra et al., 2020). This reduced perception of risk emerges from individuals with T2D who consume alcohol seeing others in the group engaging in risky behaviours of alcohol drinking giving the false perception of safety or not as risky to drink alcohol (Cruwys et al., 2020).

While these remain valid concerns and cautions, nevertheless the current study's focus is on issues relating to T2D and alcohol in a developed country in Western Europe and also T2D while affected by unhealthy lifestyles, nonetheless is not an addictive behaviour. Also, the notion of multiple group membership proposed by this study suggests those groups that do not include risky and disinhibiting behaviours. Two of the research objective of the current study are to explore the experiences of initiating and sustaining lifestyle changes and conceptualise the lived experiences of adapting to the required lifestyle changes of individuals withT2D who consume alcohol. From the heretofore discussion the role social group membership, including maintaining membership to existing social groups and creating new ones are central in initiating, sustaining and positively adapting to required lifestyle changes for individuals withT2D who consume alcohol. While not ignoring potential cultural limitations, side-effects of dysfunctional social groups and particularities of specific social groups the overall conclusion of the current study is that maintaining and creating new social groups for individuals withT2D who consume alcohol as an integral part of the care for initiating and sustaining lifestyle changes.

The above conclusion produces a set of further implications for healthcare professionals and for formal and informal healthcare organisations that provide caring services to individuals with T2D who consume alcohol. The experiences of the study's participants indicated that the mere provision of information to individuals with T2D who consume alcohol does not suffice for achieving lifestyle changes in terms of food and alcohol consumption. Therefore it would be useful for healthcare professionals, such as nurses and the caregiving organisations, such as NHS and Diabetes Support Groups to shift focus to incorporate understandings of the social identity of individuals with T2D who consume alcohol and work with these individuals in enabling growth to achieve and sustain lifestyle changes. A series of studies on individuals requiring lifestyle modifications and long term care argue for greater understanding of the complex and modifiable determinants of behavioural pattern, and the development of specific mechanisms of intervention to achieve long term changes (Joubert et al., 2009; Nelson-Laska et al., 2010).

Lawrence et al. (2010) study identified that stroke individuals typically reported having received little or no lifestyle information following a stroke, and even in those cases that they received some information they did not recall this. Similarly, Joubert et al.’s (2009) study argue despite the wide availability of published guidelines, consensus statements and directives available to both staff and patients nevertheless these are often suboptimal for bringing about modifications of behaviour patterns and achieving long-term changes. Both Lawrence et al. (2010) and Joubert et al. (2009) conclude that information-giving alone is insufficient for achieving lifestyle changes. Similarly, Chenoweth et al. (2009) are highly critical of the traditional biomedical approaches to care concerning lifestyles changes asserting that the biomedical approach dehumanises individuals, and eventually objectifies and infantilises them.

Similarly, the Humanising Framework of Care considers that health professionals excessive focus on statistical facts and the de-emphasis on the person's uniqueness can dehumanise the individual, and fail to meet their emotional and existential needs leading to forms of suffering. In accordance with the eight dimensions of humanisation of the Humanising Framework of Care, subjectivity is central to human beings. When healthcare professionals over-emphasise the need to fit individuals into neat diagnostic categories and statistical data unavoidably miss out on dealing with feelings and emotions that colour the individual's world(s) creating a state of objectification (Galvin and Todres, 2013). Moreover, this state of objectification for individuals with T2D who consume alcohol can lead health professionals to fit them into a particular group either into the diabetic group or the alcoholic group. For the Humanising Framework of Care, this effortful and intentional fitting into a group creates a state of homogenisation that reduces creativity and imagination in dealing with T2D and alcohol consumption, thus intensifying sentiments of suffering (Galvin and Todres, 2013).

The current study demonstrates that health professionals give significant emphasis on information and data relating to T2D and alcohol consumption, and how the participants fit in with this information and the diagnostic groups. Without sufficient attention to individual lifestyles and the factors that may create the preconditions for developing T2D or increased consumption of alcohol. Similarly, Borbasi et al. (2012) in a study on individuals living with dementia found that health professionals demonstrated an excessive focus on the diagnosis and to a large extent treated these individuals as a homogeneous group, thus diminishing their personhood and failing to understand their personality. Pound and Jensen (2018) study on individuals living with aphasia also concurs with findings of the current study. They propound that health professionals fail to take into account the rich insideness of these individuals and instead exert professional authority by homogenising and stereotyping them, and inadvertently dehumanising them.

When an individual find one's self in the spectrum of objectification and homogenisation dimensions of the Humanising Framework of Care, this unavoidable impacts on the individual's identity domain. Galvin and Todres (2013) assert that suffering in the identity domain that results from the objectification and homogenisation can lead to fragmentation of identity, diminish of personal potency to change anything in a meaningful manner and create feelings of annihilatory anxiety. Indeed the literature argues that individual life stories, experiences and feelings are empirically inapprehensible (De Jesus Cabral et al., 2017; McKinney, 2017). Moreover, these life stories and storytelling are tools for sense-making, continuity of identity and opportunity for creating future goals and a notion of health (Morville and Erlandsson, 2013; Castro Romero M., 2017; McKinney, 2017). Therefore the role of healthcare professionals should invite the sharing of these stories and experiences and imagine how treatment may affect individuals' sense of bodily identity (Galvin et al., 2018).

The current study agrees for extended and innovative roles for healthcare professionals and healthcare organisation in caring for individuals with T2D who consume alcohol. These roles will include not (only) the physical and information provision but as well include the focus on the effects of social identity, the role of social inclusiveness and the conduciveness to change of the social milieu within which individuals with T2D who consumes alcohol exist. Similarly, Hemingway (2012) advocates that health care professionals need to incorporate and transform the reality of individuals within their particular context(s) and views this as part of the humanising function and of the social movement aspect of caregiving.

Moreover, the current study identifies that the social environment for individuals with T2D who consume alcohol affect on the one hand their mood and willingness to become involved in their care and on the other hand influence their potential to articulate in a persuasive narrative the commencement, actualisation and sustainment of lifestyle changes. These findings relate to the what the broader literature defines as the actualisation of social and personal identity, where the humanistic values, personal aspiration and shared decision making is stressed, along with the understanding of cultural norms influence on the individual and the co-development with the individuals requiring care a common vision for change to eventually achieve individual ownership of the change processes (Epstein et al., 2010; Manley et al., 2011; Kreindler, 2013).

The current study adds to the existing literature in that it intensifies the focus on the link between understanding, maintaining and developing the social identity of individuals with T2D who consume alcohol, and their potential of developing a personal narrative for change that makes sense for individuals and has greater potential for sustaining modified behavioural patterns. Hence, complementing existing approaches relating to the respect of individuals' values and beliefs, of understanding individuals' situations and of enabling individuals' participation in decision-making incorporated (Olsson et al., 2012; Kitson et al., 2013; Sabourin and Pursley, 2013) with understanding the social identity of individuals and working towards maintaining and developing individuals' social group memberships.

6.1.3. Food and alcohol labelling policies

Another significant and emerging issue from the experiences of individuals with T2D who consume alcohol relating to the commencement and sustainment of lifestyle changes is the (in)comprehensibility of food and alcohol labelling. Individuals with T2D who consume felt that in most cases the labelling of food and alcohol explaining the ingredients of their content are insufficient, unfriendly or incomprehensible to support their potential to make the healthier choice in food and alcohol selection. There is an acknowledged association between food labelling and the reduction of obesity, wellbeing and healthy lifestyles, and evidence that UK and EU regulations of the last decade on food labelling has had a positive, empowering and informative effect on dietary choices (Hignett, 2007; Cecchini and Warin 2016; Clark, 2016; Lee and Lee, 2016; Price et al., 2016). Similarly, studies on alcohol labelling argue that sufficiently comprehensible label descriptors coupled with labels of images and unambiguous information of the health effects of alcohol can increase the recognition on the dangers of alcohol consumption and eventually reduce the number of alcohol units consumed (Al-hamdani and Smith, 2015; Kersbergen and Field, 2017; Shemilt et al., 2017).

The literature also acknowledges that there are issues that may be confusing and problematic in the labelling of food and alcohol schemes. For instance, the lack of standardisation and the use of multiple labelling schemes, such as back-of-pack labelling, traffic light system and front-of-pack labelling can be disorientating for consumers (Hignett, 2007; Miles 2007; Clark, 2016). Also, labelling with a full display of the content for foods remains at large a voluntary commitment and alcohol is not treated as a food product with alcoholic beverages being exempt from the mandatory labelling of the list of ingredients it contains and the nutrition declaration (Baggott, 2012; Milligan 2014; Rehm et al., 2014).

Lastly, the literature argues that food and alcohol labels without expert knowledge may be confusing to read and understand, consumers may misinterpret such labels and wrongly generalise their information. For example, consumers may misconstrue a whole grain product to be also low in calories, saturated fats and sugars (Milligan 2014; Cecchini and Warin 2016; Coutts, 2018). Also, food and alcohol labelling may be of limited benefits for individuals with lower income, less education and greater time constraints as these individuals may not have the money to buy alternatives, the potential to understand the labelling and the time to read the labels carefully (Milligan 2014; Cecchini & Warin 2016; Coutts, 2018).

The sense-making of food and alcohol labelling is a significant component of individuals with T2D who consume alcohol in understanding their situation and in altering their dietary and alcohol drinking patterns. When meaning is incomprehensible or lost, as may be in the case of labelling of food and alcohol products in the current study, individuals are unable to find significance and relate the information provided to their situation. From the Humanising Framework of Care perspective, the incomprehensibility of language use and attempts to create large scale representations contribute in creating sentiments of disconnect between human experience and what is labelled (Galvin and Todres, 2013). Such loss of meaning impedes any impetus or motivation for individuals to bring together their experience of food/ alcohol consumptions and the information provided in the labels rendering the labelling meaningless and essentially disempowering individuals in altering food and alcohol habits (Galvin and Todres, 2013).

The current study concurs with other studies in suggesting that forcing individuals to do things that they do not understand bewilders individual as their conceptual frameworks, emotional attachments, and conscious and unconscious desires delimit their ability to settle the meaning with past meaningful for them events (Borbasi et al., 2012; Zembylas 2014; Pound and Jensen, 2018). When an individual positions one's self in the spectrum of "loss of meaning" dimensions of the Humanising Framework of Care, this impacts as well on the individual's "temporality of dwelling in the present" domain. Galvin and Todres (2013) assert that suffering in the "temporality of dwelling in an elusive present" domain the individual is unable to absorb the information in the present moment and temporally exists in the past with the present remaining elusive. Such elusiveness of the present further leads to clinging in the past, making changes and adaptation to new behavioural patterns equally elusive (Eustache et al., 2014).

The current study argues that healthcare professionals have an added responsibility in enabling individuals with T2D who consume alcohol to make healthier choices and in empowering them to alter their eating and alcohol consuming habits. To achieve this added responsibility healthcare professionals have a dual function, on the one hand, to educate individuals with T2D who consume alcohol, and on the other hand to act upon policies regulating the food and alcohol industry. Miles (2007) and Coutts (2018) assert that nurses ought to teach individuals to read, evaluate and interpret food labels, to educate them in understanding the nutritional quality implied in the labelling and to support them in comparing this to the recommended levels for a healthy diet and safe alcohol consumption. Furthermore, on a practical note of educating individuals with T2D on food and alcohol labelling the literature proposes to have available a variety of food and drink products in the consulting room and analyse, discuss and interpret them during the consultation, and to enable greater engagement, link this educational process to issues of feeling better or losing weight, rather than merely to diabetes or alcohol management (Dunbar et al. 2010; DeVille-Almond and Halliwell, 2014).

On a policy level, the literature concedes that the maximisation of sales is the prime incentivisation of the food and alcohol industry, potentially making self-regulation of the industry an insufficient mechanism for adopting good practices. For example, the food industry may make packaging more luring for buying foods, despite the labelling of the package suggesting its' low dietary value. In other cases, the food industry may overemphasise the healthy aspects of the content, while simultaneously omitting less flattering details of the food (Coutts, 2018; Milligan 2014). These are aspects of the food and alcohol industry that are both challenging for healthcare professionals, and emerging opportunities for healthcare professionals to become proactive in partnering with food and alcohol industries to influence consumer knowledge and behaviour (Hignett, 2007; Price et al., 2016). Furthermore, the literature asserts that healthcare professionals need be more active at the highest level of government as well in making a case for affordable healthy food choices for lower-income populations via government subsidies and to lobby for specific labelling on food and alcohol packages for individuals with T2D who consume alcohol (Miles 2007; Milligan 2014).

However, the literature goes on to make the case that healthcare professionals and in specific, nurses are poorly prepared to contribute to the policy agenda, are primarily absent from policy processes, have themselves difficulty in understanding policy procedures and in general are absent from the policy debate (Hewison, 2008; Fyffe, 2009). The participants' experiences of the current study highlight their sense of insufficient information giving or support provision from nurses in understanding the policy of labelling or other aspects of food and alcohol regulations. The participants of the study felt that there was very limited or no information provision or discussion concerning policy issues relating to food and alcohol.

The literature coins the phrase policy literacy to suggest some basic understanding of the processes of shaping policy and a degree of critical analyses on policy content (Malone, 2005). The means for achieving policy literacy for nurses and other healthcare professionals, amongst others, require policy document analysis to become part of the undergraduate and postgraduate curriculum, to promote and encourage nurse researchers to engage in the public policy arena, to become engaged with the media and to coalesce with patient alliances and professional organisations (Hewison, 2008; Fyffe 2009).

The constraints emerging from the limited policy literacy of health professionals, as stated by the above literature, may partly explain the influential role of the pharmaceutical industry on healthcare organisation and health professionals. The individuals with T2D who consume alcohol of the current study felt that care organisations and health professionals tendency is to over-emphasise the somatic, pharmacological and impersonal aspects of T2D or alcohol effects, rather than the individual lifestyle expectations and demands. The influential role of the pharmaceutical industry as a major power within the global economy has been well described in the literature suggesting it to be a complex market business that systematically, methodically and intentionally target health professionals and in a subtle, but persuasive manner, influence their clinical decision-making concerning drug promotion and drug prescription (Crock, 2009; Jutel and Menkes, 2010; Springer 2011; Bell and Figert 2012).

Two of the research objective of the current study are to explore the experiences of initiating and sustaining lifestyle changes, and the supportive (or not) role of health professionals in assisting individuals with T2D who consume alcohol in dealing with the challenges of lifestyle alterations. From the heretofore discussion participants of the current study felt that health professionals, in general, provided them with minimal information and in specific, this information solely focused on the diabetes diagnosis and alcohol effects with a strong biomedical nuance, and with a total absence of lifestyle information. Similarly, participants felt that health professionals did not provide them with sufficient education to read and understand labels on food and alcohol products comprehensively. The discussion suggests that the role of health professionals need to shift focus toward providing information on lifestyle changes, to educate individuals on reading and comprehending food and alcohol labelling, and to become active in policymaking concerning food and alcohol labelling. The fact that health professionals currently have a significantly narrower role than expected by individuals with T2D who consume alcohol negatively affect their potential to initiate and sustain lifestyle changes.

6.1.4. The pharmaceutical industry and medicalisation of care

It may be possible that the pharmacological over-emphasis that health professionals exhibited and experienced by participants of the current study to be in part a result of the subtle and influential role that the pharmaceutical industry has on the minds of health professionals. Drug companies target beyond doctors other health professionals as well, primarily nurses and pharmacists and even students, despite their non-prescribing status, due to their influential role in biasing medical and nursing prescribing personal in prescribing medications and their vital role in encouraging medication compliance to patients and in supporting and moulding patients' choices (Crock, 2009; Jutel and Menkes, 2010; Springer 2011). Therefore, creating a culture amongst health professionals and healthcare organisations that overwhelmingly focuses on drug prescription, drug administration and drug compliance ignoring other aspects of patient care, such as lifestyle choices and potentially overlooking lifestyle changes or side-stepping them as being too laborious and effort-demanding alternatives and even unachievable without concurrent medication use (Crigger et al. 2009; Crock, 2009; Frosch et al., 2011; Unruha et al., 2016).

The literature terms the culture whereby bodily conditions and human behaviours are labelled as illnesses or abnormalities and therefore deemed in need of and treated with pharmaceuticals as the pharmaceuticalisation of healthcare. This approach is the dominant form of health care in western societies and closely linked with the labels of pathologisation and medicalisation (Busfield 2010; Bell and Figert 2012; Conrad, 2015; Unruha et al., 2016; Sholl, 2017). The dominance of the pharmaceuticalisation culture whereby pharmaceuticals are the only or predominant means for treating human conditions is systematically cultivated and consistently perpetuated by pharmaceutical companies with an explicit interest in increasing medicine use, maximising profits for the pharmaceutical industry and amplifying profiteering opportunities of the pharmacological enterprise (Busfield 2010; Clark; 2014a).

The strategies and tactics deployed by pharmaceutical industry to achieve this includes; 1) financial ties, sponsorships, giftings and fundings provided to healthcare practitioners, professional organisations, and patient advocacy groups, 2) control over the science, knowledge, information and education of health professionals by organising research studies, providing information about new medicine, and determining drug safety and effectiveness, 3) skillfully exploitation of the seductive power for recognition, status and prestige emerging from the cachet of the hero-like healthcare professional stepping in and resolving or healing the condition, and 4) clinical guidelines that promote interventionism and the view when faced with the risk of treating a person who is not ill with a treatment they do not need, and the risk of not treating a person who is ill, who could become worse if not treated to err on the side of treating with medication (Olsen, 2009; Busfield, 2010; Springer, 2011; Bell and Figert, 2012; Unruha et al., 2016).

While the intention of the current study is not to explore the pharmaceuticalisation and medicalisation of care, nonetheless the experiences of individuals with T2D who consume alcohol of the current study is that care and support for lifestyle changes are not top priorities for the pharmaceutical industry. In other words, the pharmaceuticalisation and medicalisation of care have specific intents guided by the maximisation of medical prescription and the emerging profits which may not necessarily coincide with what is beneficial for individuals with T2D who consume alcohol. Flaskerud (2012) reached to a similar conclusion when suggesting that the medicalisation of primary care and mental health is not beneficial for people requiring such care because Psychiatric/Mental Health Nurses are pressurised by and succumb to the market forces, especially Big Pharma, and eventually over-diagnose, misdiagnose, stereotype and ignore the personality of the person requiring care.

The current study based on the lived experiences of participants diagnosed with T2D further explains that pharmaceuticalisation and medicalisation of care entails an impersonal transmission of knowledge by health professionals ignoring personal needs and subjective complexities. Part of the literature is critical of the medicalisation model of care as masquerading its' strategies of dealing with T2D and alcohol consumption as public health strategies, and consider that the medicalisation model should to cease framing the debate on T2D and alcohol consumption (Clark, 2014a). The key argument here is that the impersonal or generic approach to knowledge transmission significantly impedes the meaningful construction of a useful lifestyle change narrative.

There are two key aspects of the current medicalised approach concerning the care of individuals with T2D who consume alcohol that hinder their lifestyle changes, namely; the impersonal approach and the unwillingness to focus on subjective complexities. From the Humanising Framework of Care perspective, the biomedical microanalysis is overly narrow in describing and explaining in a meaningful manner, the complexities of an individual (Galvin and Todres, 2013). Merely viewing the body as the absence of disease and in those cases of the presence of a disease as an object to be fixed is a highly reductionist view of the body, neglecting the broader meaningful contexts within which the body exists and limits in this way the vitality of the body and the everyday possibilities and potentials of the body for finding purpose in the future (Galvin and Todres, 2013).

The current study concurs with other studies in suggesting that medical diagnosis and biomedical results overpower more human data relating to the context of individuals' everyday existences and their interactions with the world, eventually producing narrower versions of the individual and ultimately failing to promote a more extensive range of healing or caring possibilities (Borbasi et al., 2012; Pound and Jensen, 2018). When an individual positions one's self in the spectrum of a reductionist view of the body dimensions of the Humanising Framework of Care, this impacts as well on the individual's embodiment domain leading to stasis and exhaustion. Galvin and Todres (2013) assert that suffering in the "embodiment of mobility in a stasis and exhaustion" domain the individual drains from energy and lacks the vitality to pursue and sustain aspirations significantly, thus curtailing the possibilities for meaningful projects of change.

The emphasis on the personal and on the subjective complexities suggested by the current study does not aim to create the false impression that this refers to the inherent individualism that the literature acknowledges to the medicalised framework of care (Clark, 2014b; Hofmann, 2016, Flynn, 2017). Indeed the literature suggests a neat dovetailing of medicalisation and individualism, since medicalisation targets the individual and is associated with individual choice, whereby the onus of getting well and staying well is on the individual (Clarke and van Amerom, 2008; Clark, 2014b; Goldberg, 2014; Hofmann, 2016). In other words, individuals like consumers have choices, are free to choose from various options, they have the responsibility of making the “correct” choices, and failure to choose the healthy option is a blameful attribute indicative of poor choice-making or unwillingness to be healthy on the part of the individual (Clarke and van Amerom, 2007; Scott and Schurer, 2008; Clark, 2014b).

In recent years the introduction of the terms healthism or healthicisation aims at counteracting some of the negative connotations of medicalisation and in tipping the discussion towards health, rather than illness, arguing for proactive processes in altering behaviours to maintain health and avoid becoming ill (Venn et al., 2013; Potter et al., 2016). However, a similar frame of thinking permeates healthicisation, as does medicalisation, as the logic of individual choice maintains a pivotal position, whereby the individual has a range of ideal options of maintaining health and the individual has the responsibility for acting to opt for the healthy lifestyle choice eclipsing in this process any collective perspective (Venn et al., 2013; Potter et al., 2016). Finally, the inherent individualism of medicalisation and healthicisation over-emphasise the benefits of educational provision to individuals assuming that if health professionals impart sufficient knowledge to individuals with T2D who consume alcohol, then it should be straightforward that they will make the healthy choice or otherwise they are at blame that in spite the imparted education they make the unhealthy choices (Cockerham, 2005; McGuire and Anderson 2012; Moshki et al., 2017).

The findings of the current study do not argue for individualism as described by the literature associated with medicalisation, instead what is put forward by the findings is for health professionals to work towards understanding the person as a human existence in context and in relation to others taking into account the complexity, interrelatedness and messiness of their inhabited worlds at the specific time. These findings coincide with what the literature defines as the humanisation of care and the acknowledgement of personhood (Dewing, 2008; Fujita et al., 2012; Hemingway et al., 2012; Hunter et al., 2013; Borbasi et al., 2016). The characteristics of personhood as acknowledged by the literature includes the distinctiveness, the continuity and the autonomy of the person as dynamically evolved and shaped by the social context, the existing interpersonal relationships and the reflections on one’s own life experiences (Dewing 2008; Hunter et al., 2013). Similarly, the concept of humanness or humanisation focuses on the uniqueness of the person, the person's relationships and the meaning the person attributes to being human, rather than focusing on problems, needs or diseases (Speraw 2009; Hemingway, Scammell and Heaslip, 2012; Galvin and Todres, 2013).

In the context of the Humanising of Care Framework, there is no absolution of the person from making choices. Choices are contextual, woven into interactions the person has with others, linked to the spaces the person inhibits and positioned within the continuity of the person's past, current and future experiences (Hemingway, Scammell and Heaslip, 2012; Galvin and Todres, 2013). Thus, the person remains an agent of choice. However, the availability of choices is limited or broadened by the person's potential to translate the complexities of events, find their significance, bring together seemingly unconnected issues and make meaning out of events and experiences to create stories and construct narratives (Hemingway et al., 2012; Galvin and Todres, 2013; Gualda et al., 2013). Failure to create new, explanatory and persuasive narratives concerning the individual's changing health status often leads to dissatisfaction with the provided care (Speraw 2009; Goldberg, 2014; Chochinov et al., 2015).

6.1.5. Narratives of lifestyle changes

The findings of the current study suggest individuals with T2D who consume alcohol who lacked the support in constructing meaningful stories for the need to change lifestyles were unable to identify with the suggested lifestyle changes and were incapable of commencing change processes. Even if they commenced any change, they were unable to sustain the change and reverted to previous lifestyles. Part of the literature considers that personal narratives have greater human significance, more meaningfully felt truths and increased therapeutic and changing potentials, than statistical evidence or normative messages (Sharf and Vanderford, 2003; Galvin and Todres, 2013; Chen et al., 2016).

Sharf et al. (2011) consider the provision of healthcare to be an impossibility without the human capacity to organise and embody lived experience in a narrative form, since narratives not only reflect individual views of the world, but also provide explanations for why things happen in certain ways, assist people to account for motives, causes, and reasons, and involves others in one’s world view. Narratives have a fivefold function, namely; a) sense-making, b) asserting control, c) transforming identity, d) warranting decisions, and e) building community (Sharf & Vanderford, 2003).

However, the same literature acknowledges that until recently there was a presumed strict dichotomy between scientific fact and affective narratives with an uncritical acceptance of the superiority of biomedical knowledge and with narratives reduced to mere whispers on the fringes of mainstream medicine (Sharf et al., 2011; Vannatta and Vannatta, 2013). Recently, a shift is slowly taking place, and individual narratives are acquiring a greater role and significance in the care of individuals. For instance, narratives of living with epilepsy, dealing with female menopause and developing in partners of Alzheimer patients coping potentials are acquiring research interest and are finding their place in the health-related literature (Rhodes et al., 2008; Hyde et al., 2010; Galvin and Todres, 2013).

For individuals with T2D, such studies sparingly appear in the literature and T2D narratives related publications are primarily associated with data collection and data analysis methods of qualitative narrative studies. In the nursing literature, the emphasis on narratives from individuals with T2D is even more sparse with most prominent the works of Wilkinson et al. (2014) that studied the narratives of individuals with T2D in self-managing and Johansson et al. (2009) study that elaborated on the lifeworld narration of individuals with T2D of falling ill with diabetes. A similar scarcity of narratives on alcohol consumption is as well present in the nursing literature with most prominent the works of Thurang et al. (2011) that studied male alcohol dependency and Arai et al. (2014) study on alcohol-dependent individuals and their narration of their pre-alcoholic phase. While this shift to include personal narratives is welcoming, nevertheless there is a need for significantly more research and writing to take place on the inclusion of narrative construction for lifestyle changes of individuals with T2D who consume alcohol.

Moreover, the current study focus is on individuals with T2D who consume alcohol and the findings of the study highlight that health professionals will exclusively focus on the T2D and avoid any discussion or efforts to narrate experiences relating to alcohol consumption. Other studies as well conclude to a similar assertion when alcohol consumption is a compounding factor in a long term condition. Niu et al. (2015) in a study on lifestyle behaviours of cancer survivors acknowledge the beneficial impact of the reduction of alcohol consumption in the survival rates of cancer survivors, but admit that counselling rates on the reduction of alcohol consumption are dismally low or non-existent. Other studies as well reach similar conclusions when it comes to alcohol counselling and living with long term conditions such as cancer or HIV. These studies suggest that health professionals frequently and consistently miss the window of opportunity at the time of the diagnosis to provide counselling or brief interventions on alcohol reduction (Montague et al., 2015; Eng et al., 2019).

The finding of the current study suggests that health professionals do not correlate or fully understand the role of alcohol consumption in deterring lifestyle changes in T2D and do not provide any information or support with regards to alcohol consumption and the development of personal narratives for change of alcohol patterns. Besides this, the literature argues that health professionals are reluctant to discuss alcohol-related issues when associated with long term conditions because this tends to be uncomfortable, particularly in response to perceived stigmatisation (Montague et al., 2015; Niu et al., 2015). Also, the pressures from the lack of time, the limitations from the lack of formal training in alcohol care and the ambivalence if alcohol care is within or beyond the scope of their care are some further explanations as to why health professionals do not provide information on alcohol consumption (Montague et al., 2015; Niu et al., 2015).

In summation, the findings of the current study assert that an integral component of the caring process for individuals with T2D who consume alcohol is the construction of explanatory, sense-making and transformative narratives that justify and warrant lifestyle changes. Therefore, formal organisations, informal support groups and health professionals need to become attentive to the individual values, preferences and needs of individuals with T2D who consume alcohol and become responsive to their capacities for change. Hence, the caring roles and activities of health professionals concerning individuals with T2D who consume alcohol places emphasis on the need to take into account cultural particularities and cultural sensitivities of these individuals. The overall aim is to empower individuals with T2D who consume alcohol to align the recommended lifestyle changes with their social circumstances and cultural beliefs (Guell 2012; Wilkinson et al., 2014). Furthermore, health professionals need to become aware of the role of alcohol consumption in lifestyle alterations for individuals with T2D making the support for alcohol consumption an integral component of the empowering processes of individuals with T2D who consume alcohol.

6.1.6. Health professionals' impact on lifestyle changes

The findings of the current study acknowledge the significance of health professionals role in providing education to individuals with T2D who consume alcohol. However, the provision of education from health professionals is of limited usefulness if not connected to previous experiences and future aims, as well as the individual’s social relationships, thus becoming appealing and goal-relevant. Sharf and Vanderford (2003) define this type of educational provision as the retrospective, emergent, interactive and plausible.

Therefore, the provision of education and information are important aspects for health professionals to provide to individuals with T2D who consume alcohol. However, if health professionals function as mere conduits for medical or physiological information, this does not achieve the aims of lifestyle changes (Sharf et al., 2011). Instead, the provision of education and information needs to link to the individual’s context, woven into the values and experiences of the individual, and working together with each individual to co-construct singular and person-specific narratives that explain, make-sense and link past experiences to future goals (Speraw, 2009; Goldberg, 2014; Malecki-Ketchell et al., 2017).

The findings of the current study agree with part of the literature that argues for interweaving both the voice of medicine and the voice of the lifeworld into a consistent, mutually agreed-upon story, unifying the scientific and humanistic components of knowledge to produce a comprehensive vision for each human being

(Sharf and Vanderford, 2003; McGloin et al. 2014; Piana, 2017). The implied difficulty for developing such co-constructed unifying narratives is the presumption of expertise and specialisation, and the related assumptions of professionalisation. Key writers in the field of professionalisation such as Eraut (1994) and Freidson (2001) assert that the concept of professionalisation is ideologically rooted and at its epicentre lies the primacy, control and monopolisation of expert knowledge. Professionals have expert knowledge, and laypeople do not, thus bestowing privilege and authority to professionals. Negating health professionals the monopolisation of expert and specialised knowledge to include individuals with T2D who consume alcohol in the decision-making processes, unavoidably creates a sense of disempowerment and de-professionalisation for health professionals (Skinner, 2013).

Some parts of the literature consider the notion of de-professionalisation as potentially problematic and possibly unuseful as they tend to equate de-professionalisation with deskilling, reduced professional autonomy and replacement of educated personnel with unskilled workers (Hall, 2005; Wetherall, 2012; McCrae and Kuzminska, 2017). However, other parts of the literature view professionalisation as anachronistic, outmoded and undesirable (Skinner, 2013). These parts of the literature argue for a paradigm shift towards post-professionalisation or new professionalisation or a life praxis profession (Scott, 2008; Skinner, 2013; Fielding, 2016; Rolfe, 2017). While the terminology may differ, nonetheless they all converge to the notion that modern health professionals need to shift from the all-knowing professional focusing on technical rationality and positivist epistemology to an inclusive partnership model with the inclusion of service users in decision-making. This view of professional practice aims to develop an egalitarian framework of care based on mutuality between health professionals and service users (Scott, 2008; Kagan et al., 2009; Rolfe, 2017; Babich, 2018).

Furthermore, the latter literature does not argue for deskilling professionals but instead argues for redefining professionalisation and shifting its core components to place at its epicentre the empowerment of individuals where the emphasis will be on diplomatic and relational caring skills (Scott 2008; Fielding 2016). The new model of professionalisation argued by parts of the literature and with which the current study agrees with maintains that professional expertise lies not in the monopolisation of specialised knowledge, but on the proficiency and wisdom of empowering each individual and health service user. Despite that this as well requires specialised knowledge, nevertheless, this specialised knowledge is developed through critical reflection of practice situations, through dialogue, through interpreting the person and through aesthetic rationality (Rolfe, 2015; Freshwater 2017; Rolfe, 2017).

Also, the current study acknowledges that the social environment and societal determinants influence individuals with T2D who consume alcohol in commencing and sustaining lifestyle changes and that the role of health professionals unavoidable ought to extend beyond the empowerment of the individual to affect the social environment and societal determinants. The participants in the study expressed their felt need for health professionals to advocate on their behalf in regulating the food and alcohol industry, to voice their issues and concerns in the public policy arena, and to act upon the costs and benefits associated with lifestyle changes. Similarly, recent literature asserts that health professionals have or should have a significant role in fiscal policymaking, such as taxation, regulation and subsidies. In this manner, health professionals will either prevent harm caused by the food and alcohol industries or promote the development of new products and new markets that would be suitable to individuals' with T2D lifestyles (Clark, 2014a).

Also, the literature recognises a role for health professionals in dealing with social inequalities and financial inequities (Clark, 2014a; Henderson et al., 2014). The literature proposes that marginalised, poor and minority groups have greater difficulties in accessing services, exploiting healthier available options and exploring alternative models of diabetes management (Clark, 2014a; Henderson et al., 2014; Macaden and Clarke, 2015). Similarly, the literature argues that there is a disproportionate effect of socio-environmental factors in the consumption of alcohol with the lowest income groups and the lower educated persons exhibiting socially differentiated vulnerability that leads to significantly increased consumption of alcohol (Grittner et al., 2012; Shortt, et al., 2018). Therefore, part of the health professionals role becomes the strengthening of the social movement, the reframing of the social debate and the re-examining of the structural contexts of health inequities (Clark, 2014a).

The current study focus is on individuals with T2D who consume alcohol and highlights that these individuals may use alcohol as a coping mechanism to deal with stressful and potentially unrelated to T2D life events. Therefore, even if these individuals adapted the changes required for T2D, nevertheless unrelated to T2D events can trigger alcohol consumption that in turn, can disrupt or undo any lifestyle changes achieved for T2D. The concept of increased alcohol consumption as a coping mechanism to stress-related, mutable and emotion-focused life events often appears in the literature (Deb et al., 2012; Myers et al., 2016). For example. Holton et al. (2016) identify alcohol drinking as the most frequently used maladaptive coping strategy, and Corbin et al. (2013) conclude that when individuals are unable to restrain behaviours under stress, they may resort to alcohol drinking, thereby increasing overall levels of weekly consumption.

Furthermore, the literature considers that alcohol drinking as a maladaptive and problem-avoidance coping strategy is often associated with a lack of other more effective coping strategies and with a previous history of alcohol consumption (Corbin et al., 2013; Myers et al., 2016). The finding of the current study seems to corroborate this assumption of the literature that individuals with T2D and with a history of alcohol consumption when confronted with stress-related life events such as family deaths or loss of job they resort to alcohol drinking to cope with these situations. The literature concludes that such individuals need assistance from health professionals to develop alternative coping strategies to deal with and manage negative and unsatisfactory life events (Myers et al., 2016; Tartaglia and Bergagna, 2019).

Two of the research objective of the current study focus on; a) exploring the supportive (or not) role of health professionals in assisting individuals with T2D who consume alcohol in dealing with the challenges of lifestyle alterations and b) conceptualising their experiences of adapting to the required lifestyle changes. From the heretofore discussion the participants of the current study felt that health professionals over-emphasised medical and physiological information and education reducing them to a set of symptoms and statistical data neglecting the broader meaningful contexts within which they existed. Such medicalisation of care led to viewing the participants emotional and existential needs from a much narrower perspective, draining any energy or vitality for lifestyle changes and creating a sense stagnation. Also, the medicalisation of care can overlook the possibility of supporting T2D who consume alcohol to develop more efficient and positive emotional coping mechanisms rather than rely on alcohol consumption as a coping mechanism for stressful events. The discussion suggests that the role of health professionals need to expand beyond the medicalised framework care to take into consideration the humanising framework of care. Such shift in the paradigm of care will enable and empower individuals with T2D who consume alcohol to successfully link changes to their personal histories and coherently explain to themselves the need to adopt lifestyle changes, acquiring both ownership of the changes and meaningfulness in the process.

6.1.7. Internet-based health literacy

Another issue that emerged from the findings is the influential role of the internet in achieving (or not) lifestyle changes for individuals with T2D who consume alcohol. In accordance with the participants of the current study internet sites and online fora provide useful knowledge, information and a place for exchanging experiences that can have an influential and liberating effect in achieving lifestyle changes. The literature of the last decade as well agrees that medical-related information, especially for chronic conditions such as diabetes, is catalogued amongst the leading search subjects in the worldwide web (Greenberg et al., 2013; Sillence et al., 2013).

Furthermore, internet support groups, online social networking sites and illness blogs have emerged as the preferred technology outlets for individuals with chronic conditions (Greenberg et al., 2013; Malpass et al., 2013; Sillence et al., 2013). Also, the literature asserts that internet support groups and online social networks beyond being important sources of information are also the places where individuals can develop relationships with community members and gain significant support for achieving and sustaining recovery from alcohol consumption (Chuang and Yang, 2013; Tracy and Wallace, 2016).

In summary, the literature asserts that online fora, blogs and chat rooms are places for like-minded individuals with similar health experiences to narrate and share their experiences. By narrating and sharing experiences, these individuals acquire the freedom of expression in articulating their lifeworld and influence others that share similar conditions in undertaking decisions concerning their care and lifestyles (Greenberg et al., 2013; Sillence et al., 2013; Thomas et al., 2018). This narration of experiences links with the already discussed findings of the current study on narrative construction as a medium for sense-making and lifestyle transformations.

Moreover, the direct, unmediated, and geographically unlimited aspects of online fora can further contribute in educating and empowering individuals because others can relate and connect with the narrated situations and in the process use these online shared experiences to cope and take some control over the conditions (Broom, 2009; Heilferty, 2009; Malpass et al., 2013). Online fora open the possibility for liberalising health-related knowledge. With online fora, the expert health professional is not any more the sole provider of information or knowledge, and individuals with access to online information can check and collate the information and knowledge provided by health professionals (Broom, 2009; Heilferty, 2009).

However, the participants of the current study also raised cautionary concerns about online fora, and the quality of information and knowledge acquired and created from such fora. Participants expressed their concerns that information acquired from online fora to be susceptible to oversimplifications, contradictions and inaccuracies. Such information may, in turn, lead to undigested knowledge and create greater confusion on lifestyle change issues. Similarly, Colditz et al. (2018) in a study on adolescents seeking online health information about mental health and well-being, conclude that the online health information is too complex, inaccurate and biased. They go on to suggest that this information contributes to distorting the dimensions and severity of common health problems and misconstruing these for rare and serious conditions, hence contributing to increased health anxieties. Additionally, Heilferty (2009) expresses concerns that online platforms may overwhelm individuals with the volumes of information provided and inundate them with the raw emotional expressiveness displayed in such websites. Heilferty (2009) refers to this effect as “brain dumping”, suggesting that this can have adverse effects in dealing with health issues.

The disembodied and anonymised messages transmitted via online fora allows authors of online messages the possibility of censoring or embellishing what they say. At the same time it deprives readers of the contextual clues about the writer, and limits readers opportunities to verify their understandings or explore alternative explanations by asking clarifying and follow-up questions (Broom, 2009; Hazelton and Morrall, 2011; Thomas et al., 2018). From the Humanising Framework of Care perspective, such unidirectional transmission of information and controlling of messaging leads individuals with T2D who consume alcohol to lose control and agency, and passively accept the influences of external forces of online fora (Galvin and Todres, 2013). Such passivity diminishes the possibility and potential to enact free choice and autonomously make personal decisions eventually stripping human dignity to varying degrees and in the process de-humanise individuals (Galvin and Todres, 2013; Pound and Jensen, 2018).

The current study concurs with other studies in suggesting that communicative passivity is a mechanism for social influence and control eventually leading online media to debase and dehumanise individuality (Picard, 2015; Jacobs et al., 2017). When an individual positions one's self in the spectrum of passivity dimensions of the Humanising Framework of Care, this impacts as well on the individual's spatiality of mobility domain. Galvin and Todres (2013) assert that suffering in the "spatiality of mobility in the imprisoned" domain, the individual is trapped in a metaphorical prison unable to move, constraining any wish for change.

These adverse influences of online fora may contravene the liberating and empowering impact previously assumed and in some cases, negatively affect the lifestyle change processes. Some participants of the current study voiced their concern that online fora create for them discomforting and dehumanising sentiments that eventually impede their happiness and their rhythm for developing new lifestyles. Part of the literature expresses similar concerns and contentions by warning about the dehumanising and disembodying effect that the internet technology may have (Jung and Berthon, 2009; Hazelton and Morrall, 2011; Archibald and Barnard, 2018). Online acquired knowledge and information lacks direct and mediated interactions and can become cold, impersonal, anonymised and dominated by sentiments of loneliness and isolation (Jung and Berthon, 2009; Tufekci, 2013; Archibald and Barnard, 2018).

A further consequence of the dehumanised and isolated knowledge developed on online mediums is the waning of the therapeutic byproduct emerging from the social interaction and the emotional relationships fostered between healthcare providers and healthcare receivers. The literature makes the case that online interactions for health issues may lead to losing the healing effect of physical interaction. Such healing effects include the therapeutic touch, the face-to-face clinical visits, and the identification of loneliness and isolation, sentiments otherwise remaining undetected and adversely affecting the health and wellbeing of individuals (Maville et al., 2008; Mehta, 2014; Chana et al., 2016.).

However, it is important to acknowledge that online fora on their own are not necessarily the source or the underpinning factor for developing uncaring sentiments or for providing dehumanised care. Indeed, the literature purports that the dehumanisation of care is most often the product of cultural and social influences of healthcare organisations. In specific, it is related to the target-driven closed culture, to the paper-based indicators of 'quality care' culture and the threat-based fear-driven culture of whistleblowers (Hayter, 2013; Zulueta, 2013; Traynor, 2014). All these cultural influences are not necessarily related to online fora, but depending on the use of online fora can either contribute to altering the uncaring and dehumanising care environments or amplifying it. The literature acknowledges that online fora are relatively new means of interacting, are currently understudied and lack evidence on their role and effects on health-related issues, suggesting the need for more research on the topic (Sillence et al., 2013; Archibald and Barnard, 2018; Colditz et al., 2018).

The aim of the current study is not to delve into the role of online fora relating to health, but to consider the dimensions of online fora in becoming helpful and useful for individuals' with T2D who consume alcohol to achieve lifestyle changes. The participants in the current study felt that being directed to online fora was a good starting point, but, if the information found online remains unelaborated, then these fora can become counterproductive for changing lifestyles. Participants expected that healthcare professional and in specific nurses to assist in identifying gaps between the various types of available knowledge in online fora, to facilitate them in evaluating online information to deduce meaning and consider the applicability of that information. Furthermore, participants expected that healthcare professional to promote specific online fora as sources of information and to themselves contribute with their writings in various online fora. The relevant literature admittingly agrees with the findings of the current study and recommends the re-shaping of the ways health professionals employ information technology (Hazelton and Morrall, 2011; Graffigna et al., 2012; Archibald and Barnard, 2018).

Also, the current study focus is on individuals with T2D who consume alcohol and the findings of the study highlight that the study's participants exclusively sought information in internet sources on T2D and not on alcohol consumption. Other studies report similar findings. For instance, Ravert et al. (2015) in a study on online fora and type 1 diabetes with college students concluded that the students are either reluctant to bring up the topic of alcohol consumption in public internet fora or fail to consider alcohol consumption as a central issue of diabetes management. Similarly, Tamony et al. (2015) study on online apps concluded that while there are numerous of online apps for diabetes, nevertheless alcohol content among diabetes apps remain poor.

The two main reasons individuals with T2D who consume alcohol do not seek information in online fora for alcohol is their inability to comprehend the risky relation between T2D and alcohol, and the fear of judgemental comments about the individual's character due to alcohol consumption (Jones et al., 2013; Ravert et al., 2015; Tamony et al., 2015). However, this literature argues that alcohol plays a central and detrimental role in both glucose management and lifestyle modification and suggest that health professionals have a unique opportunity to harness the power on online networking to provide appropriate, easily accessible and useful information concerning alcohol and T2D (Jones et al., 2013; Tamony et al., 2015).

Moreover, the literature suggests the re-envisaging of healthcare roles through technological integration and the rethinking of healthcare organisational boundaries (Hazelton and Morrall, 2011; Graffigna et al., 2012; Archibald and Barnard, 2018). The literature announces a new role for health professionals in the current digital age that will include the integration of online technology with humanistic components of care and heralds this as the new frontier for health intervention (Graffigna et al., 2012). This role includes safeguarding that healthcare service users have access to quality and credible online information taking into consideration the variability of fora and socioeconomic, educational, and generational disparities regarding internet access. Also, part of this role is to expand the boundaries of knowledge dissemination beyond healthcare organisations to support groups and individuals at their homes (Graffigna et al., 2012; Yang et al., 2013; Greenberg et al., 2013; Gesser-Edelsburg et al., 2017).

The credibility of online information inextricably links with the internet literacy of individuals with T2D who consume alcohol. Health professionals need to work with individuals with T2D who consume alcohol in developing their internet literacy skills in seeking high-quality online health information. This supportive work includes assisting these individuals to acquire familiarity with internet-based information sources, and to assist in developing their critical assessment skills of information retrieval (Greenberg et al., 2013; Colditz et al., 2018). To achieve such support, health professionals need to raise awareness on the inclination of accepting with greater ease information that appears to confirm their prejudices and to alert on the need to discern between the presentational style of a site and the provided information (Greenberg et al., 2013; Colditz et al., 2018).

Furthermore, the expanded role of health professionals concerning online fora includes reviewing online sites before directing individuals with T2D who consume alcohol to them. Health professionals need to ensure that useful online portals are easy to find in organisations' webpages and need to assess the credibility of online fora based on balanced personal experience, and healthcare facts and figures (Sillence et al., 2013). Finally, this new role includes the active participation of health professionals in writing on online fora. Hence, interacting and partaking in the online dialogue with individuals with T2D who consume alcohol in more accessible manners, in plain English, void of medical jargon and in short texts possibly complemented by pictures, images, videos, and other formal weblinks (Yang et al., 2013; Dowling and Albarran, 2017; Castro and Andrews, 2018).

Two of the research objective of the current study focus on; a) exploring the supportive (or not) role of health professionals in assisting individuals with T2D who consume alcohol in dealing with the challenges of lifestyle alterations and b) exploring how individuals with T2D who consume alcohol perceive the role of social networks in achieving a sense of well-being. From the heretofore discussion, the participants of the current study perceived online social networks to have both the potential of creating passivity and constraints in achieving well-being, and a liberating and important component in achieving well-being. Key role in how the online social networks will affect individuals with T2D who consume alcohol are health professionals and if they successfully (or not) integrate online social networks with humanistic components of care, and adequately prepare individuals with T2D who consume alcohol to use online social networks. Furthermore, health professionals need to harness the power of the internet and online networks to make explicit the links between T2D and alcohol consumption and to provide appropriate, easily accessible and useful information concerning alcohol and T2D.

6.1.8. The role of the family in lifestyle changes

Another issue that emerged from the findings of the current study is the role and significance of family contribution in enabling lifestyle changes for individuals with T2D who consume alcohol. The participants of the current study expressed their positive experiences of family contributing in understanding the workings of T2D, in attributing meaning to lifestyle changes, and in acting as their emotional outlets and sentimental buffers, ergo limiting the role and significance of food and alcohol as outlets for emotional expressions. The recent literature as well underscores the importance and critical role of the family in dealing with diabetes primarily focusing on parents in dealing with obesity, overweight and exercise issues of children with type 1 diabetes (T1D). Thus, suggesting a correlation between positive parenting behaviour and the impact of dealing with and maintaining the lifestyle changes in children with T1D (Sabmann et al. 2012; Sullivan-Bolyai et al., 2012; Eg et al., 2017).

However, the literature acknowledges that there are relatively limited studies exploring the role of the family in dealing with T2D and the impact that family has on these individuals' lifestyle changes. Those few studies researching family members of individuals with T2D are largely inconsistent in their approach and with limited evidence on the influence of family in the health outcomes of individuals with T2D (Mayberry et al., 2012; Stuckey et al., 2016; Eg et al., 2017). Also, the influence family has on children with T1D may potentially differ in type and extent from those concerning adults with T2D. The literature asserts that parents for children with T1D have direct responsibility for the monitorisation of insulin levels, for buying, providing and planning food and meals, for controlling and checking exercise and activities, and for serving as role models (Pereira et al., 2008; Eg et al., 2017). The families for adults with T2D do not exhibit the same influences or at least do not exhibit them at the same extent. Hence, the influence that families have on lifestyle changes for individuals with T2D may vary from the influences identified by the literature relating to T1D.

Tensions, conflicts, frustrations and increased levels of stress are sometimes present in the literature relating to the family's role in managing and supporting family member diagnosed with T2D (Pereira et al., 2008; Rintala et al., 2013; Stuckey et al., 2016). Rintala et al. (2013) consider that the family may grieve for the health condition of its' member, and in the process become over-protective and highly controlling of the individual’s life with T2D, thus leading to confrontations and conflicts between family members and the individual with T2D. Mayberry et al. (2012) define this conflict in terms of miscarried helping behaviour and explain the term as the associated rebellious attitude of individuals with T2D towards the family members inclination to infringe upon their self-efficacy and individual lifestyle, and the imposition upon them strict rules as to what and how much to eat and drink.

Similarly, a set of other studies demonstrated in a counter-intuitive manner that the greater involvement the family members have in the care of individuals with T2D, the worse the psychological outcomes are for the family members (Peyrot et al., 2015; Stuckey et al., 2016). Individuals with T2D express sentiments of sabotage and a notion of family disharmony due to the unwillingness of family members to make changes themselves in their lifestyle and by doing so to support them in initiating and sustaining lifestyle changes (Mayberry et al., 2012; Rintala et al., 2013).

The findings of the current study did not identify rebellious attitudes or sabotaging sentiments of individuals with T2D who consume alcohol towards their families and any success in initiating and sustaining lifestyle changes links to this being a collective family endeavour. The participants of the current study consider that once lifestyle changes become a collective family challenge, rather than an individual one, this intensifies the family cohesion and make the change an all including and worthwhile effort. Also, when lifestyle changes are a collective family endeavour, this maximises the motivation of individuals with T2D for lifestyle changes because they are striving for a greater cause that has ramifications to the happiness and well-being of their family and not just for their well-being.

The literature describes this collectivist familial effort in coping with (health) stressors and adversities as family resilience (Black and Lobo, 2008; Henry et al., 2015). According to the literature, family resilience models shift focus away from individual personality factors in dealing with stressors and emphasise the relational and interactional patterns of family members in dealing with stressors. The assumption is that these are qualitatively greater than each family members' characteristics (Black and Lobo, 2008; Henry et al., 2015). The key factors that enable family resilience include, amongst others shared value systems for attributing meaning to stressors, a sense of family cohesion and stable roles for its' members. Further, contributing factors to family resilience include shared time for coming together, embedded daily routines and activities, and clarity and openness of expression and communication (Black and Lobo, 2008).

Cultivating these synergetic factors in the family ecosystem leads to developing the family into an adaptive system that provides the structure and capacity to protect its member, to resolve conflict and to provide emotional support to adhere to therapeutic regimes and collectively adapt helpful lifestyles (Pereira et al., 2008; Henry et al., 2015). The findings of current study sides with the literature that highlights the importance of stable and cohesive family bonds in empowering individuals with T2D who consume alcohol to control their sentiments and emotions, and to make rational decisions and construct logical meanings of the lifestyle change processes. In other words, the family has a useful impact and beneficial outcomes when it empowers individuals with T2D who consume alcohol to be in control and to make decisions autonomously. In return, this amplifies the will power of these individuals to sustain healthy lifestyle changes as they are striving for a greater cause than one’s self, and cyclically further strengthen the family bonds that further empowers the individual's control and autonomy.

Also, the current study focus is on individuals with T2D who consume alcohol and the findings of the study highlight that family members unintentionally and contrary to their wishes, sometimes do not create a conducive environment for lifestyle changes concerning alcohol consumption. In some cases, family members unintentionally encourage alcohol drinking and may inadvertently discourage lifestyle changes in individuals with T2D who consume alcohol. Other studies on family members who are aware of the need for lifestyle changes relating to diabetes or cardiovascular disease of their relative admit to cooking unhealthy food or providing to their relative alcohol under the pressure to satisfy the tastes of the family members (Abel et al., 2018; Wekesah et al., 2019).

Also, studies exploring the required modification of alcohol consumption due to cancer or mental health problems, conclude to the assumption that the more affluent families are, the greater difficulty they have in altering alcohol drinking patterns. Spending money to buy alcohol was done unconsciously and in part as a display of affection for their family member (McDonnell et al., 2019; Maenhout et al., 2020). Other factors that lead family members to discourage changes in alcohol consumption unconsciously are the need to cope with other changes rated as a higher priority, limited time and the need of the entire family to change alcohol-consuming patterns (Pearson et al., 2012; McDonnell et al., 2019; St. George et al., 2019). The family members need support to avoid this unconscious discouraging attitude towards the alteration in alcohol drinking patterns for individuals with T2D, and such support includes concurrent educational sessions with individual with T2D who consume alcohol and actively encouraging family interactions (St. George et al., 2019; Asril et al., 2020). In this way, family members will acquire greater awareness of the impact of alcohol consumption and be in a position to provide greater support in the reduction of alcohol consumption.

Furthermore, the family can provide a sense of continuity with the past for individuals with T2D who consume alcohol acting as the connective bond linking the familiarity of their past lifestyles with the unfamiliarity of the required future altered lifestyle, and in this manner ease the required lifestyle changes. From the Humanising Framework of Care perspective, to be a human is to be on a journey and constantly move from the past to the future. This personal journey is put in jeopardy when the individual is oppressed by the past to remain in that past, or is shocked by the unfamiliarity of the future and becomes unwilling to move forward (Galvin and Todres, 2013). The fracturing of continuity between past and future, and the subsequent unwillingness to move forward is in part a result of over-focusing on the present and dealing with individuals in snapshot approaches, disregarding their context, past experiences and hopes for the future, thus leading to loss of personal journey (Galvin and Todres, 2013; Norton, 2013).

The current study concurs with other studies in suggesting that individuals can move forward and achieve lifestyle changes when considering their unique life context as shaped by others in the past and take in consideration their sense of a future with others. Failure to do so inevitably traps these individuals in the present. It creates a sense of being condemned to a future similar to their current situation, feeling as being on a conveyor belt of treatment that they cannot get off and eventually dominated by feelings of loss of personal journey (Knight, 2018; White and Tait, 2018; Diniz et al., 2020). When an individual position one's self in the spectrum of "loss of personal journey" dimensions of the Humanising Framework of Care, this impacts as well on the individual's identity of "dwelling-mobility in the "I am fragmented" domain. Galvin and Todres (2013) assert that suffering in the "identity of dwelling-mobility "I am fragmented" domain the individual typically loses coherence of self, feels depersonalised and fragmented. This consequently, leads these individuals to deep resignation, disempowered in making major life transitions and rendered weak to move forward.

Findings from other studies in a similar manner highlight the importance of family involvement in the care, especially relating to children (Tidwell et al., 2011, Kuo et al., 2012; Macdonald et al., 2012; Eg et al., 2017), but also in cases requiring palliative care or ageing population (Feinberg; 2014; Wolff and Boyd, 2015), and some limited studies in intensive care units (Vandijck et al., 2010). All these studies conclude and argue for the introduction and implementation of a family-centred care model as the most appropriate for providing care. The core concept underpinning the family-centred care model is the inclination to define some conditions as family diseases, and the development of a partnership between health professionals and families to engage in shared decision-making and shared responsibility of care (Mikkelsen and Frederiksen, 2010; Smith et al., 2015; Stuckey et al., 2016).

The main body of research on the family-centred care model relates to child care, where the family and especially parents are the main caregivers or to cases, where individuals have limited capacity in making decisions such as in dementia or ICU cases (Mitchell and Chaboyer, 2010; Eichner and Johnson, 2012; Coyne et al. 2013; Lopez et al., 2013). Furthermore, there are limited publications that discuss the family-centred care model in chronic conditions involving lifestyle changes. There is a lack of systematic studies that prove the benefits of the family-centred care model, and there are cultural variations in terms of family bonds and collectivism that restrict the application of family-centred care model (Peyrot et al., 2015; Deek et al., 2016).

Therefore, the current study while sharing some general principles of the family-centred care model, such as the involvement of family members in a collaborative partnership, the expressed respect of differences amongst families, and the negotiated care, nevertheless the findings of the current study are not able to make a case for implementing family-centred care model for supporting individuals with T2D who consume alcohol in altering unhealthy lifestyles and sustaining healthy lifestyles (Kuo et al., 2012). The reasons the current study cannot support the family-centred care model for lifestyle changes of individuals with T2D who consume alcohol initially relates to the self-admission of the relevant literature of conceptual ambiguity and definitional inconsistencies in respect to family-centred care model (Mikkelsen and Frederiksen 2011; Smith et al., 2015).

Furthermore, there appears to be a theoretical conflation of patient-centred care with family-centred care or even misappropriation of terms and concepts amongst patient-centred care and family-centred care (Kuo et al., 2012; Feinberg; 2014; Wolff and Boyd, 2015). Also, at times, the literature uses the terms interchangeably or complementary to each other, thus further adding to the conceptual confusion (Kuo et al., 2012; Feinberg; 2014; Wolff and Boyd, 2015). Lastly, it appears that the concept of family-centred care emerges and relates to situations whereby the individual has limited decision-making capacities, restricted potential in making choices and resolving problems, and diminished ability to take control of their care. Therefore requiring the family to step in and partner with healthcare professionals to decide, problem-solve and control care (Lusk and Fater, 2013; Smith et al., 2015). Such positioning contravenes to key aspects already developed in the current discussion that advocate for the use of the Humanising Framework of Care where the individual's personhood, humanity and autonomy is respected, considered and promoted.

However, the current study recognises the importance of family in terms of the cultural, and social influence that can motivate, empower and further develop meaning in the required lifestyle changes of individuals with T2D who consume alcohol. Therefore, health professionals, on the one hand, empower individuals with T2D who consume alcohol and facilitate them to use their family as supportive and inspirational sources for change, and on the other hand include in their caring repertoire educational and supportive services for family members (Peyrot et al., 2015). Furthermore, the education and support provided to the individual and the family should be strength-based orientated by accentuating in their interactions the positive qualities of the family, such as relationship patterns, interpersonal skills, and competencies, rather than on focusing on family deficits (Black and Lobo, 2008). Also, health professionals need to be aware of and responsive to policy issues and society-wide problems. Such issues include as poverty and reducing disparity amongst members of the family and to contribute in developing organisational policies that allow for the time and space to meet, educate and listen to family members (Black and Lobo, 2008; Stuckey et al., 2016).

6.1.9. Well-being

Finally, the participants of the current study achieved a sense of well-being when they were able to adapt and become attuned to the altered lifestyle. Furthermore, when the sense of attunement to the new lifestyle actualised, this felt as progression to a higher level of personal development that created both feelings of satisfaction with their new lifestyle and a vision of their future life. The feeling of satisfaction with the new lifestyle and planning for the future are key factors for sustainable lifestyle changes because these are also key factors for well-being. Todres and Galvin (2010) suggest that the concept of well-being emerges from and resides in the individual’s sense of dwelling and mobility. The variations of well-being lie in the dialectic relationship of mobility and dwelling, hence offering a wide variation of well-being sentiments. The concept of dwelling relates to being-at-home-with what has been given or coming to terms and accepting a situation. The concept of mobility relates to having the opportunity and feeling of being able to develop and of having a vision and a possibility for a desirable future (Smith and Shaw, 2017).

Those participants of the current study that expressed feelings of satisfaction, joy and well-being during the interviews were those that adapted and were attuned to their new lifestyle and felt comfortable with both the diagnosis of T2D and with their new lifestyle. Liu and Kohlen (2018) refer to this as the normalising process of managing diabetes and Smith and Shaw (2017) as the assimilation of T2D into the individual’s life and at the same time retaining their agency. Hence ceasing to conceptualise diabetes as a disruption, a disharmony or a disease and making it part of everyday normality (Smith and Shaw, 2017). This type of acceptance is not a stoic attitude of no alternative but is a sense of taking control and having the freedom and responsibility for choices (Vestman et al., 2014; Berglund et al., 2015; Smith and Shaw, 2017).

Moreover, the individuals with T2D who consume alcohol who expressed attunement to the new lifestyle also expressed plans for the future. The expressed desire and energy of making plans for the future and wishing to live their lives fully is similar to Todres and Galvin (2010) concept of existential mobility. In accordance to the literature, the notion of mobility is the second component (after dwelling) for achieving a sense of well-being (Todres and Galvin, 2010; Hemingway et al., 2016; Smith & Shaw, 2017). Therefore, well-being also includes the ability to achieve one’s life potentials, to have a purpose and to keep growing as a person (Hemingway et al., 2016).

Two of the research objective of the current study focus on; a) conceptualising the experiences of individuals with T2D who consume alcohol in adapting to the required lifestyle changes and b) exploring how these individuals perceive the role of social networks in achieving a sense of well-being. From the heretofore discussion, the participants of the current study when conceptualised lifestyle modifications as a collective family endeavour, then the change was much easier in achieving and with greater possibilities of sustaining the change. Family members as a social network can be for individuals with T2D who consume alcohol a supportive source to come to terms with their situation and inspirational force for making desirable plans for the future. Hence, family as a social network has a central role in the well-being of individuals with T2D who consume alcohol.

The current study uses Galvin and Todres' (2013) well-being model embedded in the Humanising Framework of Care to analyse and discuss the findings. Key aspects of Galvin and Todres' (2013) well-being model are the three dimensions of "dwelling", "mobility" and the unity of "dwelling-mobility". Galvin and Todres (2013) make the case that the greater levels of "dwelling", "mobility" and the unity of "dwelling-mobility" achieved, the greater the levels of well-being the individual achieves. Furthermore, Galvin and Todres (2013) make more tangible the processes of moving towards greater levels of "dwelling", "mobility" and the unity of "dwelling-mobility", and therefore achieving greater levels of well-being by developing a typology of well-being with eighteen domains. As analysed in sub-heading 3.4. of the current study these eighteen domains while related and implicated with each other, nevertheless retain a degree of distinctiveness and there are different levels of emphasis with different individuals and in different cases and contexts. Hence, in various cases and different context, some of the eighteen domains of the well-being typology require from individuals and health professionals greater emphasis to achieve greater levels of well-being.

From the findings of the current study and the above discussion, there are a set of domains from Galvin and Todres' (2013) well-being model that individuals with T2D who consume alcohol and health professionals need to place greater emphasis on to direct these individuals towards greater levels of well-being. The first domain that requires emphasis is that of "kinship and belongingness" within existing social groups and avoidance of social isolation and social dislocation. The second domain that requires emphasis is that of "layered continuity" and closely linked domain of "I am" to avoid the objectification of the individual and to promote individuals identity in making sense of the T2D and alcohol consumption, and to create a future with unique goals. The third domain that requires emphasis is that of "present centredness" and avoidance of clinging on to past or previous ways of living life. The fourth domain that requires emphasis is supporting the "vitality" of the individual in finding purpose in the future and avoiding sentiments of exhaustion or stasis in the diagnosis of T2D. The fifth domain that requires emphasis is that of "adventurous horizons" where the individual with T2D who consume alcohol is promoted to an agency of choice and is encouraged to make personal decisions autonomously. The sixth domain that requires emphasis is that of "at-homeness" where the individual with T2D who consume alcohol settles and feels at peace with their T2D diagnosis and the need to alter lifestyles.

The above six domains of the well-being typology highlighted by the findings of the current study are those that require the greater emphasis when caring and supporting individuals with T2D who consume alcohol. However, this does not imply ignoring the rest of the domains. The current study acknowledges the intertwining nature of all eighteen domains of the well-being typology. However, the findings suggest that when caring for and supporting individuals with T2D who consume alcohol to acheive a sense of well-being the above six domains are the starting points of the caring process.

6.2. Strengths and Limitations

The current study using interpretive phenomenology explores and illuminates the meaning that individuals with T2D who consume alcohol attribute to their lived experiences and their notion of well-being.

One of the study's limitations is the interview design and process. For the researcher to gain in-depth information regarding the experiences of the participants, the data relied on the retrospective recall of participants' experiences. Participants' memory of such experiences and how they internalised such processes over time may have biased or distorted the provided information. The second study limitation relates to semi-structured interviews. As the interview schedule was preconceived and did not emerge from the participants, the researcher may unintentionally have given priority to some areas of experiences over others. The flexibility semi-structured interviews balanced this limitation to some degree since semi-structured interviews allow for degrees of deviation from the pre-designed interview questions and participants were free to discuss as well other issues. However, like all qualitative researchers using semi-structured interviews, the researcher of the current study as well could not control the material a participant chose to offer or the way the participant offered it, and the effect this may have had on the study. Finally, another potential limitation identified was the researcher's pre-understandings and fore-conceptions and how much these influenced the research process. The researcher, before the commencement of the current study, became aware of her pre-understandings (as presented in chapter 1) through the process of reflection. However, one can never be truly aware of one's pre-understandings and fore-conceptions nor can fully understand the influence these may have had on the study.

One of the strengths of the current study is the semi-structured interview schedule that allowed the gathering of rich and detailed information from participants, as is evident from the amount of data collected. As indicated in chapter four, the researcher took a set of steps to ensure and secure the quality, reliability and validity of the study. Regular supervision and reflection allowed a robust analysis of the data. Evidence of these is found throughout the study as the researcher uses both direct quotes from the original transcripts and the reflective understandings to analyse, present and discuss the findings. Another strength of the current study is the richness of data and the variety of understandings that this study added to the existing literature regarding individuals with T2D who consume alcohol. The semi-structured interviews allowed the participants to discuss openly other topics that might not come to light otherwise. Finally, the researcher achieved transparency and coherence by providing a transparent account of the data collection and interpretation of the data and by connecting the research aim and objectives with the theoretical framework, the chosen methods and the broader literature.

6.3. Reflections

My experience as a researcher conducting an interpretive phenomenology was both challenging and enjoyable. I learned many things during the research process. Some of the learning points I will present relate to my clinical experience, some relate to my work as a researcher and PhD student, and some relate to my personal experiences of T2D and lifestyle changes. This research project has a personal meaning for me and allowed me to fully experience the importance of reflection and its role in transparency.

I found it complicated to understand the concept of reflection and interpretation of the data before the analysis. I initially felt anxious that discussing and presenting my previous experiences, and how they have shaped this project may invalidate the academic qualities of the project. However, I soon realised that this type of research requires and inevitably involves me as the researcher to interpret and present the data. Conducting this study and using interpretative phenomenology, I realise that as a researcher, I could never really be objective, since the research endeavour is a human activity. As such, I will inevitably bring myself into the research process.

Also, I have reflected on my role as a clinician. During the current study, I used myself as a tool for interpreting the data, and I felt familiar with this process because I realised I am using myself as a tool for interpretation during my daily interaction with patients in my clinical area. This realisation made me aware that reflection is not only an important tool of the research process, but it is also a tool for my work as a clinician and my overall continuous professional development.

I found interpretive phenomenology a complicated and difficult in understanding and applying it. I feel proud of the work I have done and the way I have interpreted, organised and presented the data. Moreover, I felt honoured that the participants of the study trusted me and openly shared their very personal moments and experiences. The participants' trusting attitude made me even more determined to present in the best possible way their experiences and beliefs. Also, I enjoyed reading and trying to analyse the participants' unique and sometimes unusual choice of words or the use of extraordinary phrases. Finally, interpretive phenomenology provided me with a liberating feeling because I was allowed and empowered to make my interpretations (as long as they were grounded in the data).

Now that the project ended I realise the value of this type of research because it allows for the production of rich data and in-depth understandings. Lastly, on a personal level, I learnt to believe and be confident with my abilities, and I learnt how to use strategies that can help me remain organised and help me plan my time in the best possible way. I believe that the above points will help me in my future career and will help me work effectively and confidently not only as a researcher but also a clinical practitioner and human being.

CHAPTER 7: CONCLUSION

7.1. Conclusion

The conclusion section provides a summary of the study's key findings and issues, and also demonstrate how the study aim and objectives are met and answered (Bettany-Saltikov, 2012; Glasper and Rees, 2013). Furthermore, the literature suggests that the conclusion section of studies should incorporate some form of reference to the implications the study findings have for improving and enhancing practice, and to suggest recommendations emerging from the findings concerning policy, practice and further research (Cronin et al., 2008; Bettany-Saltikov, 2012; Glasper and Rees, 2013). Therefore, the current conclusion section commences by providing a summary of key ideas on relevant issues, and explicitly demonstrate how these answer and satisfy the aim and objectives of the study as originally set out at the commencement of the study. Furthermore, this chapter includes sections entitled implications and recommendations that demonstrate how the study findings can assist in improving and enhancing practice, and also what suggestions emerge from the study findings for policy, practice and further research.

The inspiration of the current study was the researcher problematisation on issues relating to T2D, alcohol consumption, lifestyle changes and well-being. The review of the literature further highlights that increased alcohol consumption can intensify T2D complications and affect the overall well-being of these individuals. Furthermore, the potential for individuals with T2D to change lifestyles requires personal maturation and growth, but this is a difficult process and in most cases remains an aspiration and the lifestyle changes become illusory adaptations. Therefore, in most cases, lifestyle change lack sustainability and overall affects the lives and sense of well-being of individuals with T2D. Furthermore, the literature identifies that there is a lack of studies focusing on individuals with T2D that consume alcohol and their potential to change lifestyles, in spite the fact that alcohol consumption is an additional barrier to lifestyle changes. The current study aimed at acquiring an in-depth understanding of lifeworld experiences, lifestyle changes and well-being of individuals with T2D who consume alcohol. The objectives of the study are:

- To explore how individuals with T2D who consume alcohol experience its effects on initiating and sustaining lifestyle changes
- To identify the processes by which individuals with T2D who consume alcohol develop meanings from their experiences of lifestyle modification
- To explore how individuals with T2D who consume alcohol understand the support role of healthcare professionals in meeting their emotional and existential challenges.
- To conceptualise the lived experiences of individuals with T2D who consume alcohol in adapting to the required lifestyle changes.
- To explore how individuals with T2D who consume alcohol perceive the role of social networks in achieving a sense of well-being.

The current study employs interpretive phenomenology and identifies that the first study objective concerning the effects of alcohol consumption on initiating and sustaining lifestyle changes to have both overt and covert influences. The findings highlight that individual withT2D who consume alcohol view alcohol to have similar qualities as that of food, and at points conflate the role food and alcohol consumption has in affecting lifestyle changes. Like food, alcohol has greater significance for these individuals than the mere need to drink. Alcohol takes on a symbolic form signifying the manner individuals with T2D wish to live their social lives and unconsciously internalise the significance that their social network attribute to alcohol consumption. Alcohol consumption takes the symbolic form of forging the participants' social identity, of constructing the internalised norms of their social belongingness, and of attaining and maintaining group membership in social groups. Lifestyle changes that alter and limit alcohol consumption directly affect the individual’s internalised social identity and their membership in social groupings that previously belonged. Also, individuals with T2D who consume alcohol the alcohol-consuming social groups tend to forge in most cases the salient social identity adding more barriers and greater social costs when attempting lifestyle changes in comparison to non-alcohol consuming individuals with T2D.

Also, the participants of the current study view the labelling of alcohol products as insufficient, unfriendly and in cases incomprehensible. Furthermore, labelling with a full display of contents and ingredients remains a voluntary commitment and alcohol is at large not treated as a food product. Alcoholic beverages are exempt from the mandatory labelling of the list of ingredients and the nutritional declaration. This insufficient labelling affects the potential of individuals with T2D who consume alcohol to select a healthier life option. Moreover, the lack of appropriate and mandatory labelling on alcohol drinks has a negative and disempowering influence for individuals with T2D who consume alcohol and affect their potential to alter their drinking patterns and styles of life.

The second study objective focuses on the meaning-making potentials of individuals with T2D who consume alcohol concerning their lifeworld experiences of their current situation. The study findings identify multiple sources that influence and impact on the meaning-making processes of these individuals. Initially, social norms, social conditions and social relationships, along with memberships in social groups all influence how individuals with T2D attribute meaning to their condition. Also, the study findings point out that multiple group memberships provide the social capital to buffer the negative consequences of the T2D, and that the multiplicity of group memberships increases the likelihood that individuals will be able to maintain at least some of these memberships following the life-changing event of T2D. Thus, functioning as psychological resources and existential security to achieving lifestyle modifications.

Another meaning-making source for individuals with T2D who consume alcohol is the development of personal narratives. The findings of the current study assert that an integral component of the caring provision for individuals with T2D is to assist and support them in constructing explanatory, sense-making and transformative narratives that justify and warrant lifestyle changes. However, the findings also caution that the pharmaceuticalisation and medicalisation paradigms that focus on the impersonal transmission of knowledge by health professionals ignoring personal needs, and subjective complexities dominate the current health system further impeding the development of meaningful narratives. Failure to create new, explanatory and persuasive narratives concerning the T2D can lead to dissatisfaction with the provided care, disempower, marginalise and alienate these individuals.

However, genuine provision of care without enhancing the human capacity to organise and embody the lived experiences into narrative forms is considered to be an impossibility. Therefore the findings of the current study consider that a core aspect of care is the development and reinforcement of individual reflections on their reality to provide explanations for why things happen in certain ways, account for motives, causes, and reasons, and involve others in one's world view.

The current study uses the Humanising Framework of Care to explicate the processes by which individuals with T2D who consume alcohol achieve meaning-making narratives. The Humanising Framework of Care argues for the provision of continuous and bidirectional education and information exchange between health professional and individuals with T2D who consume alcohol connecting education with previous experiences and future aims. The finding of the current study suggests that health professionals do not correlate or fully understand the role of alcohol consumption in deterring lifestyle changes in T2D. Therefore, they do not provide any information or support with regards to alcohol consumption and the development of personal narratives for changing alcohol drinking patterns. The focus of the provided information to individuals with T2D who consume alcohol is on T2D and not on alcohol consumption. Hence, making it even harder for individuals with T2D who consume alcohol to achieve lifestyle changes in comparison to non-alcohol consuming individuals with T2D.

Therefore, health professionals need to become aware of the role of alcohol consumption in lifestyle alterations for individuals with T2D and make support for the reduction of alcohol consumption an integral component of the empowering processes of individuals with T2D who consume alcohol. Also, the Humanising Framework of Care can assist these individuals to link their education with their social relationships and can make information appealing and goal-relevant. All this entails the involvement of individuals and families in the designing of lifestyle changes, and continuously evaluating the influence of the various socio-economic, cultural and geographical settings that affect individuals' lifestyles.

Also, another source for meaning-making for individuals with T2D who consume alcohol is online and web-based fora. Online fora provide the space for individuals with T2D to narrate their experiences and in the process, assist them in their narrative construction as a medium for sense-making and lifestyle transformations. Moreover, online fora can further contribute to developing the meaning-making source by empowering individuals with T2D because they can relate and connect with others’ narrated situations and in the process use these online shared experiences to cope and take some control over the T2D condition. However, for individuals with T2D who consume alcohol in comparison to non-alcohol drinking individuals with T2D, the meaning-making of lifestyle changes from internet and online fora may as well pose some difficulties. The two main difficulties individuals with T2D who consume alcohol face are their unwillingness to seek information in online fora for modification of alcohol consumption patterns due to their inability to comprehend the risky relation between T2D and alcohol, and the fear of judgemental comments about their character due to alcohol consumption.

The third study objective focuses on individuals with T2D who consume alcohol and their experiences of interacting with health professionals. The current study findings identify variations of roles with some being more effective and others less effective for supporting lifestyle changes and conclude with suggestions for maximising health professionals effectiveness in supporting individuals withT2D to achieve lifestyle changes. Ineffective health professional attitudes for achieving a lifestyle for individuals with T2D are those that sterilely focus on one-way information-giving primarily typified by physiological information. The overwhelming emphasis of health professionals on drug prescription, drug administration and drug compliance ignores the individual's personality and indiscriminately position the concept of diagnosis at the epicentre of the caring processes.

Such, ineffective attitudes for lifestyle changes have roots in the paradigm of medicalisation model and the culture of pharmaceuticalisation that still dominate health professionals minds and attitudes. This paradigm and culture dehumanises individuals, objectifies persons and overlooks the significance of lifestyle in T2D and therefore negatively affects these individuals sense of well-being. The paradigm of medicalisation and the cultural of pharmaceuticalisation appear to serve the professional interests of health professionals and the financial interests of drug companies, rather than the interests of individuals with T2D who consume alcohol.

On the contrary, effective health professional attitudes for achieving a lifestyle change for individuals with T2D are those that focus on the personhood and the humanisation elements of these individuals. Furthermore, health professionals need to understand the social context, the developed interpersonal relationships of individual with T2D, and the reflections on one's own life experiences that shape the personhood of the individual. In this manner the uniqueness of the person, the person's relationships and the meaning the person attributes to being human acquire a prominent role in constructing meaningful stories for the need to change lifestyles, for commencing the change process, and for sustaining change. Furthermore, and in specific for individuals with T2D who consume alcohol health professionals need to assist these individuals in developing alternative, to alcohol consumption, coping strategies to deal with and manage negative and unsatisfactory effects of various life events.

To materialise the overall adaptation effective and caring attitudes from health professionals that enable lifestyle changes for individuals with T2D requires a shift in professional culture and a reframing of health professionals' roles. This shift includes the move from professional and specialised knowledge to developing the expertise and wisdom of empowering individual health service user to critically reflect on specific situations, to constructively develop dialogues, and to creatively interpret specific situation through aesthetic rationality. This shift of expertise for health professionals reframes their roles to include; a) the analysis of social identity, social belongingness and social group membership of individuals with T2D who consumes alcohol, b) the understanding of the cultural and financial variables in the planning of care, c) the emphasis on policy education and involvement in policy regulation, internet literacy and participation in online interactions, d) the inclusion of family members in the support and caring processes, and allowing time and space to meet, educate and listen to the family members, and e) the targeting of poverty and the reduction of disparity amongst individuals and groups.

The fourth study objective focuses on individuals with T2D who consume alcohol experiences in adopting lifestyle changes. The findings of the current study identify factors that impede lifestyle changes and factors that promote lifestyle changes. Factors that impede lifestyle changes for individuals with T2D who consume alcohol are; a) the role that alcohol and food consumption has on social identity and group belongingness, b) the lack of understanding of food and alcohol labelling, c) the over-emphasise by health professionals on the somatic, pharmacological and impersonal aspects of T2D, d) the individual blaming culture inherent in the medicalisation model of care and e) the neglect in the care process of the subjective complexities and family relationships. Factors that promote lifestyle changes for individuals with T2D who consume alcohol are; a) the development of multiple group memberships, b) the articulation of a persuasive narrative that links the lifestyle changes with individual histories and gives meaning to the change process, c) the experience of feeling comfortable with the lifestyle change and developing a future vision, d) the weaving of education and formal information with personal values and experiences, e) the sense that the lifestyle change is for a greater purpose, such as for the benefit of the family, rather than for the mere personal benefit and f) the development of ownership of the lifestyle changes.

The more of the above impeding factors an individual has, the more negative the experience from the lifestyle change becomes. The result is for individuals with T2D who consume alcohol to implement any lifestyle changes superficially and either quickly revert to their previous lifestyle behaviours or to become nostalgic of their previous lifestyles and melancholic for their loss. Thus, minimising any chances of sustaining the lifestyle changes. In contrast, the more of the above promoting factors an individual has, the more positive the experience from the lifestyle change becomes. The result is for individuals with T2D who consume alcohol to feel happy with their new lifestyle and to look forward to their future within the context of their new lifestyle.

The fifth study objective focuses on individuals with T2D who consume alcohol and their sense of well-being. The study findings identify a series of preconditions that can contribute to the well-being of individuals with T2D. Increased group membership and support for developing new group memberships is a significant precondition for the well-being of these individuals. New group memberships provide psychological resources, existential security, and increased opportunities for developing their new social identity based on their new lifestyle that can promote a sense of well-being. Also, the collectivist familial effort and family resilience is another precondition for achieving a sense of well-being. When the focus shifts away from individual personality factors in dealing with stressors and directed towards the relational and interactional patterns that family members develop this acts as emotional outlets and sentimental buffers for the individual contributing to their sense of well-being.

Finally, the sense of attunement to the new lifestyle and integrating the new lifestyle in everyday normality, the sentiment of growth and progression, and the planning for the future are key preconditions for the development of sentiments of well-being. To achieve the sentiments of attunement and growth health professionals need to promote the concepts of "belongingness" within existing social groups and avoiding objectifying the individual. Also, it requires an emphasis on the present and not the past, and underscoring the "vitality" of the individual in avoiding clinging on to the past and in finding purpose in the future. Finally, it requires the empowerment of the individual as an agency of choice to develop new horizons and to feel at home with their T2D diagnosis and the need to alter lifestyles.

7.2. Study implications

The literature considers that the implications of the study findings as a significant subsection of a thesis as these refer to the applicability of the findings and their usefulness for practice. This study provides an understanding of the lived experiences of individuals with T2D who consume alcohol concerning the existential challenges they face in changing their lifestyles, in making meaning of their lifeworld and in this manner they perceive the caring processes to achieve a sense of well-being in the new lifestyle.

The recommendations that emerge from the study findings include a set of care processes that can assist in confronting the existential challenges of lifestyle changes for individuals with T2D who consume alcohol. These include support and empowerment of these individuals in finding meaning in their new lifestyle and making sense of what well-being is for them. Healthcare professionals and the caregiving organisations, such as NHS and Diabetes Support Groups need to shift focus from merely providing information and delivering sterile educational programs to incorporate understandings of the social identity of individuals with T2D and work with these individuals in enabling personal growth, in maintaining and developing group memberships and in constructing personal narratives that link the lifestyle change to the history of the individual and the context within which the individual with T2D exists.

Another implication that emerges from the study findings is the substitution of the medical model of care that focuses on the condition or “disease” with the Humanising Framework of Care model. The Humanising Framework of Care has the benefit of providing continuous and bidirectional information and educational provision, along with the active involvement of individuals and families in designing of lifestyle changes. Also, the Humanising Framework of Care continuous evaluation of the various socio-economic, cultural and geographical settings that affect individuals’ lifestyles, along with the humanistic care values of human dignity, coming to terms and making peace with T2D and the related lifestyle changes.

Also, another implication that emerges from the study findings is the greater social and policy involvement of health professionals. For health professionals to assist individuals with T2D who consume alcohol to initiate and sustaining lifestyle changes, it does not suffice to be aware of physiological, symptomatology and medicational issues only, but require greater involvement and action at a social level by partnering with food and alcohol industries to influence consumer knowledge and behaviour, lobby for affordable healthy food choices for lower-income populations and act upon the social environment and societal determinants to enable lifestyle changes. Also, health professionals need to have greater awareness and involvement in policy processes to educate T2D individuals, to act upon policy regulation of the food and alcohol industry, to become more engaged with the media, to advocate on behalf of T2D in the public policy arena and to coalesce with patient alliances and professional organisations.

A final implication that emerges from the study findings is the need for greater internet literacy of health professionals and increased focus on family support of individuals with T2D. Health professionals who work with individuals with T2D need to support them in order acquire familiarity with internet-based information sources, assist in developing critical assessment skills of online information, raise awareness for issues they feel are relevant and alert them in making distinctions between the presentational style of the provided information and its' content. Also, health professionals need to make space and time to meet, listen and inform family members of individuals with T2D who consume alcohol. Of course, this does not imply that the family will become the epicentre of care supplanting the individual with T2D, but by supporting family members the individuals with T2D can become empowered, inspired and motivated to achieve lifestyle changes.

7.3. Recommendations

The study recommendations include all the “should do” sentences that emerge from the discussion of the study findings (Cronin et al., 2008). For individuals with T2D who consume alcohol to successfully achieve lifestyle changes and attain a sense of well-being in the new lifestyle, the study provides the following recommendations:

- Health professional should further study the implication relating to multiple group memberships and its' significance for enabling lifestyle changes for individuals with T2D who consume alcohol.
- Health professionals should intervene and develop spaces and opportunities for individuals to maintain connections and links with communities to which they used to belong.
- The undergraduate and postgraduate curriculum of health professionals should, amongst others incorporate policy document analysis, to promote and encourage health researchers to engage in the public policy arena and to become engaged with the media.

- Further research and discussion should take place concerning the role and effects of personal narratives and their contributions in enabling lifestyle changes in individuals with T2D who consume alcohol.
- Health professionals should interweave the voices of medicine and the individual lifeworld into a consistent, mutually agreed-upon story, thus unifying the scientific and humanistic components of knowledge to produce a comprehensive vision for each human being
- Qualitative research studies should be carried out on family members to gain greater insight into cultural differences regarding desired educational objectives and needs of families.
- Further research and discussion should take place about online health-related information and online fora as they constitute relatively new means of interacting and are currently understudied.
- Health professionals should educate individuals withT2D who consume alcohol on food and alcohol labelling discussing and interpreting food and alcohol labels.
- A paradigm shift from the medicalisation of care to a humanistic framework of care model should take place in practice to understand the individual as a human existence in context and in relation to others taking into account the complexity, interrelatedness and messiness of individuals' with T2D inhabited worlds at the specific time.

REFERENCE LIST

Abel, S., Whitehead, L.C. and Coppell, K.J. 2018. Making dietary changes following a diagnosis of prediabetes: a qualitative exploration of barriers and facilitators*.* *Diabetic Medicine.* **35**(12), pp. 1693-1699.

Agee, J. 2009. Developing qualitative research questions: a reflective process. *International Journal of Qualitative Studies in Education*. **22**(4), pp. 431-447.

Ahlin, K. and Billhult, A. 2012. Lifestyle changes- a continuous, inner struggle for women with type 2 diabetes: a qualitative study. *Scandinavian Journal of Primary Health Care.* **30**(1), pp. 41-47.

Al-hamdani, M. and Smith, S. 2015. Alcohol warning label perceptions: emerging evidence for alcohol policy. *Canadian Journal of Public Health.* **106**, pp. 395-400.

AllPsych. 2011*. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).* [Online]. West Palm Beach, FL: Heffner Media Group. [Accessed 22 November 2014]. Available from: http://allpsych.com/disorders/dsm.html.

American Diabetes Association (ADA). 2008. Diagnosis and classification of diabetes mellitus. *Diabetes Care*. **31(**s1), pp. S55-S60.

American Psychiatric Association. 2000. *Diagnostic and statistical manual: mental disorders.* 4th ed. Washington, DC: American Psychiatric Association.

American Psychiatric Association. 2013. *Diagnostic and statistical manual of mental disorders (DSM-V)*. 5th ed. Washington, DC: American Psychiatric Association.

Arai, K., Oka, M. and Motegi, E. 2014. Awareness of pre-alcoholic status and changes in such awareness. *Journal of Addictions Nursing*. **25**(1), pp. 35-40.

Arain, M., Campbell, M.J., Cooper, C.L. and Lancaster, G.A., 2010. What is a pilot or feasibility study? A review of current practice and editorial policy. *BMC Medical Research Methodology*. **10**, article no: 67 [no pagination]

Archibald, M. and Barnard, A. 2018. Futurism in nursing: Technology, robotics and the fundamentals of care. *Journal of Clinical Nursing*. **27**(11-12), pp. 2473-2480.

Ashworth P. 2015. The lifeworld - enriching qualitative evidence. *Qualitative Research in Psychology*. **13**(1), pp. 20-32.

Asril, N.M., Tabuchi, K., Tsunematsu, M., Kobayashi, T. and Kakehashi, M. 2020. Predicting healthy lifestyle behaviours among patients with type 2 diabetes in rural Bali, Indonesia. *Clinical Medicine Insights: Endocrinology and Diabetes.* **13**, article no: 117955142091585 [no pagination]

Athyros, V., Liberopoulos, E.N., Mikhailidis, D.P., Papageorgiou, A.A., Ganotakis, E.S., Tziomalos, K., … Elisaf, M. 2008. Association of drinking pattern and alcohol beverage type with the prevalence of metabolic syndrome, diabetes, coronary heart disease, stroke, and peripheral arterial disease in a Mediterranean cohort. *Angiology*. **58**(6), pp. 689-697.

Averill, J. 2015. Qualitative data analysis. In: de Chesnay, M. ed. *Nursing research using data analysis: qualitative designs and methods in nursing*. N.Y.: Springer Publishing Company, pp. 1-10.

Babich, B. 2018. Ivan Illich's medical nemesis and the 'age of the show': on the exploration of death. *Nursing philosophy*. **19**(1), pp. 1-14.

Baggott, R. 2012. Policy success and public health: the case of public Health in England. *Journal of Social Policy*. **41**, pp. 391-408.

Bailie L. 2015. Promoting and evaluating scientific rigour in qualitative research. *Nursing Standard*. **29**(46), pp. 36-42.

Bakhshi, A. and While, E. 2014. Older people and alcohol use. *British Journal of Community Nursing*. **19**(8), 370-374.

Baliunas, D.O., Taylor, B.J., Irving, H., Roerecke, M., Patra, J., Mohapatra, S. and Rehm, J., 2009. Alcohol as a risk factor for type 2 diabetes. *Diabetes Care*. **32**, pp. 2123-2132.

Barbour, R.S. 2001. Checklists for improving rigour in qualitative research: a case of the tail wagging the dog? *British Medical Journal*. **322**(7294), pp. 1115-1117.

Barry, C.A., Stevenson, F.A., Britten, N., Barber, N. and Bradley, C.P. 2001. Giving voice to the lifeworld. More humane, more effective medical care? a qualitative study of doctor–patient communication in general practice. *Social Science & Medicine*. **53**(4), pp. 487-505.

Basu, S., Vellakkal, S., Agrawal, S., Stuckler, D., Popkin, B., and Ebrahim, S. 2014. Averting obesity and type 2 diabetes in India through sugar-sweetened beverage taxation: an economic-epidemiologic modeling study. *PLoS Medicine.* **11**(1), article no: e1001582 [no pagination].

Baxter, P. and Jack, S. 2008. Qualitative case study methodology: study design and implementation for novice researchers. *The Qualitative Report*. **13**(4), pp. 544-559.

Beebe, L.H. 2007. What can we learn from pilot studies? *Perspectives in Psychiatric Care*. **43**(4), pp. 213-218.

Beglar, D. and Murray, N. 2009. *Contemporary topics 3: academic listening and note-taking skills.* 3rd ed. London: Pearson Education.

Bell, S. and Figert, A. 2012. Medicalization and pharmaceuticalization at the intersections: looking backward, sideways and forward. *Social Science & Medicine*. **75**, pp. 775-783.

Benavides-Vaello, S., Brown, S.A., and Vandermause, R. 2017. Can you keep it real?" : practical, and culturally tailored lifestyle recommendations by Mexican American women diagnosed with type 2 diabetes: a qualitative study. *BMC Nursing,* **16**(36)*,* article no: 02324 [no pagination]

Bengtsson J., 2013. With the lifeworld as ground: a research approach for empirical research in education: the Gothenburg tradition. *Indo-Pacific Journal of Phenomenology*, **13**, pp. 1-18.

Berglund M. 2014. Learning turning points - in life with long-term illness - visualized with the help of the life-world philosophy. *International Journal of Qualitative Studies on Health and Well-being*. **9**(1), article no: 22842 [no pagination]

Berglund, M., Nässén, K. and Gillsjö, C. 2015. Fluctuation between powerlessness and sense of meaning: a qualitative study of health care professionals' experiences of providing health care to older adults with lone term musculoskeletal pain. *BMC Geriatrics*. **15**, article no: 96 [no pagination]

Best, D., Beckwith, M., Haslam, C., Haslam, A., Jetten, J., Mawson, E. and Lubman, D. 2016. Overcoming alcohol and other drug addictions as a process of social identity transition: the social identity model of recovery (SIMOR). *Addiction Research &Theory*. **24**(2), pp. 111-123.

Bettany-Saltikov, J. 2010. Learning how to undertake a systematic review: part 1. *Nursing Standard*. **24**(50), pp. 47-55.

Bettany-Saltikov, J. 2012. *How to Do a Systematic Literature Review in Nursing: A Step-By-Step Guide*. Berckshire: Open University Press.

Bhar, S. 2019. Introducing phenomenological research methodology in sustainable consumption literature: illustrations from India*. International Journal of Qualitative Methods*. **18**, pp. 1-14.

Bish, M., Kenny, A. and Nay, R. 2012. A scoping review identifying contemporary issues in rural nursing leadership. *Journal of Nursing Scholarship*. **44**(4), pp. 411-417.

Black, K. and Lobo, M. 2008. A conceptual review of family resilience factors. *Journal of Family Nursing*. **14**(1), pp. 33-55.

Blattner, W. 2006. *Heidegger's being and Time: a Reader's guide*. London: Continuum International Publishing Group.

Boehm, J.K., Trudel-Fitzgerald, C., Kivimaki, M., and Kubzansky, L.D. 2015. The prospective association between positive psychological well-being and diabetes. *Health Psychology.* **34**(10), pp. 1013-1021.

Borbasi, S., Galvin, K., Adams, T., Todres, L. and Farrelly, B. 2012. Demonstration of usefulness of a theoretical framework for humanising care with reference to a residential aged care service in Australia. *Journal of Clinical Nursing*. **22**, pp.881-889.

Bowling, A. 2009. *Research methods in health: investigating health and health services*. Berkshire, Open University Press.

Bowling, A. and Dieppe, P. 2005. What is successful ageing and who should define it? *British Medical Journal*. **331**(7531), pp. 1548-1551.

Braun, V. and Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*. **3**(2), pp. 77-101.

Breton, M.C., Guénette, L., Amiche, M.A., Kayibanda, J.F., Grégoire, J.P. and Moisan, J. 2013. Burden of diabetes on the ability to work: a systematic review. *Diabetes care*. ***36***(3), pp. 740-749.

Brinkmann, S. 2013. *Qualitative interviewing: understanding qualitative research*. Oxford: Oxford University Press.

Brook, D.W., Rubenstone, E., Zhang, C., Morojele, N.K. and Brook, J.S. 2011. Environmental stressors, low well-being, smoking, and alcohol use among South African adolescents. *Social Science & Medicine*. **72**(9), pp. 1447-1453.

Broom, A. 2009. The role and implications of the internet in healthcare delivery. In: Oliver, : D., Livermore, C.R. and Sudweeks, F. eds. *Self-service in the internet age: expectations and experiences*. London: Springer-Verlag, pp. 19-36.

Brown, P. 2011. The concept of lifeworld as a tool in analysing health-care work: Exploring professionals' resistance to governance through subjectivity, norms and experiential knowledge. *Social Theory & Health*. **9**(2), pp. 147-165.

Bryman, A. 2012. *Social research methods*. 4th ed. Oxford: Oxford University Press.

Burke, L., 2014. Oneself as another: intersubjectivity and ethics in Alzheimer's illness narratives. *Narrative Works: Issues, Investigations, & Interventions*. **4**(2), pp. 28-47

Burke, M., Marlow, C., and Lento, T. 2010. Social network activity and social well-being. *CHI' 10: Proceedings of the SIGCHI conference on human factors in computing systems, 25-30 April 2010, Atlanta, Georgia, USA.* [Online], N.Y.: CHI, pp. 1909-1912. [Accessed 17 December 2014]. Available from: https://dl.acm.org/doi/10.1145/1753326.1753613

Burnard, P., Gill, P., Stewart, K., Treasure, E. and Chadwick, B. 2008. Analysing and presenting qualitative data*. British Dental Journal*, **204**(8), pp. 429-432.

Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y. and Landsverk, J. 2004. Mental health need and access to mental health services by youths involved with child welfare: a national survey. *Journal of American Academy of Child & Adolescent Psychiatry.* **43**(8), pp. 960-970.

Burns, N. and Grove, S.K. 2009. T*he practice of nursing research: appraisal, synthesis and generation of evidence.* 6th ed. Missouri: Saunders Elsevier.

Busfield, J. 2010. ‘A pill for every ill’: explaining the expansion in medicine use. *Social Science & Medicine*. **70**, pp. 934-941.

Capolongo, S., Gola, M., di Noia, M., Nickolova, M., Nachiero, D., Rebecchi, A., Settimo, G., Vittori, G. and Buffoli, M. 2016. Social sustainability in healthcare facilities: a rating tool for analysing and improving social aspects in environments of care. *Ann Ist Super Sanità*. **52**(1), pp. 15-23.

Castellanos, D. 2019. An ethnographic analysis of Latino gay youth’s paths to homelessness. In: Humble, A. and Radina, M.E. eds. *How qualitative data analysis happens: moving beyond “themes emerged”*. London: Routledge, pp. 190-206.

Castro, A. and Andrews, G. 2018. Nursing lives in the blogosphere: a thematic analysis of anonymous online nursing narratives. *Journal of Advanced Nursing*. **74**(2), pp. 329-338.

Castro Romero, M. 2017. Humanising mental health contexts for elders. In: Lane, P. and Tribe, R. Eds. *Anti-discriminatory practice in mental health for older people*. London: Jessica Kingsley Publishers, pp. 48-68

Cecchini, M. and Warin, L. 2016. Impact of food labelling systems on food choices and eating behaviours: a systematic review and meta-analysis of randomized studies. *Obesity Reviews*. **17**, pp. 201-210.

Cerbone, D.R. 2010. *Heidegger: A guide for the perplexed*. London: Continuum International Publishing Group.

Chana, R., Marshall, P. and Harley, C. 2016. The role of the intermediate care team in detecting and responding to loneliness in older clients. *British Journal of Community Nursing*. **21**(6), pp. 292-298.

Chang, M., Jetten, J., Cruwys, T., Haslam, C. and Praharso, N. 2016. The more (and the more compatible) the merrier: Is the case for Asians?. *Frontiers in Psychology*. **7**, article no: 1001 [no pagination]

Chen, M., Bell, R. and Taylor, L. 2016. Narrator point of view and persuasion in health narratives: the role of protagonist–reader similarity, identification, and self-referencing. *Journal of Health Communication*. **21**(8), pp. 908-918.

Chenoweth, L., King, M., Jeon, Y.H., Brodaty, H., Stein-Parbury, J., Norman, R., Haas M. and Luscombe G. 2009. Caring for aged dementia care resident study (CADRES) of person-centred care, dementia-care mapping, and usual care in dementia: a cluster-randomised trial. *Lancet Neurological*. **8**, pp. 317-325.

Chochinov, H.M., McClement, S., Hack T., Thompson, G., Dufault, B. and Harlos, M. 2015. Eliciting personhood within clinical practice: effects on patients, families, and health care providers. *Journal of Pain and Symptom Management*. **49**(6), pp. 974-980.

Chuang, K.Y. and Yang, C.C. 2013. Informational support exchanges using different computer-mediated communication formats in a social media alcoholism community. *Journal of the Association for Information Science and Technology*. **65**(1), pp. 37-52.

Clark, J.2014a. Medicalization of global health 3: the medicalization of the non-communicable diseases agenda. *Global Health Action*. **7**, article no: 24002 [no pagination]

Clark, J.2014b. Medicalization of global health 2: the medicalization of global mental health. *Global Health Action*. **7**, article no: 24000 [no pagination]

Clark, J. 2016. Encouraging patients to eat well: the new Eatwell Guide. *Practice Nursing*. **27**(7), pp. 346-348.

Clark, C.J. and Knight, I. 2017. A humanisation approach for the management of joint hypermobility syndrome/ehlers-danlos syndrome-hypermobility type (JHS/EDS-HT). *International Journal of Qualitative Studies on Health and Well-Being.* **12**(1), article no:1371993 [no pagination]

Clarke, J. and van Amerom, G. 2008. Mass print media depictions of cancer and heart disease: community versus individualistic perspectives? *Health and Social Care in the Community*. **16**(1), pp. 96-103.

Clarke, V. and Braun, V. 2013. Teaching thematic analysis: overcoming challenges and developing strategies for effective learning. *The Psychologist*. **26**(2), pp. 120-123.

Cockerham, W. 2005. Health lifestyle theory and the convergence of agency and structure. *Journal of Health and Social Behaviour*. **46**, pp. 51-67.

Cohen, D.J. and Crabtree, B.F. 2008. Evaluative criteria for qualitative research in health care: controversies and recommendations. *The Annals of Family Medicine*. **6**(4), pp. 331-339.

Colditz, J., Woods, M. and Primack, B. 2018. Adolescents seeking online health information: topics, approaches, and challenges. In: Moreno, M. and Radovic, A. eds. *Technology and adolescent mental health*. N.Y.: Springer Publishing Company, pp. 21-35.

Collins, M.M. 2009. Quality of life and quality of care in patients with diabetes experiencing different models of care. *Diabetes Care*. **32**(4), pp. 603-605.

Conrad, P. 2015. *Reimagining (bio) medicalization, pharmaceuticals and genetics: old critiques and new engagements*. London: Routledge.

Corbin, W.R., Farmer, N.M. AND Nolen-Hoekesma, S. 2013. Relations among stress, coping strategies, coping motives, alcohol consumption and related problems: a mediated moderation model. *Addictive Behaviors*. **38**(4), pp. 1912-1919.

Coutts, A. 2018. Changing dietary habits: culture and psychology. *Gastrointestinal Nursing*. **16**, pp. 18-21

Coyne, I., Murphy, M., Costello, T., O'Neill C. and Donnellan, C. 2013. A survey of nurses' practices and perceptions of family-centered care in Ireland. *Journal of Family Nursing*. **19**(4), pp. 469-488.

Creswell, J.W. 2013. *Qualitative inquiry and research design: choosing among five approaches*. London: Sage Publications.

Creswell, J.W. 2014. *A concise introduction to mixed methods research*. London: Sage Publications.

Creswell, J. and Poth, C. 2017. *Qualitative inquiry and research design: choosing among five approaches*. London: Sage Publications Ltd.

Crigger, N., Barnes, K., Junko, A., Rahal, S. and Sheek, C. 2009. Nurse practitioners' perceptions and participation in pharmaceutical marketing. *Journal of Advanced Nursing*. **65**(3), pp. 525-533.

Crock, E. 2009. Ethics of pharmaceutical company relationships with the nursing profession: no free lunch....and no more pens? *Contemporary Nurse*. **33**(2), pp. 202-209.

Cronin, P., Ryan, F. and Coughlan, M. 2008. Undertaking a literature review: a step-by-step approach. *British Journal of Nursing*. **17**(1), pp. 38-43.

Cruwys, T., Bevelander, K. and Hermans, R. 2015. Social modeling of eating: a review of when and why social influence affects food intake and choice. *Appetite*. **86**, pp. 3-18.

Cruwys, T., Greenaway, K.H., Ferris, L.J., Rathbone, J.A., Saeri, A.K., Williams, E., Parker, S.L., Chang, M.X.L., Croft, N., Bingley, W. and Grace, L. 2020. [Forthcoming]. When trust is a liability: a social identity model of risk taking. *Journal of Personality and Social Psychology*. [Online]. [Accessed 10 July 2020]. Available from: https://psyarxiv.com/5fwre/

Dahlberg. K. 2006. The essence of essences - the search for meaning structures in phenomenological analysis of lifeworld phenomena. *International Journal of Qualitative Studies on Health and Well-being.* **1**(1), pp. 11-19.

Dahlberg, K., Todres, L. and Galvin, K. 2009. Lifeworld-led healthcare is more than patient-led care: an existential view of well-being. *Medicine, Health Care and Philosophy.* **12**(3), pp. 265-271.

Dahlberg, K. 2011. Lifeworld phenomenology for caring and for health care research. In: Thomson, G., Downe, S., and Dykes, F. eds. *Qualitative research in midwifery and childbirth: phenomenological approaches*. London: Routledge, pp.19-33.

Darcy, J. 2019. A narrative analysis of the stories of mothers who have parented a child with Hodgkin Lymphoma who is currently in early survivorship. *Journal of Clinical Nursing.* **28**, pp. 138-147.

Deb, P., Gallo, W.T., Ayyagari, P., Fletcher, J.M. and Sindelar, J.L. 2011. The effect of job loss on overweight and drinking. *Journal of Health Economics*. **30**(2), pp. 317-327.

De Jesus Cabral, M., Hervé, C., Mamzer, M.F., Leroy, P. and Scotté, F. 2017. *Personalised medicine. bringing narrative tools to Carpem. Ethics, Medicine and Public Health*. **3**(2), pp. 246-252.

Deci, E.L., and Ryan, R.M. 2008. Self-determination theory: a macrotheory of human motivation, development, and health. *Canadian Psychology*. **49**(3), pp. 182-185.

Denzin N.K. and Lincoln, Y.S. 2018. Introduction: the discipline and practice of qualitative research. In: Denzin N.K. and Lincoln Y.S. eds. *The sage handbook of qualitative research*. 5th ed. London. Sage Publications Inc. pp. 29-71.

Deek, H., Hamilton, S., Brown, N., Inglis, S., Digiacomo, M., Newton, P., Noureddine, S., MacDonald, P. and Davidson, P. 2016. Family-centred approaches to healthcare interventions in chronic diseases in adults: a quantitative systematic review. *Journal of Advanced Nursing*. **72**(5), pp. 968-979.

Department of Health. 2002. *National service framework for diabetes: delivery strategy*. [Online]. London: Department of Health. [Accessed 09 December 2014]. Available from: http://www.yearofcare.co.uk/sites/default/files/images/national%20service%20-%20delivery%20strategy.pdf .

Department of Health. 2005. *Creating a patient-led NHS, delivering the NHS improvement plan*. [Online]. London Department of Health. [Accessed 09 December 2014]. Available from: https://www.plymouth.ac.uk/uploads/production/document/path/1/1921/dh_4106507.pdf

Department of Health. 2008. *Safe. Sensible. Social. The government's alcohol strategy.* [Online]. London Department of Health. [Accessed 09 December 2014]. Available from: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_085386 .

Department of Health. 2009. *Putting people first: a vision and commitment to the transformation of adult social care*. [Online]. [Accessed 25 November 2014]. Available from: http://www.cpa.org.uk/cpa/putting_people_first.pdf

DeVille-Almond, J. and Halliwell, K. 2014. Understanding and interpreting nutrition information on food labels. *Nursing Standard*. **28**(29), pp. 50-57.

Devis-Rozental, C. 2018. Humanising higher education by meeting scholars' needs with socio-emotional intelligence. In: Devis-Rozental, C. ed. *Developing Socio-Emotional Intelligence in Higher Education Scholars.* London: Palgrave Macmillan, pp. 103-130*.*

Dewing, J. 2008. Personhood and dementia: revisiting Tom Kitwood's ideas. *International Journal of Older People Nursing*. **3**, pp.3-13.

Diabetes in the UK. 2011. *Key statistics on Diabetes.* [Online]. [Accessed at 19 November 2014]. Available from: http://www.diabetes.org.uk/documents/reports/diabetes-in- the-uk-2011-12.pdf .

Dietary Guidelines for Americans. 2013. *Key recommendations for the general population.* [Online]. Colorado: Deb Miller. [Accessed 19 November 2014]. Available from: http://www.unco.edu/shc/topics/dietaryguidelines.htm .

Diniz, E., Castro, P., Bousfield, A. and Figueira Bernardes, S. 2020. Classism and dehumanization in chronic pain: a qualitative study of nurses' inferences about women of different socio-economic status. *British Journal of Health Psychology*. **25**(1), pp. 152-170.

Dingle, G., Stark, C., Cruwys, T. and Best, D. 2015. Breaking good: breaking ties with social groups may be good for recovery from substance misuse. *British Journal of Social Psychology*. **54**, pp. 236-254.

Doody, O. and Doody, C.M. 2015. Conducting a pilot study: case study of a novice researcher. *British Journal of Nursing*. **24**(21), 1074-1078.

Doody, O. and Noonan, M. 2013. Preparing and conducting interviews to collect data. *Nurse Researcher*, **20**(5), pp. 28-32.

Dowling, M. 2007. From Husserl to van Manen. a review of different phenomenological approaches. *International Journal of Nursing Studies*. **44**, pp. 131-142.

Dowling, S. and Albarran, J. 2017. Digital times: disseminating your work and networking. *British Journal of Cardiac Nursing*. **12**(9), pp. 433-436.

Doyle, L., Brady, A.M. and Byrne, G. 2009. An overview of mixed methods research. *Journal of Research in Nursing*. ***14***(2), pp.175-185.

Dunbar, J., Colagiuri, S., Reddy, P., Vita, P., Timoshanko, A., Audehm, R. and Milat, A. 2010. Scaling up type 2 diabetes prevention programs: national and state interventions in Australia. In: Schwarz, P., Reddy, P., Greaves, C., Dunbar, J. and Schwarz, J. eds. *Diabetes prevention in practice*. Dresden: Tumaini Institute for Prevention Management, pp. 45-56.

Dutton, H. Rowan, M.S., Liddy, C., Maranger, J., Ooi, T.C., Malcolm, J. and Keely, E. 2014. Patient perspectives on discharge from specialist type 2 diabetes care back to primary care: a qualitative study. *Canadian Journal of Diabetes*. **28**, pp. 191-197.

Eg, M., Frederiksen, K., Vamosi, M. and Lorentzen, V. 2017. How family interactions about lifestyle changes affect adolescents' possibilities for maintaining weight loss after a weight-loss intervention: a longitudinal qualitative interview study. *Journal of Advanced Nursing*. **73**(8), pp. 1924-1936.

Eichner, M. and Johnson, H. 2012. Patient- and family-centered care and the pediatrician's role. *Pediatrics*. **129**(2), pp. 394-404.

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K. and Kyngäs, H. 2014. Qualitative content analysis*. Sage Open.* **4**(1), pp. 1-10

Eng, L., Pringle, D., Su, J., Espin-Garcia, O., Niu, C., Mahler, M., … Liu, G. 2019. Patterns, perceptions and their association with changes in alcohol consumption in cancer survivors. *European Journal of Cancer Care.* **28**(1), article no: e12933 [no pagination]

Epstein, R., Fiscella, K., Lesser, C. and Stange, K. 2010. Why the nation needs a policy push on patient-centered health care. *Health Affairs*. **29**(8), pp. 1489-1495.

Eraut, M. 1994. *Developing professional knowledge and competence*. London: Routledge, Falmer Press.

Eustache, C., Jibb, E. and Grossman, M. 2014. Exploring hope and healing in patients living with advanced non-small cell lung cancer. *Oncology Nursing Forum*. **41**(5), pp. 497-508.

Farrow, C., Tarrant, M. and Khan, S. 2017. The impact of group membership on health in the context of obesity. In: Buckingham, S. and Best, D. eds. *Addiction, behavioral change and social identity: the path to resilience and recovery*. Oxford: Routledge, pp. 52-70.

Feinberg, L.F. 2014. Moving toward person- and family-centered care. *Public Policy & Aging Report*. **24**, pp. 97-101.

Fernández-Solà, J. 2015. Cardiovascular risks and benefits of moderate and heavy alcohol consumption. *Nature Reviews Cardiology*. **12**(10), 576–587.

Fielding, S. 2016. Empowerment evaluation, postprofessionalization, and oligarchy: a retrospective. *Journal of Applied Social Science*. **10**(1), pp. 44-54.

Finfgeld-Connett, D. 2010. Generalizability and transferability of meta-synthesis research findings. *Journal of Advanced Nursing*. **66**(2), pp. 246–254.

Finlay, L. 2003. The reflexive journey: mapping multiple routes. In: Finlay, L. and Gough, B. eds. *Reflexivity: a practical guide for researchers in health and social sciences.* Oxford: Blackwell Publishing Company, pp. 3-20.

Finlay, L. 2012. Debating phenomenological methods. In: Friesen, N., Henriksson C. and Saevi, T. eds. *Hermeneutic Phenomenology in Education: method and practice.* Rotterdam: Sense Publisher, pp. 17-37.

Finlayson, J. 2005. *Habermas: a very short introduction*. Oxford: Oxford University Press.

Flaskerud, J. 2012. DSM-5: implications for mental health nursing education. *Issues in Mental Health Nursing*. **33**,pp. 568-576.

Flynn, S. 2017. Ex machina: possessing and repossessing the body. *ethos: a digital review of arts, Humanities, and Public Ethics*. **3**(1), pp. 32-45.

Freidson, E. 2001. *Professionalism: the third logic on the practice of knowledge*. Chicago: The University of Chicago Press.

Freshwater, D. 2017. Contemporary political debates, social theory and nursing practice in mental healthcare. In: Lipscomb, M. ed. *Social theory and nursing*. London: Routledge. pp. 169-180.

Frosch, D., May, S., Tietbohl, C. and Pagán, J. 2011. Living in the “land of no”? Consumer perceptions of healthy lifestyle portrayals in direct-to-consumer advertisements of prescription drugs. *Social Science & Medicine*. **73**, pp. 995-1002.

Fujita, N., Perrin, X., Vodounon, J., Gozo, M., Matsumoto, Y., Uchida, S. and Sugiura, Y. 2012. Humanised care and a change in practice in a hospital in Benin. *Midwifery.* **28**, pp. 481-488.

Fyffe, T. 2009. Nursing shaping and influencing health and social care policy. *Journal of Nursing Management*. **17**, pp. 698–706.

Gadamer, H.G. 1975. Hermeneutics and social science. *Cultural Hermeneutics*. ***2***(4), pp. 307-316.

Gale, N., Heath, G., Cameron, E., Rashid, S. and Redwood, S. 2013. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*. **13**, article no: 117 [no pagination]

Galvin, K. and Todres, L. 2013. *Caring and well-being: a lifeworld approach*. London: Routledge.

Galvin, K.T., Cowdell F., Sloan C., Pound C., Ellis-Hill C., Ersser S., Watson R., Brooks, S. 2016. *Humanising services: a new transferable leadership strategy for improving 'what matters to older people' to enhance dignity in care*. [Online]. Bournemouth: Project Report Burdett Trust for Nursing. [Accessed 27 June 2019]. Available from: www.http://www.btfn.org.uk/our-reports/

Galvin, K.T., Sloan, C., Cowdell, F., Ellis-Hill, C., Pound, C., Watson, R., … Brooks, S. 2018. Facilitating a dedicated focus on the human dimensions of care in practice settings: Development of a new humanised care assessment tool (HCAT) to sensitise care. *Nursing Inquiry.* **25**(3), article no: 12235 [no pagination]

Ganapathy, M. 2016. Qualitative data analysis: making it easy for nurse researcher. *International Journal of Nursing Education*. **8**(2), pp. 106-110.

Gately, I. 2008*. Drink: a cultural history of alcohol*. New York, NY: Gotham Books.

Gerish, K. and Lacey, A. 2010. *The research process in nursing*. Oxford: Blackwell Publishing Ltd.

Gesser-Edelsburg, A., Walter, N. and Shir-Raz, Y. 2016. The "New Public" and the "Good Ol' Press": evaluating online news sources during the 2013 polio outbreak in Israel. *Health Communication*. **32**(2), pp. 169-179.

Giles, T.M., de Lacey, S. and Muir-Cochrane, E. 2016. Coding, constant comparisons, and core categories. *Advances in Nursing Science*. **39**(1), pp. 29-44.

Gillespie, M. and Peterson, B.L. 2009. Helping novice nurses make effective clinical decision: the situated clinical decision-making framework. *Nursing Education Perspectives*. **30**(3), pp. 164-170.

Ginter, E. and Simko, V. 2012. Global prevalence and future of diabetes mellitus. *Advances in Experiment Medicine and Biology*. **771**, pp. 35-41.

Glasper, A. and Rees, C. 2013. *How to write your nursing dissertation*. Oxford: Willey-Blackwell.

Goldberg, D. 2014. Fatness, medicalization, and stigma: on the need to do better. *Narrative Inquiry in Bioethics*. **4**(2), pp. 117-123.

Goodman, B. 2014. Risk, rationality and learning for compassionate care: the link between management practices and the 'lifeworld' of nursing. *Nurse Education Today*. **34**(9), pp. 1265-1268.

Gorter J. K. 2011. Opinions of patients with type 2 diabetes about responsibility, setting targets and willingness to take medication. a cross-sectional survey. *Patient Education and Counselling*. **84**, pp. 56-61.

Gow, A.J., Watson, R., Whiteman, M., and Deary, I.J. 2011. A stairway to heaven? structure of the religious involvement inventory and spiritual well-being scale. *Journal of Religion and Health*. ***50***(1), pp.5-19.

Grado, M.E.V. 2013. Does smoking and alcohol abuse precipitate and aggravate the risk of metabolic syndrom? *Journal Metabolic Syndrome*. **3**(2), article no: 1000141 [no pagination].

Graffigna, G., Libreri C. and Bosio, C. 2012. Online exchanges among cancer patients and caregivers. *Qualitative Research in Organizations and Management: An International Journal*. **7**(3), pp. 323-337.

Greenberg, S., Yaari, E. and BarIlan, J. 2013. Perceived credibility of blogs on the internet - the influence of age on the extent of criticism. *New Information Perspectives*. **65**(1), pp. 4-18.

Greenwood, M., Kendrick, T., Davies, H. and Gill, F.J. 2017. Hearing voices: Comparing two methods for analysis of focus group data. *Applied Nursing Research*. **35**, pp. 90-93.

Grittner, U., Kuntsche, S., Graham, K. and Bloomfield, K. 2012. Social inequalities and gender differences in the experience of alcohol-related problems. *Alcohol and Alcoholism*. **47**(5), pp. 597-605.

Gualda, D.M.R., Narchi, N.Z. and Campos, E.A. 2013. Strengthening midwifery in Brazil: education, regulation and professional association of midwives. *Midwifery*. **29**, pp. 1077-1081.

Guell, C. 2012. Self-care at the margins. *Medical Anthropology Quarterly*. **26**(4), pp. 518-533.

Hackett , A. and Strickland, K. 2019. Using the framework approach to analyse qualitative data: a worked example. *Nurse Researcher*. **26**(2), pp. 8-13.

Hall, L.M. 2005. Strategies employed to rebuild nursing following restructuring. *Journal of Research in Nursing*. **10**(1), pp. 57-64.

Handley, J., Pullon, S. and Gifford, H. 2010. Living with type 2 diabetes: putting the person in the pilots seat. *Australian Journal of Advanced Nursing*. **27**(3), pp. 12-19.

Haslam, C., Holme, A., Haslam, A., Iyer, A., Jetten, J. and Williams H. 2008. Maintaining group memberships: social identity continuity predicts well-being after stroke. *Neuropsychological Rehabilitation: An International Journal*. **18**(5-6), pp. 671-691.

Hasson-Ohayon, I., Kravetz, S. and Lysaker, P.H. 2016. The special challenges of psychotherapy with persons with psychosis: intersubjective metacognitive model of agreement and shared meaning. *Clinical Psychology & Psychotherapy*. **24**(2), pp. 428-440.

Hawker, S., Payne, S., Kerr, C., Hardey, M. and Powell, J, 2002. Appraising the evidence: reviewing disparate data systematically. *Qualitative Health Research.* **12**(9): pp. 1284-1299.

Hayter, M. 2013. The UK Francis Report: the key messages for nursing. *Journal of Advanced Nursing*. **69**(8), pp. e1-e3.

Hayward, R.M. and Tuckey, M.R. 2011. Emotions in uniform: How nurses regulate emotion at work via emotional boundaries*. Human Relations.* **64**(11), pp. 1501-1523

Hazelton, M. and Morrall, P. 2011. Nursing, information technology and the humanization of health care. In: Cash, A. and Cook, R. eds. *Evidence-based practice in nursing informatics: concepts and applications*. PA: IGI Global, Hershey, pp. 135-148.

Heaslip, V. and Board, M. 2012. Does nurses' vulnerability affect their ability to care? *British Journal of Nursing*. **21**(15), pp. 912-916.

Heianza, Y., Arase, Y., Saito, K., Tsuji, H., Fujihara, K., Hsieh, S.D., … Sone, H. 2013. Role of alcohol drinking pattern in type 2 diabetes in Japanese men: the Toranomon Hospital Health Management Center Study 11 (TOPICS 11). *The American Journal of Clinical Nutrition.* **97**(3), 561-568.

Heilferty, C.M. 2009. Toward a theory of online communication in illness: concept analysis of illness blogs. *Journal of Advanced Nursing.* **65**(7), pp. 1539-1547.

Heimbrock, H.G. 2001. Beyond globalism and relativism: religious education, plurality and life-world orientation. In: Heimbrock, H.G., Scheilke, C. and Schreiner, P. eds. *Towards religious competence: diversity as a challenge for education in Europe*. Münster: Lit Verlag, pp. 85-102.

Hemingway, A. 2011. Lifeworld-led care: Is it relevant for well-being and the fifth wave of public health action? *International Journal of Qualitative Studies on Health and Well-being*. **6**(4) article no: 10364 [no pagination].

Hemingway, A. 2012. Can humanization theory contribute to the philosophical debate in public health? *Public Health*. **126**, pp. 448-453.

Hemingway, A., Scammell, J. and Heaslip, V. 2012. Humanising nursing care: a theoretical model. *Nursing Times*. **108**(40), pp.26-27.

Hemingway, A., Ellis-Hill, C. and Norton, E. 2016. What does care farming provide for clients? the views of care farm staff. *NJAS - Wageningen Journal of Life Sciences*. **79**, pp. 23-29.

Henderson, J., Wilson, C., Roberts, L., Munta, R. and Crottya, M. 2014. Social barriers to type 2 diabetes self-management: the role of capital. *Nursing Inquiry*. **21**(4), pp. 336-345.

Henry, C., Morris, A. and Harrist, A. 2015. Family resilience: moving into the third wave. *Family Relations*. **64**, pp. 22-43.

Heras La Calle, G., Oviés, Á.A. and Tello, V.G. 2017. A plan for improving the humanisation of intensive care units. *Intensive Care Medicine.* **43**(4), pp. 547-549.

Hewison, A. 2008. Evidence-based policy: Implications for nursing and policy involvement. *Policy, Politics, & Nursing Practice*. **9**(4), pp. 288-298.

Hex, N., Bartlett, C., Wright, D., Taylor, M. and Varley, D. 2012. Estimating the current and future costs of type 1 and type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs. *Diabetic Medicine.* **29**(7), pp. 855-862.

Heyman, R. and Pierson, J. 2015. Social media, delinguistification and colonization of lifeworld. *Social Media + Society*. **1**(2), pp. 1-11.

Hicks, D. 2010. Self-management skills for people with type 2 diabetes. *Nursing Standard*. **25**(6), pp. 48-56.

Higgs, S. 2015. Social norms and their influence on eating behaviours. *Appetite*. **86**, pp. 38-44.

Hignett, R. 2007. Front-of-pack nutritional information: the only way. *British Journal of Cardiac Nursing*. **2**(4), pp 162-163.

Hill, M.L. 2006. Representin(g): negotiating multiple roles and identities in the field and behind the desk. *Qualitative Inquiry*. **12**(5), pp. 926-949.

Hofmann, B. 2016. Medicalization and overdiagnosis: different but alike. *Medicine, Health Care and Philosophy*. **19**, pp. 253-264.

Holloway, I. and Wheeler, S. 2010. Qualitative Research in Nursing and Healthcare. 3rd ed. Oxford: Wiley-Blackwell.

Holloway, I. and Galvin, K. 2016. Qualitative Research in Nursing and Healthcare. 4th ed. Oxford: Wiley-Blackwell.

Holton, M.K., Barry, A.E. and Chaney, J.D. 2016. Employee stress management: an examination of adaptive and maladaptive coping strategies on employee health. *Work.* **53**(2), pp. 299-305.

Home, P.D., Kahn, S.E., Jones, N.P., Noronha, D., Beck-Nielsen H. and Vilberti G. 2009. Rosiglitazone evaluated for cardiovascular outcomes in oral agent combination therapy for type 2 diabetes (RECORD): a multicentre, randomised, open-label trial. *The Lancet*. **373**(9681), pp. 2125-2135.

Honer A. and Hitzler R. 2015. Life-world - analytical ethnography: a phenomenology-based research approach. *Journal of Contemporary Ethnography*. **44**(5), pp. 544-562.

Houghton, C., Casey, D. and Shaw, D. 2013. Rigour in qualitative case-study research. *Nurse Researcher*. **20**(4), pp.12-17.

Høye, S. and Severinsson, E. 2007. Methodological aspects of rigor in qualitative nursing research on families involved in intensive care units: a literature review. *Nursing & Health Sciences*. **9**(1), pp. 61–68.

Huber, M., Knottnerus, J.A., Green, L., Horst, H., Jadad, A.R., Kromhout, D. … Smid, H. 2011. How should we define health? *British Medical Journal.* **343**, pp. d4163–d4163.

Hunter, P., Hadjistavropoulos, T., Smythe, W., Malloy, D., Kaasalainen, S. and Williams, J. 2013. The personhood in dementia questionnaire (PDQ): establishing an association between beliefs about personhood and health providers' approaches to person-centred care. *Journal of Aging Studies*. **27**, pp. 276-287.

Hyde, A., Nee, J., Howlett, E., Drennan, J. and Butler, M. 2010. Menopause narratives: the interplay of women’s embodied experiences with biomedical discourses. *Qualitative Health Research.* **20**(6), pp. 805-815.

Inzucchi, S.E., Bergenstal, R.M., Buse, J.B., Diamant, M., Ferrannini, E., Nauck, M., Peters, A.L., Tsapas, A., Wender, R. and Matthews, D.R. 2012. Management of hyperglycaemia in type 2 diabetes: a patient-centered approach. Position statement of the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). *Diabetologia*. **55**(6), pp. 1577-1596.

Islam, M. 2019. Reflection note: confessions of a Muslim researcher - considering identity in research. *International Journal of Social Research Methodology*, article no: 5579 [no pagination]

Iyer, A., Jetten, J., Tsivrikos, D., Postmes, T. and Haslam, A. 2009. The more (and the more compatible) the merrier: multiple group memberships and identity compatibility as predictors of adjustment after life transitions. *British Journal of Social Psychology*. **48**, pp. 707-733.

Jacobs, G., van der Zijpp, T., van Lieshout, F. and van Dulmen, S. 2017. Research into person-centred healthcare technology: a plea for considering humanisation dimensions. In: McCormack, B., van Dulmen, S., Eide, H., Skovdahl, K. and Eide, T. eds. *Person-centred healthcare research*. Oxford: John Wiley & Sons Ltd, pp. 61-68.

James, N. and Busher, H. 2012. Internet interviewing. In: Gubrium, J., Holstein, J., Marvasti, A. and McKinney, K. *eds*. The Sage handbook of interview research: The complexity of the craft, 2nd edition. London: Sage, pp. 177-192.

Jansink, R., Braspenning, J., van der Weijden, T., Elwyn, G., and Grol, R. 2010. Primary care nurses struggle with lifestyle counseling in diabetes care: a qualitative analysis. *BMC Family Practice*. **11**(41), article no: 2889883 [no pagination]

Jarvinen, M., Ellergaard, C.H. and Larsen, A.G. 2014. Drinking successfully: alcohol consumption, taste and social status. *Journal of Consumer Culture.* **14**(3), pp. 384-405.

Jenkins, R. 2008. *Social Identity*. 3rd ed. London: Routledge.

Jetten, J., Haslam, S., Cruwys, T. and Branscombe, N. 2017. Social identity, stigma and health. In: Major, B., Davidio, J. and Link, B. eds. *The Oxford handbook of stigma, discrimination, and health*. Oxford: Oxford University Press, pp. 301-316.

Joffe, H. 2011. Thematic analysis. In Harper, D. and Thompson, A.R. eds. *Qualitative methods in mental health and psychotherapy: a guide for students and practitioners.* Chichester: Wiley, pp.209–224.

Johnson, M.E. 2000. Heidegger and meaning: implications for phenomenological research. *Nursing Philosophy*. **1**(2), pp.134-146.

Johansson, K., Ekebergh, M. and Dahlberg K. 2009. A lifeworld phenomenological study of the experience of falling ill with diabetes. *International Journal of Nursing Studies*. **46**, 197–203.

Johansson, K., Österberg, S.A., Leksell, J. and Berglund, M. 2016. Patients' experiences of support for learning to live with diabetes to promote health and well-being: a lifeworld phenomenological study. *International Journal of Qualitative Studies on Health and Well-Being.* **11**(1), article no: 31330 [no pagination]

Jones, E., Sinclair, J.M.A., Holt, R.I.G. and Barnard, K.D. 2013. Social networking and understanding alcohol-associated risk for people with type 1 diabetes: friend or foe? *Diabetes Technology & Therapeutics.* **15**(4), pp. 308-314.

Joubert, J., Reid, C., Barton, D., Cumming, T., McLean, A., Joubert, L., … Davis, S. 2009. Integrated care improves risk-factor modification after stroke: initial results of the Integrated Care for the Reduction of Secondary Stroke model. *Journal of Neurology, Neurosurgery & Psychiatry*. **80**(3), pp. 279-284.

Jung, M.L. and Berthon P. 2009. Fulfilling the promise: a model for delivering successful online health care. *Journal of Medical Marketing*. **9**(3), pp. 243-254.

Jutel, A. and Menkes, D.B. 2010. Nurses' reported influence on the prescription and use of medication. *International Nursing Review*. **57**, pp. 92-97.

Kagan, P., Smith, M., Cowling, R. and Chinn, P. 2009. A nursing manifesto: an emancipatory call for knowledge development, conscience, and praxis. *Nursing Philosophy*. **11**, pp. 67-84.

Kahneman, D. and Deaton, A. 2010. High income improves evaluation of life but not emotional well-being. *Proceeding of the National Academy of Sciences.* **107**(38), pp.16489-16493.

Kalda, R., Ratsep, A. and Lember, M. 2008. Predictors of quality of life of patients with type 2 diabetes. *Patient Prefer Adherence*. **2**, pp. 21-26.

Kalinowski, A., and Humphreys, K. 2016. Governmental standard drink definitions and low-risk alcohol consumption guidelines in 37 countries. *Addiction.* **111**(7), 1293-1298*.*

Karlsson M., Friberg F., Wallengren C. and Öhlén J. 2014. Meanings of existential uncertainty and certainty for people diagnosed with cancer and receiving palliative treatment: a life-world phenomenological study. *BMC Palliative Care*, **13**(28), article no: 5397 [no pagination]

Katon, J.W. 2008. The comorbidity of diabetes mellitus and depression. *American Journal of Medicine*. **121**(11), pp. 8-15.

Kersbergen, I. and Field, M. 2017. Alcohol consumers' attention to warning labels and brand information on alcohol packaging: findings from cross-sectional and experimental studies. *BMC Public Health*. **17**, article no: 123 [no pagination]

Kitson, A., Marshall, A., Bassett, K. and Zeitz, K. 2013. What are the core elements of patient-centred care? a narrative review and synthesis of the literature from health policy, medicine and nursing. *Journal of Advanced Nursing*. **69**(1), pp. 4-15.

Kneck, A., Klang, B. and Fageberg, I. 2012. Learning to live with diabetes-integrating an illness or objectifying a disease. *Journal of Advanced Nursing*. **68**(11), pp. 2486-2495.

Knight, A. 2018. From nurse to service user: a personal cancer narrative. *British Journal of Nursing*. **27**(4), pp. s18-s21.

Knott, C., Bell, S., and Britton, A. 2015. Alcohol consumption and the risk of type 2 diabetes: a systematic review and dose-response meta-analysis of more than 1.9 million individuals from 38 observational studies*. Diabetes Care.* **38**(9), pp. 1804-1812.

Koloverou, E., Panagiotakos, D.B., Pitsavos, C., Chrysohoou, C., Georgousopoulou, E.N., Metaxa, V., and Stefanadis, C. 2015. Effects of alcohol consumption and the metabolic syndrome on 10-year incidence of diabetes: The ATTICA study*. Diabetes & Metabolism.* **41**(2), pp. 152-159.

Kopak, A.M., Proctor, S.L. and Hoffmann, N.G. 2014. The elimination of abuse and dependence in DSM-5 substance use disorders: what does this mean for the treatment? *Current Addiction Reports.* **1**(3), pp.166-171.

Krauss, S.E. 2005. Research paradigms and meaning making: a primer. *The Qualitative Report*. **10**(4), pp. 758-770.

Kreindler, S. 2013. The politics of patient-centred care. *Health Expectations*. **18**, pp. 1139-1150.

Kun Leddy, S. 2006. *Health promotion: mobilizing strengths to enhance health, wellness, and well-Being.* Philadelphia: F.A. Davis Company.

Kuo, D., Houtrow, A., Arango, P., Kuhlthau, K., Simmons, J. and Neff, J. 2012. Family-centered care: current applications and future directions in pediatric health care. *Maternal and Child Health Journal*. **16**, pp. 297-305.

Lacan, J. 2007. The seminar of Jacques Lacan book XVII: the other side of psychoanalysis (translated by Russell Grigg). New York: W.W. Norton and Company.

Lamers, F., Jonkers, C.C.M., Bosma, H., Knottnerus, J.A., and van Eijk, J.T.M. 2011. Treating depression in diabetes patients: does a nurse-administered minimal psychological intervention affect diabetes-specific quality of life and glycaemic control? A randomized controlled trial. *Journal of Advanced Nursing*. **67**(4), pp. 788-799.

Lancaster, G.A., Dodd, S. and Williamson, P.R. 2004. Design and analysis of pilot studies: recommendations for good practice. *Journal of Evaluation in Clinical Practice*. **10**(2), pp.307-312.

Lawrence, M., Kerr, S., Watson, H., Paton, G., and Ellis, G. 2010. An exploration of lifestyle beliefs and lifestyle behaviour following stroke: findings from a focus group study of patients and family members. *BMC Family Practice*. **11**, article no: 97, [no pagination]

Lee, C.G. 2013. Systemic colonization of the educational lifeworld: an example in literacy education*. Educational Philosophy and Theory*. **46**(1), pp. 87-99.

Lee, S. and Lee, K. 2016. The association of food label use with objective and subjective obesity among a Korean population. *Journal of Korean Academic Community Health Nursing*. **27**(3), pp. 262-271.

Li, Z., Bai, Y., Guo, X., Zheng, L., Sun, Y. and Roselle, A.M. 2016. Alcohol consumption and cardiovascular diseases in rural China. *International Journal of Cardiology*. **215**, pp. 257-262.

Li, W., Liu, L., Puente, J.G., Li, Y., Jiang, X., Jin, S., Ma, H., Kong, L., Ma, L., He, X. and Ma, S. 2005. Hypertension and health-related quality of life: an epidemiological study of patients attending hospital clinics in China. *Journal of Hypertension*. **23**, pp. 1635-1636.

Lincoln, Y.S., Lynham, S.A. and Guba, E.G. 2018. Paradigmatic controversies, contradictions, and emerging confluences, revisited. In: Denzin, N.K. and Lincoln Y.S. eds. *The sage handbook of qualitative research*. 5th ed. London: Sage Publications Inc. pp. 213-263.

Lindsay, B. 2007. *Understanding research and evidence based practice*. Exeter: Reflect Press Ltd.

Lindsay, J. 2010. Healthy living guidelines and the disconnect with everyday life. *Critical Public Health*. **20**(4), pp. 475-487.

Lindström, J., Pilvikki, A., Katri, H., Paivi, P. and Markku, P. 2010. Reducing the risk of type 2 diabetes with nutrition and physical activity - efficacy and implementation of lifestyle interventions in Finland*. Public Health Nutrition*. **13**(6), pp. 993-999.

Liu, P.Y. and Kohlen H. 2018. Tensions in diabetes care practice: ethical challenges with a focus on nurses in a home-based care team. In: Krause, F. and Boldt, J. eds. *Care in healthcare: reflections on theory and practice*. London: Palgrave Macmillan, pp. 211-235.

Lo, M.M. and Bahar R. 2013. Resisting the colonization of the lifeworld? immigrant patients' experiences with co-ethnic healthcare workers. *Social Science & Medicine*. **87**, pp. 68-76.

Lo Monaco, G., Bonetto, E., Codaccioni, C., Araujo, M.V. and Piermattéo, A. 2020. Alcohol "use" and "abuse": When culture, social context and identity matter. *Current Opinion in Food Science.* **33**, pp. 9-13.

Local Alcohol Profiles for England. 2013. *Public Health England centre area - Cumbria and Lancashire.* [Online]. London: Public Health England. [Accessed 25 November 2014]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/669264/Cumbria_and_Lancashire_Centre_prospectus.pdf

Long, H. 2011. Diagnostic gestational diabetes: can expert opinions replace scientific evidence? *Diabetologia*. **54**(9), pp. 2211-2213.

Long, T. and Johnson, M. 2000. Rigour, reliability and validity in qualitative research. *Clinical Effectiveness in Nursing*. **4**, pp. 30-37.

Lopez, R.P., Mazor, K., Mitchell ,S. and Givens, J. 2013. What is family-centered care for nursing home residents with advanced dementia?*.American Journal of Alzheimer's Disease & Other Dementias*. **28**(8), pp. 763-768.

Lusk, J. and Fater, K. 2013. A concept analysis of patient-centered care. *Nursing Forum*. **48**(2), pp. 89-98.

Macaden, L. and Clarke, C. 2015. Model of diabetes management: have we got it right for South Asian people in the UK?. *Journal of Diabetes Nursing*. **19**(5), pp. 183-189.

Macdonald, M.E., Liben, S., Carnevale, F. and Cohen, S.R. 2012. An office or a bedroom? Challenges for family-centered care in the pediatric intensive care unit. *Journal of Child Health Care*. **16**(3), pp. 237-249.

Maenhout, L., Peuters, C., Cardon, G., Compernolle, S., Crombez, G. and DeSmet, A. 2020. The association of healthy lifestyle behaviors with mental health indicators among adolescents of different family affluence in Belgium. *BMC Public Health*. **20**(1) article no: 958 [no pagination]

Malecki-Ketchell, A., Marshall, P. and Maclean, J. 2017. Adult patient decision-making regarding implantation of complex cardiac devices: a scoping review. *European Journal of Cardiovascular Nursing*. **16**(7), pp. 567-584.

Malone, R. 2005. Assessing the policy environment. *Policy, Politics, & Nursing Practice*. **6**(2), pp. 135-143.

Malpass, A., Rob, A. and Turner, K.M. 2009. Patients with type 2 diabetes experiences of making multiple lifestyle changes: a qualitative study. *Patient Education and Counselling*. **74**, pp. 258-263.

Malpass, J.K., Albrecht, T., Steeves, R. and Danhauer, S. 2013. Young women's experiences with complementary therapies during cancer described through illness blogs. *Western Journal of Nursing Research*. **35**(10), pp. 1309-1324.

Manderson, L. and Kokanovic, R. 2009. Worried all the time: distress and the circumstances of everyday life among immigrant Australians with type 2 diabetes. *Chronic Illness.* **5**, pp. 21-32.

Manley, K., Hills, K. and Marriot, S. 2011. Person-centred care: principle of nursing practice. *Nursing Standard*. **25**(31), pp. 35-37.

Mantzouka, C., Morrall, P., Gilmartin J. and Waite-Jones J. 2017. Well-being, type 2 diabetes and alcohol consumption: a literature review. *Primary Health Care*. **27**(3), 26-30.

Marshall, C. and Rossman, G.B. 2006. *Designing Qualitative Research*. 4th ed. Thousand Oaks: Sage Publications.

Martin, C.S. 2008. How should we revise diagnostic criteria for substance use disorders in the DSM-V? *Journal of Abnormal Psychology*. **117**(3), pp. 561-575.

Mason, J. 2018. *Qualitative researching*. 3rd ed. Qualitative researching. London: Sage Publication Ltd.

Mason, B.J., Light, J.M., Williams, L.D. and Drobes, D.J. 2009. Proof-of-concept human laboratory study for protracted abstinence in alcohol dependence: effects of gabapentin. *Addiction Biology*.**14**(1), pp. 73-83.

Maville, J., Bowen, J. and Benham, G. 2008. Effect of healing touch on stress perception and biological correlates. *Holistic Nursing Practice*. **22**(2), pp. 103-110.

Maxwell, E., Baillie, L., Rickard, W. and McLaren, S.M. 2013. Exploring the relationship between social identity and workplace jurisdiction for new nursing roles: a case study approach. *International Journal of Nursing Studies*. **50**, pp. 622-631

May, V. 2008. On being a ‘good’ mother: the moral presentation of self in written life stories. *Sociology*. **42**(3), pp. 470-486.

Mayberry, L and Osborn, C. 2012. Family support, medication adherence, and glycemic control among adults with type 2 diabetes. *Diabetes Care*. **35**, pp. 1239-1245.

McConnell-Henry, T., Chapman, Y. and Francis, K. 2009. Unpacking heideggerian phenomenology. *Southern Online Journal of Nursing Research*. **9**(1), pp.1-11.

McCormack, B. and McCance, T.V. 2006. Development of a framework for person-centred nursing*. Journal of Advanced Nursing*. **56**(5), pp. 472-479.

McCrae, N. and Kuzminska, K. 2017. The origins of a two-tier profession: a nursing school at a Poor Law infirmary. *British Journal of Nursing*. **26**(5), pp. 266-271.

McDonnell, K.K., Owens, O.L., Hilfinger Messias, D.K., Heiney, S.P., Friedman, D.B., Campbell, C. and Webb, L.A. 2019. Health behavior changes in African American family members facing lung cancer: tensions and compromises. *European Journal of Oncology Nursing*. **38**, pp. 57-64.

McGloin, H., Timmins, F., Coates, V. and Boore, J. 2014. A case study approach to the examination of a telephone-based health coaching intervention in facilitating behaviour change for adults with type 2 diabetes. *Journal of Clinical Nursing*. **24**, pp.1246-1257.

McGuire, A. and Anderson, D. 2012. Lifestyle risk factor modification in midlife women with type 2 diabetes: theoretical modelling of perceived barriers. *Australian Journal of Advanced Nursing*. **30**(1), pp. 49-57.

McKinney, A. 2017. *The value of life story work for staff, people with dementia and family members. Nursing Older People*. **29**(5), pp. 25-29.

Mehta, S. 2014. Medicine and society: telemedicine's potential ethical pitfalls. *American Medical Association Journal of Ethics*. **16**(12), pp. 1014-1017.

Miao, F.F., Koo, M., and Oishi, S. 2013. Subjective well-being. In *Oxford Handbook of Happiness*. In: David, S.A., Boniwell, I. and Conley-Ayers, A. eds. *The Oxford Handbook of Happiness*. Oxford: Oxford University Press, pp. 174-184.

Michaleson, J., Mahony, S., and Schifferes, J. 2012. *Measuring wellbeing: a guide for practitioners*. [Online]. London: New Economics Foundation. [accessed 15 December 2014]. Available from: https://b.3cdn.net/nefoundation/8d92cf44e70b3d16e6_rgm6bpd3i.pdf

Mikkelsen, G. and Frederiksen, K. 2011. Family-centred care of children in hospital-a concept analysis. *Journal of Advanced Nursing*. **67**(5), pp. 1152-1162.

Miles, L. 2007. What's in a label? choosing healthier food. *Practice Nursing*. **18**(4), pp. 181-185.

Miles, M., Huberman, M. and Saldana, J. 2014. *Qualitative data analysis: a method sourcebook*. 3rd ed. London: Sage Publications Ltd.

Milligan, F. 2014. Projected costs of the obesity epidemic: influences and interventions. *British Journal of Cardiac Nursing*. **9**(9), pp. 459-461.

Min, L.J. 2010. The experiences of and meaning for women living and coping with type 2 diabetes: a systematic review protocol. *The JBI Database of Systematic Reviews and Implementation Reports*. **8**(34), pp. 395-413.

Miao, F., Koo, M. and Oishi, S. 2013. Subjective Well-being. In: David S., Boniwell I. and Conley Ayers A. eds. *The Oxford Handbook of Happiness*. Oxford: Oxford University Press, pp. 174-184.

Mitchell, M. and Chaboyer, W. 2010. Family centred care - a way to connect patients, families and nurses in critical care: a qualitative study using telephone interviews. *Intensive and Critical Care Nursing*. **26**(3), pp. 154-160.

Mohanty, J.N. 1985. *The possibility of transcendental philosophy*. Lancaster: Martinus Nijhoff Publishers.

Moher, D., Liberati, A., Tetziaff, J. and Atman, D.G. 2009. Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Annals of Internal Medicine*. **151**(4), pp. 264-269.

Moitra, E., Anderson, B.J., Herman, D.S., Hayaki, J., Pinkston, M.M., Kim, H.N. and Stein, M.D. 2020. [Forthcoming] Examination of using alcohol to cope, depressive symptoms, and perceived social support in persons with HIV and Hepatitis C. *AIDS Care*. [Online]. [Accessed 14 July 2020]. Available from: https://doi.org/10.1080/09540121.2020.1734177

Montague, B.T., Kahler, C.W., Colby, S.M., McHugh, R.K., Squires, D., Fitzgerald, B., … Mayer, K.H. 2015. Attitudes and training needs of New England HIV care and addiction treatment providers. *Addictive Disorders & Their Treatment.* **14**(1), pp. 16-28.

Moran, D. 2000. Introduction to phenomenology. London: Routledge .
Moran D., 2013. From the natural attitude to the life-world. In: Embree L. and Nenon T. eds. *Husserl's Ideen*. N.Y.: Springer Publishing Company, pp. 105-124.

Moran, D. 2016. The ego as substrate of habitualities: Edmund Husserl's phenomenology of the habitual self. *Phenomenology and Mind*. **6**, pp. 24-39.

Morrison, J. 2002. Developing research questions in medical education: the science and the art. *Medical Education*. **36**(7), pp. 596–597.

Morse, J. 2008. Confusing categories and themes. *Qualitative Health Research*. **18**(6), pp. 727-728.

Morse, J.M. 2015. Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research.* **25**(9), pp. 1212-1222.

Morse, J.M. 2018. Reframing rigor in qualitative inquiry. In: Denzin, N.K. and Lincoln, Y.S. eds. The sage handbook of qualitative research. 5th ed. London: Sage Publications Inc., pp.1373-1409.

Morse, J.M., Barnett, N., Mayan, M., Olson, K. and Spiers, J. 2002. Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, **1**(2), article no: 2 [no pagination]

Morse, J.M. and Mitcham, C. 2002. Exploring qualitatively-derived concepts: inductive-deductive pitfalls. *International Journal of Qualitative Methods*. **1**(4), pp.28-35.

Morville, A. L. and Erlandsson, L.K. 2013. The experience of occupational deprivation in an asylum centre: the narratives of three men. *Journal of Occupational Science*. **20**(3), pp. 212-223.

Moshki, M., Dehnoalian, A. and Alami, A. 2017. Effect of precede-proceed model on preventive behaviors for type 2 diabetes mellitus in high-risk individuals. *Clinical Nursing Research*. **26**(2), pp. 241-253.

Moule, P. and Goodman, M. 2009. *Nursing research: an introduction*. London: Sage Publications.

Munhall, P. 2007. A phenomenological method. In: Munhall, P. ed., *Nursing research: a qualitative perspective*. London: Jones and Bartlett Publishers, pp. 145-211.

Murata, C., Kondo, T., Tamakoshi, K., Yatsuya, H. and Toyoshima, H. 2006. Factors associated with life space among community-living rural elders in Japan. *Public Health Nursing*. **23**(4), pp. 324-331.

Myers, B., Sorsdahl, K., Morojele, N.K., Kekwaletswe, C., Shuper, P.A. and Parry, C.D.H. 2016. In this thing I have everything I need: perceived acceptability of a brief alcohol-focused intervention for people living with HIV*. AIDS Care.* **29**(2), pp. 209-213*.*

Nakar, S. 2007. Transition to insulin in type 2 diabetes: family physicians' misconception of patients' fears contributes to existing barriers. *Journal of Diabetes Complications*. **21**, pp. 220-226.

Nash, M. 2014. Mental health service users' experiences of diabetes care by mental health nurses: an exploratory study .*Journal of Psychiatric and Mental Nursing*. **21**,pp. 715-723.

National Health System. 2007.*Statistics on alcohol: England, 2007.* [Online]. London: Health and Social Care Information Centre. [Accessed 25 November 2014]. Available from: https://files.digital.nhs.uk/publicationimport/pub00xxx/pub00094/alco-eng-2007-rep.pdf

National Health System. 2013. *Alcohol misuse.* [Online]. [Accessed 20 November 2014]. Available from: https://www.nhs.uk/conditions/alcohol-misuse/

National Health System. 2014.*Type 2 Diabetes*. [Online]. [Accessed18 November 2014]. Available from: https://www.nhs.uk/conditions/type-2-diabetes/

National Institute for Health and Clinical Excellence. 2009. *Type 2 diabetes: the management of type 2 diabetes*. [Online]. London: National Institute for Health and Clinical Excellence. [Accessed on 19 November 2014]. Available from: https://www.nice.org.uk/guidance/cg87

Nelson Laska, M., Larson, N.I., Neumark-Sztainer, D. and Story, M. 2010. Dietary patterns and home food availability during emerging adulthood: do they differ by living situation? *Public Health Nutrition*, **13**(02), pp. 222-228.

Nieswiadomy, R.M. and Bailey C. 2018. *Foundations of nursing research*. 7th ed. N.Y.: Pearson Education Inc.

Niu, C., Eng, L., Qiu, X., Shen, X., Espin-Garcia, O., Song, Y., … Alibhai, S.M.H. 2015. Lifestyle Behaviors in Elderly Cancer Survivors: A Comparison With Middle-Age Cancer Survivors. *Journal of Oncology Practice.* **11**(4), pp. e450–e459.

Noble, H. and Smith J. 2015. Issues of validity and reliability in qualitative research. *Evidence Based Nursing*. **18**(2), pp. 34-35

Norton, E. 2013. The application of humanization theory to health-promoting practice. *Perspectives in Public Health*. **135**(3), pp. 133-137.

Noy, C. 2008. Sampling knowledge: the hermeneutics of snowball sampling in qualitative research. *International Journal of Social Research Methodology*. **11**(4), pp. 327-344.

O'Leary, D.F., Casey, M., O'Connor, L., Stokes, D., Fealy, G.M., O'Brien, D., … Egan, C. 2017. Using rapid reviews: an example from a study conducted to inform policy-making. *Journal of Advanced Nursing*. **73**(3), pp. 742-752.

Olsen, D. 2009. Nurses and the pharmaceutical industry: part 1: the subtle and not-so-subtle efforts to influence clinical practice. *American Journal of Nursing*. **109**(1), pp. 36-39.

Olsson, L.E., Jakobsson Ung, E., Swedberg, K. and Ekman, I. 2012. Efficacy of person-centred care as an intervention in controlled trials - a systematic review. *Journal of Clinical Nursing*. **22**, pp. 456-465.

Parahoo, K. 2014. *Nursing research: principles, process and issues*. 3rd ed. Basingstoke: Palgrave Macmillan.

Paulweber, B., Valensi, P., Lalic, M., Greaves, M., McKee, K... Szendroedi, J. 2010. A European evidence based guideline for the prevention of type 2 diabetes. *Hormone and Metabolic Research*. **42**(s01), pp. S3-S36.

Pearson, E.S., Irwin, J.D., Burke, S.M. and Shapiro, S. 2012. Parental perspectives of a 4-week family-based lifestyle intervention for children with obesity*. Global Journal of Health Science.* **5**(2), pp. 111-122.

Pereira, M.G., Berg-Cross, L., Almeida, P. and Machado, C. 2008. Impact of family environment and support on adherence, metabolic control, and quality of life in adolescents with diabetes. *International Journal of Behavioral Medicine*. **15**, pp. 187-193.

Petty, N.J., Thomson, O.P. and Stew, G. 2012. Ready for a paradigm shift? part 2: introducing qualitative research methodologies and methods. *Manual therapy*. **17**(5), pp. 378-384.

Peyrot, M., Egede, L., Funnell, M., Hsu, W., Ruggiero, L., Siminerio, L. and Stuckey, H. 2015. Ethnic differences in family member diabetes involvement and psychological outcomes: results from the second diabetes attitudes, wishes and needs (DAWN2) study in the USA. *Current Medical Research and Opinion*. **31**(7), pp. 1297-1307.

Phillips, C., 2012. Mutual humanization: a visual exploration of relationships in medical care. *Journal of Medical Humanities*. **33**(2), pp. 109-116.

Piana, N. 2016. Narrative medicine in diabetes care: report from FEND conference Munich 2016. *International Diabetes Nursing*. **13**(1-3), pp. 67-70.

Picard, R. G. 2015. The humanisation of media? social media and the reformation of communication. *Communication Research and Practice*. **1**(1), pp. 32-41.

Polit, D.F. and Beck, C.T. 2012. *Nursing research: principles and methods*. 9th ed. Philadelphia: Lippincott Williams & Wilkins.

Potter, D., Markowitz, L., Smith, S., Rajack-Talley, T., D'Silva, M., Della, L., Best, L. and Carthan, Q. 2016. Healthicization and lay knowledge about eating practices in two African American communities. *Qualitative Health Research*. **26(**14), pp. 1961-1974.

Pound, C. and Jensen, L.R. 2018. Humanising communication between nursing staff and patients with aphasia: potential contributions of the Humanisation Values Framework. *Aphasiology*. **32**(10), pp. 1209-1233.

Price, B. 2002. Laddered questions and qualitative data research interviews. *Journal of Advanced Nursing*. **37**(3), pp. 273-281.

Price, S., Viglia, G., Hartwell, H., Hemingway, A., Chapleo, C., Appleton, K., Saulais, L., Mavridis, I. and Perez-Cueto, F. 2016. What are we eating? consumer information requirement within a workplace canteen. *Food Quality and Preference*. **53**, pp.39-46.

Priest, H. 2003. An approach to the phenomenological analysis of data. *Nurse Researcher*. **10**(2), pp. 50-63.

Prior, M.T. 2018. Accomplishing "rapport" in qualitative research interviews: empathic moments in interaction*. Applied Linguistics Review*. **9**(4), pp. 487-511.

Quinlan, E., Thomas, R., Ahmed, S., Fichtner, P., McMullen, L., and Block, J., 2014. The aesthetic rationality of the popular expressive arts: lifeworld communication among breast cancer survivors living with lymphedema. *Social Theory & Health*. **12**(3), pp. 291-312.

Ravert, R.D., Boren, S.A. and Wiebke, E. 2015. Transitioning through college with diabetes: themes found in online forums. *Journal of American College Health.* **63**(4), pp. 258-267.

Rehm, J. and Hingson, R. 2014. Measuring burden: alcohol's evolving impact on individuals, families and society. *Alcohol Research*. **35**(2), pp. 117-118.

Rehm, J. and Shield, D.K. 2014. Alcohol and mortality: global alcohol-attributable deaths from cancer, liver cirrhosis, and injury in 2010. *Alcohol Research*. **35**(2), pp. 174-183.

Rehm, J., Lachenmeier, D. and Room, R. 2014. Why does society accept a higher risk for alcohol than for other voluntary or involuntary risks? *BMC Medicine*. **12**, article no: 189 [no pagination]

Reichenberg, L. 2013. *DSM-5 essentials: the savvy clinician's guide to the changes in criteria*. Hoboken, NJ: John Willey & Sons, Inc.

Reicherzer, S., Shavel, S. and Patton, J., 2013. Examining research issues of power and privilege within a gender-marginalized community. *Journal of Social, Behavioral, and Health Sciences.* **7**(1), pp. 79-97

Rhodes, P., Nocon, A., Small, N. and Wright, J. 2008. Disability and identity: the challenge of epilepsy. *Disability & Society*. **23**(4), pp.385-395.

Rich S., Graham M., Taket A. and Shelley J. 2013. Navigating the terrain of lived experience: the value of lifeworld existentials for reflective analysis. *International Journal of Qualitative Methods*. **12**, pp. 499-510.

Richards, L. and Morse, J. 2013. *Readme first for a user's guide to qualitative methods.* 3rd ed. London: Sage Publications.

Ricketts, T.C. and Goldsmith, L.J. 2005. Access in health services research: the battle of the frameworks. *Nursing Outlook.* **53**(6), pp. 274-280.

Rintala, T.M., Jaatinen, P., Paavilainen, E. and Åstedt-Kurki, P. 2013. Interrelation between adult persons with diabetes and their family: a systematic review of the literature. *Journal of Family Nursing*. **19**(1), pp. 3-28.

Ritchie, J. 2013. Indigenous onto-epistemologies and pedagogies of care and affect in Aotearoa. *Global Studies of Childhood*. ***3*(**4), pp.395-406.

Robinson, O.C. 2014. Sampling in interview-based qualitative research: a theoretical and practical guide. *Qualitative Research in Psychology*. **11**(1), pp. 25-41.

Rolfe, G. 2006. Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing*. **53**(3), pp. 304-310.

Rolfe, G. 2015. Foundations for a human science of nursing: Gadamer, Laing, and the hermeneutics of caring. *Nursing Philosophy*, **16**, pp. 141-152.

Rolfe. G. 2017. The reflective practitioner as critical theorist. In: Foth, T., Holmes, D., Hülsken-Giesler, M., Kreutzer, S. and Remmers, H. eds. *Critical approaches in nursing theory and nursing research implications for nursing practice*. Göttingen: V & R unipress GmbH, pp. 169-186.

Rolfe, G., Jasper M. and Freshwater D. 2010. *Critical reflection in practice: generating knowledge for care*. 2nd ed. Basingstoke: Palgrave.

Rorty, R. 1989. *Contingency, irony, and solidarity*. Cambridge: Cambridge University Press.

Rosenblatt, P. and Wieling E. 2019. Thematic and phenomenological analysis in research on intimate relationships. In: Humble, A. and Radina, M.E. eds. *How qualitative data analysis happens: moving beyond "themes emerged"*. London: Routledge, pp. 50-63.

Rubin, H. and Rubin, I. 2012. *Qualitative interviewing: the art of hearing data*. 3rd ed. London: Sage.

Ryff, C.D. and Singer, B.H. 2013. Know thyself and become what you are: A eudaimonic approach to psychological well-being. In: Delle Fave, A. ed. *The exploration of happiness: present and future perspectives.* New York: Springer Publishing Company, pp. 97-116.

Sabmann, H., de Hair, M., Danne, T. and Lange, K. 2012. Reducing stress and supporting positive relations in families of young children with type 1 diabetes: A randomized controlled study for evaluating the effects of the DELFIN parenting program. *BMC Pediatrics*. **12**, article no: 152 [no pagination]

Sabourin, B.C. and Pursley, S. 2013. Psychosocial issues in diabetes self-management: strategies for healthcare providers. *Canadian Journal of Diabetes*. **37**(1), pp. 36-40.

Saldana, J. 2015. *The coding manual for qualitative researchers*. 3rd ed. London: Sage Publications Ltd.

Sampson, H. 2004. Navigating the waves: the usefulness of a pilot in qualitative research. *Qualitative Research*. **4(**3), pp. 383-402.

Sarantakos, S. 2013. Social Research. 4th ed. London: Red Globe Press.

Saucedo, R.S. 2013. *Background paper 6.14 Harmful use of alcohol use disorders and alcoholic liver diseases*. Background paper.

Saunders, M., Lewis, P. and Thornhill, A. 2007. *Research methods for business students*. London: Prentice Hall.

Saylor, J. and Calamaro, C. 2016. Transitioning young adults with type 1 diabetes to campus life. *The Journal for Nurse Practitioners*. **12**(1), pp. 41-46.

Scambler, G. and Britten, N. 2001. System, lifeworld and doctor-patient interaction: issues of trust in a changing world. In: Scambler, G. ed. *Habermas, critical theory and health*. London: Routledge, pp. 46-67.

Schiøtz, M.L., Bøgelund, M., Almdal, T., Jensen, B.B., and Willaing, I. 2012. Social support and self-management behaviour among patients with type 2 diabetes. *Diabetic Medicine*. **29**(5), pp. 654–661.

Schram, M.T., Baan, C.A. and Pauwer, F. 2009. Depression of life in patients with diabetes: a systematic review from the European Depression in Diabetes (EDID) research consortium. *Current Diabetes Reviews.* **5**(2), pp.112-119.

Schulman-Green, D., Jaser, S., Martin, F., Alonzo, A., Grey, M., McCorkle, R., Redeker, N.S., Reynolds, N. and Whittemore, R. 2012. Processes of self-management in chronic illness. *Journal of Nursing Scholarship.* **44**(2), pp.136-144.

Scott, A. and Schurer, S. 2008. *Financial incentives, personal responsibility and prevention*. Melbourne: Melbourne Institute of Applied Economic and Social Research.

Scott, S. 2008. 'New professionalism' – shifting relationships between nursing education and nursing practice. *Nurse Education Today*. **28**, pp. 240-245.

Scott, S., Reilly, J., Giles, E. L., Hillier-Brown, F., Ells, L., Kaner, E. and Adamson, A. 2017. Socio-ecological influences on adolescent (aged 10–17) alcohol use and linked unhealthy eating behaviours: protocol for a systematic review and synthesis of qualitative studies. *Systematic Reviews*. **6**(1), article no: 180 [no pagination].

Seamon, D. 2015. Situated cognition and the phenomenology of place: lifeworld, environmental embodiment, and immersion-in-world. *Cognitive Processing*, **16**(Suppl 1), pp. S389–S392.

Seidman, I. 2006. *Interviewing as qualitative research: a guide for researchers in education and social sciences*. 3rd ed. New York: Teachers College Press.

Sharf, B. and Vanderford, M. 2003. Illness narratives and the social construction of health. In: Thompson, T., Dorsey, A., Miller, K. and Parrott, R. eds. *Handbook of health communication*. New Jersey: Lawrence Erlbaum Associates, pp. 9-34.

Sharf, B., Harter, L., Yamasaki, J. and Haidet, P. 2011. Narrative turns epic: continuing developments in health narrative scholarship. In: Thompson, T., Parrott, R. and Nussbaum, J. eds. The routledge handbook of health communication. 2nd ed. Oxford: Routledge, pp. 36-51

Shemilt, I., Hendry, V. and Marteau, T.M. 2017. *What do we know about the effects of exposure to "low alcohol" and equivalent product labelling on the amounts of alcohol, food and tobacco people select and consume? a systematic review. BMC Public Health,* **17**, article no: 29 [no pagination]

Shield, K., Parry, C. and Rehm, J. 2014. Chronic diseases and conditions related to alcohol use. *Alcohol Research*. **35**(2), pp.155-171.

Sholl, J. 2017. The muddle of medicalization: pathologizing or medicalizing? *Theoretical Medicine and Bioethics*. **38**,pp. 265-278.

Shortt, N.K., Rind, E., Pearce, J., Mitchell, R. and Curtis, S. 2018. Alcohol risk environments, vulnerability, and social inequalities in alcohol consumption. *Annals of the American Association of Geographers*. **108**(5), pp. 1210-1227.

Siddiqui, F.J. 2014. Uncontrolled diabetes mellitus: prevalence and risk factors among people with type 2 diabetes mellitus in an urban district of Karachi, Pakistan. *Diabetes Research and Clinical Practice.* **107**(1), pp. 148-156.

Sillence, E., Hardy, C. and Briggs, P. 2013.Why don't we trust health websites that help us help each other?: an analysis of online peer-to-peer healthcare. In: *Web science conference, 02/04 May 2013, Paris*. Paris: Proceedings of the 5th Annual ACM WebSci Conference, pp. 396-404.

Skinner, J. 2013. Professional approaches to care. In: Chilton, S., Bain, H., Clarridge, A. and Melling, K. eds. *A textbook of community nursing*. Florida: CRC Press, pp. 36-56.

Sloan, A. and Bowe, B. 2014. Phenomenology and hermeneutic phenomenology: the philosophy, the methodologies and using hermeneutic phenomenology to investigate lecturers' experiences of curriculum design. *Quality & Quantity*. **48**(3), pp.1291-1303.

Smith, J.A. 2009. *Qualitative psychology: a practice guide to research methods.* 2nd ed. London: Sage Publications Ltd.

Smith, J. and Firth, J. 2011. Qualitative data analysis: the framework approach. *Nurse Researcher*. **18**(2), pp. 52-62

Smith, J., Swallow, V. and Coyne I. 2015. Involving parents in managing their child's long-term condition: a concept synthesis of family-centered care and partnership-in-care. *Journal of Pediatric Nursing*. **30**, pp. 143-159.

Smith, L. and Shaw, R. 2017. Learning to live with Parkinson's disease in the family unit: an interpretative phenomenological analysis of well-being. *Medical Health Care and Philosophy*. **20**, pp. 13-21.

Spaten, O.M., Byrialsen, M.N. and Langdridge, D. 2012. Men's grief, meaning and growth: a phenomenological investigation into the meaning of loss. *Indo-Pacific Journal of Phenomenology*, **11**(2), pp. 1-15.

Speraw, S. 2009. "Talk to me - I'm human": the story of a girl, her Personhood, and the failures of health care. *Qualitative Health Research.* **19**(6), pp. 732-743.

Springer, R.A. 2011. Pharmaceutical industry discursives and the marketization of nursing work: a case example. *Nursing Philosophy*. **12**(3), pp. 214-228.

St. George, S.M., Noriega Esquives, B., Agosto, Y., Kobayashi, M., Leite, R., Vanegas, D., … Penedo, F.J. 2019. Development of a multigenerational digital lifestyle intervention for women cancer survivors and their families. *Psycho-Oncology.* **29**(1), pp. 182-194.

Staiton-Rogers, W. 2006. Logics of inquiry. In: Potter, S. *Doing postgraduate research*. Thousand Oaks: Sage Publications.

Stuckey, H., Mullan-Jensen, C., Kalra, S., Reading, J., Wens, J., Vallis, M., Kokoszka, A., Malek, R., Kovacs Burns, K., Piana, N., Skovlund, S. and Peyrot, M. 2016. Living with an adult who has diabetes: qualitative insights from the second Diabetes Attitudes, Wishes and Needs (DAWN2) study. *Diabetes Research and Clinical Practice*. **116**, pp. 270-278.

Sullivan-Bolyai, S., Bova, C., Lee, M. and Johnson, K. 2012. Development and pilot testing of a parent education intervention for type 1 diabetes: parent education through simulation–diabetes. *The Diabetes Educator*. **38**(1), pp. 50-57.

Sundström, B.W. and Dahlberg, K. 2012. Being prepared for the unprepared: a phenomenology field study of Swedish prehospital care. *Journal of Emergency Nursing*. **38**(6), pp. 571-577.

Svenaeus F., 2011. Illness as unhomelike being-in-the-world: Heidegger and the phenomenology of medicine. *Medicine, Health Care and Philosophy*, 14, 333–343

Tamony, P., Holt, R. and Barnard, K. 2015. The role of mobile applications in improving alcohol health literacy in young adults with type 1 diabetes. *Journal of Diabetes Science and Technology.* **9**(6), pp. 1313-1320.

Tang, T.S., Brown, M.B., Funnell, M.M. and Anderson, R.M. 2008. Social support, quality of life, and self-care behaviours among African Americans with type 2 diabetes. *The Diabetes Educator*. **34**(2), pp.266-276.

Tartaglia, S. and Bergagna, E. 2019. Alcohol consumption as amaladaptive coping strategy to face low life satisfaction. *Drugs: Education, Prevention and Policy*. **27**(4), pp. 306-311.

Thomas, C., Allison, R. and Latour J. 2018. Using blogs to explore the lived-experience of life after stroke: “a journey of discovery I never wanted to take”. *Journal of Advanced Nursing*. **74**, pp. 579-590.

Thorne, S.E., Henderson, A.D., McPherson, G.I. and Pesut, B.K. 2004. The problematic allure of the binary in nursing theoretical discourse. *Nursing Philosophy*. **5**(3), pp. 208-215.

Thurang, A., Rydström, J. and Bengtsson Tops, A. 2011. Being in a safe haven and struggling against alcohol dependency. The meaning of caring for male patients in advanced addiction nursing. *Issues in Mental Health Nursing*. **32**(7), pp. 401-407.

Tidwell, T., Edwards, J., Snider, E., Lindsey, C., Reed, A., Scroggins, I., Zarski, C. and Brigance, J. 2011. A nursing pilot study on bedside reporting to promote best practice and patient/family-centered care. *Journal of Neuroscience Nursing*. **43**(4), pp.e1-e5.

Timmins, F. and McCabe, C. 2005. How to conduct an effective literature search. *Nursing Standard*. **20**(11), pp. 41-47.

Todres, L. 2005. Clarifying the life-world: descriptive phenomenology. In: Hollaway, I. ed. *Qualitative Research in Health Care*. Maidengead, UK: Open University Press. pp. 104-124.

Todres, L. 2007. Lifeworld-led healthcare: revisiting a humanising philosophy that integrates emerging trends. *Medicine, Health Care and Philosophy*. **10**(53), pp. 53-63.

Todres, L., Galvin, K. and Dahlberg, K. 2007. Lifeworld-led healthcare: revisiting a humanising philosophy that integrates emerging trends. *Medicine, Health Care and Philosophy.* **10**(1), pp. 53-63.

Todres, L., Galvin, K.T. and Holloway, I. 2009. The humanization of healthcare: A value framework for qualitative research. *International Journal of Qualitative Studies on Health and Well-Being.* **4**(2), pp. 68-77.

Todres, L. and Galvin, K. 2010. “Dwelling-mobility”: an existential theory of well-being. *International Journal of Qualitative Studies on Health and Well-Being*. **5**(3), article no: 5444 [no pagination]

Tracy, K. and Wallace, S. 2016. Benefits of peer support groups in the treatment of addiction. *Substance Abuse and Rehabilitation*. **7**, pp. 143-154.

Traversy, G. and Chaput, J.P. 2015. Alcohol consumption and obesity: an update. *Current Obesity Reports*. **4**(1), 122-130.

Traynor, M. 2014. Caring after Francis: moral failure in nursing reconsidered. *Journal of Research in Nursing*. **19**(7–8), pp. 546-556.

Tufekci, Z. 2013. The social internet: frustrating, enriching, but not lonely. *Public Culture*. **26**(1), pp. 13-23.

Tuckett, A. 2005. Part II. rigour in qualitative research: complexities and solutions. *Nurse Researcher*. **13**(1), pp. 29-42.

Turner, K. 2008. People’s educational needs following a diagnosis of diabetes. *Journal of Diabetes Nursing*. **12**(4), pp. 136-143.

Turner, D.W. 2010. Qualitative interview design: a practical guide for novice investigators. *The Qualitative Report*. **15**(3), pp. 754-760.

Tyndall, J. 2008. *How low can you go?: toward a hierarchy of grey literature*. [Online]. Accessed 12 December 2014]. Available from: https://dspace.flinders.edu.au/jspui/bitstream/2328/3326/1/Tyndall.pdf

Unruha, L., Rice, T., Vaillancourt Rosenau, P. and Barnes, A., 2016. The 2013 cholesterol guideline controversy: Would better evidence prevent pharmaceuticalization? *Health Policy*. **120**, pp. 797-808.

Vaes, J. and Muratore, M. 2012. Defensive dehumanization in the medical practice: A cross-sectional study from a health care worker's perspective. *British Journal of Social Psychology.* **52**(1), pp. 180–190.

Vaismoradi, M., Turunen, H. and Bondas, T. 2013. Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*. **15**(3), pp. 398-405.

Van Manen, M. 1984. Practicing phenomenological writing*. Phenomenology + Pedagogy*. **2**(1), pp. 36-69.

Van Manen, M. 1997. *Researching lived experience: human science for an action sensitive pedagogy*. 2nd ed. London: Althouse Press.

Van Manen, M. 2014. *Phenomenology of practice*. Walnut Creek, CA: Left Coast Press Inc.

Van Sant, J.E. and Patterson, B.J. 2013. Getting in and getting out whole: nurse-patient connections in the psychiatric setting*. Issues in Mental Health Nursing.* **34**(1), pp. 36-45*.*

Vandijck, D., Labeau, S., Geerinckx, C., Puydt, E., Bolders, A., Claes, B. and Blot, S. 2010. An evaluation of family-centered care services and organization of visiting policies in Belgian intensive care units: a multicenter survey. *Heart & Lung*. **39**(2), pp. 137-146.

Vannatta, S. and Vannatta, J. 2013. Functional realism: a defense of narrative medicine. *Journal of Medicine and Philosophy*. **38**, pp.32-49.

Vassilev, I., Rogers, A., Sanders, C., Kennedy, A., Blickem, C., Protheroe, J., Bower, P., Kirky, S., Chew-Graham, C. and Morris, R. 2011. Social networks, social capital and chronic illness self-management: area listreview. *Chronic Illness*. **7**, pp. 60-86.

Venn, S. Meadows, R. and Arber, S. 2013. Gender differences in approaches to self-management of poor sleep in later life. *Social Science & Medicine*. **79**, pp. 117-123.

Vestman, C., Hasselroth, M. and Berglund, M. 2014. Freedom and confinement: patients' experiences of life with home haemodialysis. *Nursing Research and Practice*. **1**, article no: 252643 [no pagination]

Way, S. and Scammell, J. 2015. Humanising midwifery care. *Practising Midwife*. **19**(3), pp. 27-29.

Wekesah, F.M., Kyobutungi, C., Grobbee, D.E. and Klipstein-Grobusch, K. 2019. Understanding of and perceptions towards cardiovascular diseases and their risk factors: a qualitative study among residents of urban informal settings in Nairobi*.* *BMJ Open.* **9**(6), article no: e026852 [no pagination]

Wetherall, C. 2012. Call yourself a nurse? time to get precious. *Journal of Clinical Nursing*. **21**, pp. 2809-2811.

White, P., Smithm S.M., Hevey, D. and O'Dowd, T. 2009. Understanding type 2 diabetes: including the family member's perspective. *The Diabetes Educator*. **35**, pp. 810-817.

White, S. and Tait, D. 2018. Humanised care and clinical decision making in critical care. In: White, S. and Tait, D. eds. *Critical care nursing: the humanised approach*. London: Sage Publication Ltd, pp. 5-35

Whiting, L. 2002. Analysis of phenomenological data: personal reflections on Giorgi's method. *Nurse Researcher*. **9**(2), pp. 60-74.

Wild, S., Roglic, G., Green, A., Sicree, R. and King, H. 2004. Global prevalence of diabetes: estimates for the year 2000 and projections for 2030. *Diabetes Care.* **27**, pp.1047–1053.

Wilkinson, A., Whitehead, L. and Ritchie, L. 2014. Factors influencing the ability to self-manage diabetes for adults living with type 1 or 2 diabetes. *International Journal of Nursing Studies*. **51**, pp.111-122.

Willetts, G. and Clarke, D. 2014. Constructing nurses' professional identity through social identity theory. *International Journal of Nursing Practice*. **20**, pp.164–169

Williamson, L. 2012. Destigmatizing alcohol dependence: the requirement for an ethical (not only medical) remedy. *American Journal of Public Health*. **102**(5), pp. e5-e8.

Wilson, A. 2014. Being a practitioner: an application of Heidegger's phenomenology. *Nurse Researcher*. **21**(6), pp. 28-33.

Wilson, J. 2014. Ward staff experiences of patient death in an acute medical setting*.* *Nursing Standard*. **28**(37), pp. 37-45.

Wilson, F., Massey, A. and Mabhala, M.A. 2015. Making sense of health improvement and well- being. In: Wilson, F., Mabhala, M.A. and Massey, A. eds. *Health improvement and well-being: strategies for action*. Berkshire: Open University Press, pp. 1-23.

Wolff, J. and Boyd, C. 2015. A look at person-centered and family-centered care among older adults: results from a national survey. *Journal of General Internal Medicine*. **30**(10), pp. 1497-1504.

World Health Organisation. 2013. *Diabetes.* [Online]. [Accessed 18 November 2014]. Available from: https://www.who.int/en/news-room/fact-sheets/detail/diabetes

World Health Organisation. 2014. *Mental and behavioural disorders due to psychoactive substance use*. [Online]. [Accessed 24 November 2014]. Available from: https://icd.who.int/browse10/2014/en#/F10-F19

Wrycraft, N. 2012. *Mental health nursing: case book.* Glasgow: Bell & Bain Ltd.

Wu, S.F.V., Huang, Y.C., Liang, S.Y., Wang, T.J., Lee, M.C., and Tung, H.H. 2011. Relationships among depression, anxiety, self-care behaviour and diabetes education difficulties in patients with type-2 diabetes: a cross-sectional questionnaire survey. *International Journal of Nursing Studies*. **48**(11), 1376-1383.

Yalcin, M.B. 2008.The effects of an emotional intelligence program on the quality of life and well-being of patients with type 2 diabetes mellitus. *The Diabetes Educator*. **34**(6), pp. 1013-1024.

Yang, T., Horneffer, M. and DiLisio, N. 2013. Mining social media and web searches for disease detection. *Journal of Public Health Research*. **2**(1), pp. 17-21.

Yegdich, T. 2000. In the name of Husserl: nursing in pursuit of things-in-themselves. *Nursing Inquiry*. **7**(1), pp.29-40.

Yoon, S., Lam, W.W.T., Sham, J.T.L. and Lam, T.H. 2015. Learning to drink: how Chinese adolescents make decisions about the consumption (or not) of alcohol. *International Journal of Drug Policy*. **26**(12), 1231-1237.

Young, P. 2004. Using the internet to conduct a literature search .*Nursing Standard*. **19**(6), pp.45-51.

Younger, P. and Boddy, K. 2009. When is a search not a search? A comparison of searching the amedcomplementary health data base via EBSCO host, OVID and DIALOG. *Health Information & Libraries Journal*. **26**(2), pp.126-135.

Zembylas, M. 2014. Theorizing “difficult knowledge” in the aftermath of the “affective turn”: implications for curriculum and pedagogy in handling traumatic representations. *Curriculum Inquiry*. **44**(3), pp. 390-412.

Zeng, Z., Pantic, M., Roisman, G.I. and Huang, T.S. 2009. A survey of affect recognition methods: Audio, visual, and spontaneous expressions. *IEEE transactions on pattern analysis and machine intelligence*. ***31***(1), pp.39-58.

Zimmer, L. 2006. Qualitative meta-synthesis: a question of dialoguing with the texts. *Journal of Advanced Nursing*. **53**(3), pp. 311-318.

Zhou, J., O’Brien, K.S. and Heim, D. 2013. Alcohol consumption in sports people: the role of social cohesion, identity and happiness*. International Review for the Sociology of Sport.* **49**(3-4), 278–293.

Zulueta, P. 2013. Reflecting on the Francis report: how we can develop more human systems of care. *Nursing Ethics*. **20**(7), pp. 838-842.

APPENDICES

APPENDICES

APPENDIX I

Publications

1. Mantzouka C., Morrall P., Gilmartin J., & Waite-Jones, J., 2017. Well-being, type 2 diabetes and alcohol consumption: a literature review. *Primary Health Care*, 27(3), 26-30.

TYPE 2 DIABETES

Well-being, type 2 diabetes and alcohol consumption: a literature review

Mantzouka C, Morrall P, Gilmartin J et al (2017) Well-being, type 2 diabetes and alcohol consumption: a literature review. Primary Health Care. 27, 3, 26-30. Date of submission: 15 June 2016; date of acceptance: 4 October 2016. doi: 10.7748/phc.2017.e1181

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Abstract

A diagnosis of type 2 diabetes is associated with lifestyle modifications, one of which concerns alcohol consumption. However, many if not all aspects of an individual's lifestyle have personal historic, symbolic and ritual qualities and patterns as well as wider social contexts. Therefore, any alteration of lifestyle has wider, possibly major and negative consequences for that individual, such as social alienation and psychological turmoil, undermining the individual's feeling of well-being. This article describes the significant themes from a literature review that aimed to identify the relationship between lifestyle modifications and type 2 diabetes. The findings may help to shed light on the issues and challenges nurses face in delivering support to individuals with type 2 diabetes in clinical practice.

Keywords

alcohol consumption, lifestyle modifications, literature review, nursing care, social networks, type 2 diabetes, well-being

Introduction

There is a steady increase in the incidence of type 2 diabetes worldwide (Long 2011, World Health Organization (WHO) 2016). Type 2 diabetes is increasing in the US, Australia and Europe, with the number of cases predicted to almost double by 2040 (International Diabetes Federation (IDF) 2015, Siddiqui et al 2015). This expected significant global increase of type 2 diabetes will make it the seventh-biggest cause of death worldwide (Long 2011, WHO 2016).

In the UK, it is estimated that incidence of type 2 diabetes will double by 2040, causing 16% of deaths (Diabetes UK 2011, Basu et al 2014, IDF 2015). It is the UK's fifth-biggest cause of death and accounts for approximately one tenth of NHS expenditure (Paulweber et al 2010, Hex et al 2012, WHO 2016).

Type 2 diabetes is linked to lifestyle choices such as unhealthy diet (sugar consumption) and increased alcohol consumption (Baliunas et al 2009, Ginter and Simko 2012). NHS guidelines (2015) state that to keep the risk of alcohol-related harm low, individuals should not drink more than 14 units of alcohol per week and should spread this amount of alcohol consumption evenly over three or more days. Excessive alcohol consumption (more than advised in NHS guidelines) can produce detrimental effects contributing to the onset and exacerbation of chronic conditions such as type 2 diabetes (Athyros et al 2007-2008). Self-regulation of excessive drinking and alteration of detrimental habits such as binge drinking are essential for individuals to manage type 2 diabetes complications (Tang et al 2008, Inzucchi et al 2015).

Lifestyle modifications are important for those with type 2 diabetes and are pursued through the development of structured education, lifestyle advice and self-monitoring training sessions (National Institute for Health and Care Excellence (NICE) 2009, NHS 2013). However, these enabling mechanisms require appropriate staff training, sufficient time, proper resources and a pertinent emphasis on psychosocial aspects relating to type 2 diabetes. These four elements are not always available, limiting the implementation of already developed guidelines for supporting individuals (Nakar et al 2007, Home et al 2009, Hex et al 2012).

The highest alcohol consumption levels among individuals aged above 15 years are found in Europe and the Americas, while the lowest levels are found in south east Asia and the eastern Mediterranean, with alcohol the third most important risk factor for disease burden in Europe (Mason et al 2009, WHO 2016). The UK is ranked 15th in the world for alcohol consumption, with an estimated 1.6 million people considered alcohol-dependent, 1.2 million alcohol-related hospital admissions per year and 8,748 deaths directly related to alcohol in 2015 (Office for National Statistics 2017, NHS 2012).

The term 'well-being' describes the happiness of individuals, signifies the presence of positive feelings and denotes the absence of negative feelings, portraying lives filled with joy and affection, which makes those lives pleasant (Deci and Ryan 2008, Kahneman and Deaton 2010). Alcohol consumption and type 2 diabetes can negatively affect someone's notion of well-being. Those with type 2 diabetes are twice as likely to exhibit negative feelings and diminished levels of well-being, and these are further intensified when type 2 diabetes is combined with over-consumption of alcohol (Schram et al 2009, Brook et al 2011).

Aim and methods

The literature review described in this article aimed to explore the relationship between type 2 diabetes, lifestyle modification such as alcohol use/misuse and well-being, and how to develop mechanisms that might offer nurses more insight into better ways of helping people to modify their lifestyles.

An electronic search was undertaken using the BNI, CINAHL, Medline, Embase, Global Health, PsycINFO and Ovid Medline databases to retrieve relevant articles. The search was further refined using advanced filters limiting the search to articles written in English and published between 2008 and 2014. This time frame was selected because 2008 is the point when a series of updates, strategy developments and service integration processes occurred regarding type 2 diabetes, alcohol management and well-being in the UK that significantly altered provision of care (Department of Health 2008, NICE 2009). A search of grey literature was also conducted at www.greylit.org, http://library.leeds.ac.uk/grey-literature and www.opengrey.eu using the same keywords and search strategy and looking only for conference documents, dissertations and government reports.

The searches retrieved 1,374 articles from mainstream databases and 79 from grey literature databases. A total of 1,453 relevant articles were retrieved and assessed using the inclusion/exclusion criteria, with 187 duplicates then removed. The titles and abstracts were reviewed: 112 met the inclusion criteria and of these 24 full-text studies and six grey literature documents fully met the criteria, for a total of 30 papers and documents. All the studies from mainstream databases were assessed for quality using the appraisal framework of Hawker et al (2002) and the grey literature was assessed using the checklist devised by Tyndall (2008).

Findings and discussion

The review used the format of Bettany-Saltikov (2012) for extracting data, and followed guides for the analysis and synthesis of reviews devised by Finfgeld-Connett (2010) and Thomas and Harden (2008). Five themes emerged from the analysis.

Theme one: type 2 diabetes and alcohol consumption

Findings from the studies reviewed suggested that low to moderate consumption of alcohol may reduce the risk of developing type 2 diabetes. However, this hypothesis is controversial as it is difficult to measure alcohol consumption as the literature defines it differently and different types of alcohol may have different effects (Baliunas et al 2009, Rehm and Shield 2014). This hypothesis is also susceptible to bias as it cannot distinguish between lifetime abstainers and former drinkers, and lacks generalisability (Rehm and Shield 2014).

It is unclear whether low alcohol consumption is a protective factor or if moderate drinking is a marker for healthy lifestyle choices that may account for the observed protective effect (Shield et al 2014).

Nevertheless, a relationship between alcohol consumption and type 2 diabetes appears to exist. Higher levels of alcohol consumption increase the risks of developing and exacerbating type 2 diabetes (Drinkware 2016). Alcohol consumption and type 2 diabetes have physical, psychological, social-cultural and environmental interconnectedness, so dealing with alcohol consumption and type 2 diabetes requires treatments tailored to the individual (European Observatory on Health Systems and Policies Series 2008, Diabetes UK 2017).

Theme two: well-being of individuals with type 2 diabetes

Kneck et al (2012) highlighted the tension between the way individuals with type 2 diabetes want to live and the way they should live. This tension creates a disharmony between their idealised and actual lives, leading to negative sentiments. Providing information and education to individuals, while necessary, is of itself insufficient to enable them to cope with type 2 diabetes. Learning to live with type 2 diabetes and harmoniously adjusting lifestyles to it requires more than education.

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FAST FACTS

15th
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Cultural and community expectations, and the inability to meet these expectations due to type 2 diabetes, trigger a sense of uneasiness, lack of fulfilment and inadequacy that adversely affect well-being (Manderson and Kokanovic 2009).

Wu et al (2011) linked cultural aspects of expressiveness and social interaction to well-being. They concluded that cultural unwillingness to share and discuss experiences related to type 2 diabetes may lead people to stoically accept the condition without rationalising it. As a result, they become unhappy, demotivating them from trying to improve their quality of life.

Theme three: illusion of change as a barrier to genuine lifestyle modification

Johansson et al (2009) said newly diagnosed individuals want to discuss their conditions or feelings, not because they have accepted it or adjusted well, but because they want to appear unaffected by the situation, accepted by others as healthy and avoid being characterised as unhealthy. This implies that this adaptation is false or illusory.

Ahlin and Billhult (2012) maintained that people with type 2 diabetes are disillusioned by change and persist in living with the illusion that they do not have diabetes or do not have to make lifestyle changes. The main point is that lifestyle changes are not easy and that individuals continuously struggle with to make them. Healthcare professionals should therefore not confuse adaptation with a facade of acceptance of the need to change.

Handley et al (2010) said people with type 2 diabetes face continuous emotional turmoil, ranging from denial to fear, when confronted with the need to change their lifestyle. Grado (2013) suggested that alcohol consumption is associated with maladaptation to having type 2 diabetes. Jansink et al (2010) concluded that lifestyle counselling is at the core of caring and is essential to overcome barriers to lifestyle modification.

Thus, those with type 2 diabetes find it difficult to modify their lifestyles, often have an illusion of change and often seem to prefer this illusory adaptation instead of genuine adaption, as genuine lifestyle changes create great levels of inner tension and struggle.

Theme four: healthcare professionals' support role

Providing information and the development of knowledge help individuals with type 2 diabetes to overcome barriers and modify their lifestyles to attain a better quality of life (Collins et al 2009, Hicks 2010). Gorter et al (2011) concluded that most of its study participants were ill-prepared by healthcare professionals to take responsibility and were unwilling to set treatment targets. This inevitably led to misunderstandings between patients and healthcare professionals, and limited patients' sense of 'owning' the treatment processes.

Partnership between individuals with type 2 diabetes and healthcare professionals situates the notion of empowerment at the centre of care. Dutton et al (2014) and Hicks (2010) suggested that people with type 2 diabetes feel they have little input in decisions and this adversely effects their potential to cope with it. Those with higher education were self-motivated, exhibited greater potential to cope and were readier to adapt (Turner 2008, Hicks 2010, Gorter et al 2011).

However, it would be self-defeating and unfulfilling to accept that healthcare professionals have only a limited, if any, contribution to make in helping people to develop coping strategies and that the ability to cope may be due to individual characteristics. Schulman-Green et al (2012) asserted that the problem for healthcare professionals is that they focus on the management of illness rather than the emotional or existential challenges of having type 2 diabetes. Lamers et al (2010) concluded that the quality of care can be improved by paying greater attention to the emotional aspects of diabetes.

The role of healthcare professionals is to assist those with type 2 diabetes to manage themselves and take responsibility for treating their own condition. However, patients are frequently unwilling to set treatment targets and healthcare professionals are the ones who usually set them instead (Collins et al 2009, Hicks 2010, Gorter et al 2011). This inevitably leads to misunderstandings and means patients have a limited sense of ownership of their treatment. Therefore, healthcare professionals should focus on addressing patients' emotional and existential challenges (Vassilev et al 2011, Schulman-Green et al 2012). Patients will only achieve personal growth and maturity when healthcare professionals tailor their relationships with patients and coach them in re-evaluating their lives by constructing new meaning in their modified lifestyles.

Theme five: stigma, social networks and well-being

Social networks are not always supportive, because they define normalcy and deviance from normalcy. Positive social networks can create supportive mechanisms for people with type 2 diabetes when they modify their lifestyles. However, negative social networks can remind people with type 2 diabetes of their responsibility for lack of control and poor management of their health, resulting in blaming and stigmatising attitudes (White et al 2009, Vassilev et al 2011, Schiøtz et al 2012, Nash 2014).

Strengthening and supporting the positive social networks of people with type 2 diabetes can help to overcome stigma from negative social networks (Schiøtz et al 2012, Nash 2014). Nonetheless, social networks can stigmatise patients for their unwillingness to modify unhealthy lifestyles (Williamson 2012), inhibiting their potential to alter their lifestyle and achieve well-being.

Conclusion

The literature accessed in this review showed that immoderate alcohol consumption exacerbates type 2 diabetes complications and affects the well-being of individuals (Baliunas et al 2009, Johansson et al 2009). Dealing with the physical, psychosocial and environmental aspect of lifestyle changes and type 2 diabetes requires individualised treatments that include education. Support is required for rationalising the condition and achieving a balance between the idealised and the actual lifestyle. Eventually, these supportive approaches can create preconditions for individuals with type 2 diabetes to move on and increase their sense of well-being.

The role of healthcare professionals includes addressing the emotional and existential challenges of living with type 2 diabetes and assisting patients in gaining benefits from their treatment. Lifestyle modifications can be impeded by social networks that stigmatise the individual for a lack of control and poor management of type 2 diabetes and their lifestyle. The healthcare professionals' role includes supporting positive social networks to enable patients to make changes.

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References

▶ Ahlin K, Billhult A (2012) Lifestyle changes – a continuous, inner struggle for women with type 2 diabetes: a qualitative study. Scandinavian Journal of Primary Health Care. 30, 1, 41-47.

▶ Athyros V, Liberopoulos EN, Mikhailidis DP et al (2007-2008) Association of drinking pattern and alcohol beverage type with the prevalence of metabolic syndrome, diabetes, coronary heart disease, stroke, and peripheral arterial disease in a Mediterranean cohort. Angiology. 58, 6, 689-697.

▶ Baliunas OD, Taylor BJ, Irving H et al (2009) Alcohol as a risk factor for type 2 diabetes: a systematic review and meta-analysis. Diabetes Care. 32, 11, 2123-2132.

▶ Basu S, Vallakkal S, Agrawal S et al (2014) Averting obesity and type 2 diabetes in India through sugar-sweetened beverage taxation: an economic-epidemiologic modeling study. PLoS Medicine. 11, 1, e1001582.

Bettany-Saltikov J (2012) How to do a Systematic Literature Review in Nursing: A Step-by-Step Guide. Open University Press, Maidenhead.

▶ Brook DW, Rubenstone E, Zhang C et al (2011) Environmental stressors, low well-being, smoking, and alcohol use among South African adolescents. Social Science & Medicine. 72, 9, 1447-1453.

▶ Collins MM, O'Sullivan T, Harkins V et al (2009) Quality of life and quality of care in patients with diabetes experiencing different models of care. Diabetes Care. 32, 4, 603-605.

▶ Deci EL, Ryan RM (2008) Hedonia, Eudaimonia, and well-being: an introduction. Journal of Happiness Studies. 9, 1, 1-11.

Diabetes UK (2011) Diabetes in the UK 2011/2013: Key Statistics on Diabetes. www.diabetes.org.uk/documents/reports/diabetes-in-the-uk-2011-12.pdf (Last accessed: 7 March 2017.)

Diabetes UK (2017) Alcohol-drinking and Diabetes. www.diabetes.org.uk/Guide-to-diabetes/Enjoy-food/what-to-drink-with-diabetes/Alcohol-and-diabetes/ (Last accessed: 13 March 2017.)

Department of Health (2008) Safe. Sensible. Social. The Government's Alcohol Strategy. webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Healthimprovement/Alcoholmisuse/DH_085386 (Last accessed: 7 March 2017.)

Drinkaware (2016) Alcohol and Diabetes. www.drinkaware.co.uk/alcohol-facts/health-effects-of-alcohol/diseases/alcohol-and-diabetes/ (Last accessed: 13 March 2017)

▶ Dutton H, Rowan MS, Liddy C et al (2014) Patient perspectives on discharge from specialist type 2 diabetes care back to primary care: a qualitative study. Canadian Journal of Diabetes. 38, 3, 191-197.

European Observatory on Health Systems and Policies Series (2008) Caring for people with chronic conditions. www.euro.who.int/data/assets/pdf_file/0006/96468/E91878.pdf. (Last accessed: 13 March 2017.)

▶ Finfgeld-Connett D (2010) Generalizability and transferability of meta-synthesis research findings. Journal of Advanced Nursing. 66, 2, 246-254.

▶ Ginter E, Simko V (2012) Global prevalence and future of diabetes mellitus. Advances in Experimental Medicine and Biology. 771, 35-41.

▶ Gorter JK, Tuytel GJ, de Leeuw RR et al (2011) Opinions of patients with type 2 diabetes about responsibility, setting targets and willingness to take medication: a cross-sectional survey. Patient Education and Counseling. 84, 1, 56-61.

Grado MEV-C (2013) Does smoking and alcohol abuse precipitate and aggravate the risk of metabolic syndrome? Journal of Metabolic Syndrome. 3, 2, 141.

Handley J, Pullon S, Gifford H (2010) Living with type 2 diabetes: 'putting the person in the pilots' seat'. Australian Journal of Advanced Nursing. 27, 3, 12-19.

▶ Hawker S, Payne S, Kerr C et al (2002) Appraising the evidence: reviewing disparate data systematically. Qualitative Health Research. 12, 9, 1284-1299.

▶ Hex N, Bartlett C, Wright D et al (2012) Estimating the current and future costs of type 1 and type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs. Diabetic Medicine. 29, 7, 855-862.

▶ Hicks D (2010) Self-management skills for people with type 2 diabetes. Nursing Standard. 25, 6, 48-56.

▶ Home PD, Pocock SJ, Beck-Nielsen H et al (2009) Rosiglitazone evaluated for cardiovascular outcomes in oral agent combination therapy for type 2 diabetes (RECORD): a multicentre, randomised, open-label trial. Lancet. 373, 9681, 2125-2135.

International Diabetes Federation (2015) IDF Diabetes Atlas. Seventh edition. Brussels, Belgium.

▶ Inzucchi SE, Bergenstal RM, Buse JB et al (2015) Management of hyperglycemia in type 2 diabetes, 2015: a patient-centered approach – update to a position statement of the American Diabetes Association and the European Association for the Study of Diabetes. Diabetes Care. 38, 1, 140-149.

▶ Jansink R, Braspenning J, van der Weijden T et al (2010) Primary care nurses struggle with lifestyle counseling in diabetes care: a qualitative analysis. BMC Family Practice. 11, 41.

▶ Johansson K, Ekebergh M, Dahlberg K (2009) A lifeworld phenomenological study of the experience of falling ill with diabetes. International Journal of Nursing Studies. 46, 2, 197-203.

▶ Kahneman D, Deaton A (2010) High income improves evaluation of life but not emotional well-being. Proceedings of the National Academy of Sciences of the United States of America. 107, 38, 16489-16493.

▶ Kalda R, Rätsep A, Lember M (2008) Predictors of quality of life of patients with type 2 diabetes. Patient Preference and Adherence. 2, 21-26.

▶ Kneck A, Klang B, Fagerberg I (2012) Learning to live with diabetes – integrating an illness or objectifying a disease. Journal of Advanced Nursing. 68, 11, 2486-2495.

▶ Lamers F, Jonkers CC, Bosma H et al (2010) Training depression in diabetes patients: does a nurse-administered minimal psychological intervention affect diabetes-specific quality of life and glycaemic control? A randomized controlled trial. Journal of Advanced Nursing. 67, 4, 788-799.

▶ Long H (2011) Diagnostic gestational diabetes: can expert opinions replace scientific evidence? Diabetologia. 54, 9, 2211-2213.

Manderson L, Kokanovic R (2009) 'Worried all the time': distress and the circumstances of everyday life among immigrant Australians with type 2 diabetes. Chronic Illness. 5, 1, 21-32.

Mason BJ, Light JM, Williams LD et al (2009) Proof-of-concept human laboratory study for protracted abstinence in alcohol dependence: effects of gabapentin. Addiction Biology. 14, 1, 73-83.

Moher D, Liberati A, Tetzlaff J et al (2009) Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. Annals of Internal Medicine. 151, 4, 264-269.

Nakar S, Yitzhaki G, Rosenberg R et al (2007) Transition to insulin in Type 2 diabetes: family physicians' misconception of patients' fears contributes to existing barriers. Journal of Diabetes and its Complications. 21, 4, 220-226.

Nash M (2014) Mental health service users' experiences of diabetes care by mental health nurses: an exploratory study. Journal of Psychiatric and Mental Health Nursing. 21, 8, 715-723.

National Institute for Health and Clinical Excellence (2009) Type 2 Diabetes: The Management of Type 2 Diabetes. NICE, London.

NHS (2012) Statistics on Alcohol: England, 2012. www.hscic.gov.uk/catalogue/PUB06166/alco-eng-2012-rep.pdf (Last accessed: 7 March 2017.)

NHS (2013) Alcohol Misuse. www.nhs.uk/conditions/alcohol-misuse/pages/introduction.aspx (Last accessed: 7 March 2017.)

NHS (2015) Alcohol Misuse. www.nhs.uk/conditions/alcohol-misuse/Pages/Introduction.aspx . (Last accessed: 13 March 2017.)

Office for National Statistics (2017) Alcohol-related deaths in the UK: registered in 2015: Deaths caused by diseases known to be related to alcohol consumption, such as cirrhosis of the liver. www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2015 (Last accessed: 12 March 2017)

Paulweber B, Valensi P, Lindström J et al (2010) A European evidence-based guideline for the prevention of type 2 diabetes. Hormone and Metabolic research. 42, 1, 3-36.

Rehm J, Shield KD (2014) Alcohol and mortality: global alcohol-attributable deaths from cancer, liver cirrhosis, and injury in 2010. Alcohol Research: Current Reviews. 35, 2, 174-183.

Schiøtz ML, Bøgelund M, Almdal T et al (2012) Social support and self-management behaviour among patients with type 2 diabetes. Diabetic Medicine. 29, 5, 654-661.

Schram MT, Baan CA, Pouwer F (2009) Depression of quality of life in patients with diabetes: a systematic review from the European depression in diabetes (EDID) research consortium. Current Diabetes Reviews. 5, 2, 112-119.

Schulman-Green D, Jaser S, Martin F et al (2012) Processes of self-management in chronic illness. Journal of Nursing Scholarship. 44, 2, 136-144.

Shield KD, Parry C, Rehm J et al (2014) Chronic diseases and conditions related to alcohol use. Alcohol Research: Current Reviews. 35, 2, 155-173.

Siddiqui FJ, Avan BI, Mahmud S et al (2015) Uncontrolled diabetes mellitus: prevalence and risk factors among people with type 2 diabetes mellitus in an urban district of Karachi, Pakistan. Diabetes Research and Clinical Practice. 107, 1, 148-156.

Tang TS, Brown MB, Funnel MM et al (2008) Social support, quality of life, and self-care behaviors among African Americans with type 2 diabetes. The Diabetes Educator. 34, 2, 266-276.

Thomas J, Harden A (2008) Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Medical Research Methodology. 8, 45.

Turner K (2008) People's educational needs following a diagnosis of diabetes. Journal of Diabetes Nursing. 12, 4, 136-143.

Tyndall J (2008) How low can you go? Toward a hierarchy of grey literature. Dreaming08: Australian Library and Information Association Biennial Conference, Alice Springs NT, September 2-5.

Vassilev I, Rogers A, Sanders C (2011) Social networks, social capital and chronic illness self-management: a realist review. Chronic Illness. 7, 1, 60-86.

White P, Smith SM, Hevery D et al (2009) Understanding type 2 diabetes: including the family member's perspective. The Diabetes Educator. 35, 5, 810- 817.

Williamson L (2012) Destigmatizing alcohol dependence: the requirement for an ethical (not only medical) remedy. American Journal of Public Health. 102, 5, e5-e8.

World Health Organization (2016) Global Report on Diabetes. www.who.int/diabetes/global-report/en/ (Last accessed: 7 March 2017.)

Wu SF, Huang YC, Liang SY et al (2011) Relationships among depression, anxiety, self-care behaviour and diabetes education difficulties in patients with type-2 diabetes: a cross-sectional questionnaire survey. International Journal of Nursing Studies. 48, 11, 1376-1383.

APPENDIX II

Conference Presentations (*oral & poster presentations*)

1. Humanising Care, Health and Wellbeing Conference, University of Bournemouth, Bournemouth, UK, 21 June 2018 "Exploring the lifeworld experiences, lifestyle changes, and well-being, of individuals with type 2 diabetes who consume alcohol". (Oral Presentation)
2. The RCN international nursing research conference 2016, Edinburgh International Conference Centre, “Exploring type 2 diabetes, alcohol use and lifestyle modifications: a systematic literature review”. (Poster)
3. Healthcare PGR Conference 2015, University of Leeds, Leeds, UK, 21 October 2015 “Exploring the experiences and the well-being of individuals diagnosed with type 2 diabetes and use alcohol”. (Oral presentation)
4. Faculty of Medicine and Health Conference, University of Leeds, Leeds, UK, 23 June 2014 “Exploring patients’ and health care professionals’ perception concerning health needs of individuals with type 2 diabetes, substance abuse and depression”. (Poster)
5. Healthcare PGR Conference, University of Leeds, Leeds, UK, 24 October 2014 “Exploring the life-world approaches of individuals with diabetes type 2 who engage in alcohol over-consumption in the North of England”. (Poster)

Number 1

Humanising Care, Health and Wellbeing Conference, University of Bournemouth, Bournemouth, UK, 21 June 2018 "Exploring the lifeworld experiences, lifestyle changes, and well-being, of individuals with type 2 diabetes who consume alcohol". (Oral Presentation)

Humanising Care, Health and Wellbeing
Bournemouth University

3rd floor, Executive Business Centre, 89 Holdenhurst Road, BH8 8EB
21st-22nd June 2018

Programme DAY 1

9.30	**Registration**	
9.50	Dr Caroline Ellis-Hill	Welcome
10.00	Dr Sophie Mackenzie	Mosaics, ambiguity and quest: constructing stories of spirituality with people with expressive aphasia
10.20	Dr Sara White & Dr Desi Tait	Critical Care Nursing – a humanised approach
10.40	Dr Sally Lee	Humanisation theory in social work education
11.00	Julie Galbally and Sarah Paterson	The Worm and the Woodpecker: Our life experiences of developing a relationship centred approach in stroke care.
11.20	**Coffee**	
11.50	Professor Ann Hemingway	The Mechanism of Action of an Equine Assisted Intervention: A Pilot Study
12.10	Hanne Morkenborg Bové , Dr Marianne Lisby, Dr Annelise Norlyk,	Scheduled care – as a way of caring. A phenomenological study of being cared for when suffering from alcohol use disorders.
12.30	Marta Paglioni, Dr. Katherine Curtis, ' Dr. Jonny Branney & Janine Valentine	A mixed methods investigation into the impact of ICCI (Intentional Compassionate Communication Interventions) for older people in A&E
12.50	Dr Mel Hughes	Humanising social work practice. Reflections on writing a book with service users and carers. A Guide to Statutory Social Work Interventions: The lived experience.

1.10	**Lunch**	
2.10	Dr Michele Board, Dr Laura Phillips; Rebecca Mitchell &and Prof. Jane Murphy	Seeing the Person not the Diagnosis – a humanised approach to dementia care through simulation-based education
2.30	Dr Jim Cowan	Realising potential through support and consciousness
2.50	Dr Jan Mojsa	Dignity and 'Other' - ethical and spiritual issues. Humanisation musings from the chaplaincy bedside
3.10	Tea	
3.30	Christine Mantzouka	Exploring the lifeworld experiences, lifestyle changes, and well-being, of individuals with type 2 diabetes who consume alcohol
3.50	Karen Cooper, Lucy Stainer, Sharon Waight, Dr Sara White	Academic Advisor (personal tutor) role modelling a humanising approach: how & why?
4.10	Dr Michelle Heward, Dr Michele Board, Ashley Spriggs, Dina Blagden and Prof Jane Murphy	'Walking in someone else's shoes': humanising dementia care through simulated learning.
4.30	**Feedback, thanks and close – Day 1**	

Number 2

The RCN international nursing research conference 2016, Edinburgh International Conference Centre, “Exploring type 2 diabetes, alcohol use and lifestyle modifications: a systematic literature review”. (Poster)

The RCN international nursing research conference 2016, Edinburgh International Conference Centre, “Exploring type 2 diabetes, alcohol use and lifestyle modifications: a systematic literature review” (Poster)

RCN International Nursing Research Conference and Exhibition 2016
Wednesday 6 – Friday 8 April 2016
Edinburgh International Conference Centre, Edinburgh

Royal College of Nursing

Programme at a glance

Wednesday 6 April 2016

08.00 - 10.00 *Strathblane Hall* — **Registration, refreshments, exhibition and poster judging/ viewing**

10.00 - 10.05 *Pentland Auditorium* — **Chair’s welcome and introduction to the conference**
Professor Daniel Kelly, RCN Professor of Nursing Research, Cardiff University, United Kingdom

10.05 - 10.20 *Pentland Auditorium* — **Welcome to Edinburgh**
Theresa Fyffe, Director, RCN Scotland, United Kingdom
Dr Sheila Rodgers, Senior Lecturer, University of Edinburgh, United Kingdom

10.20 - 11.00 *Pentland Auditorium* — **Keynote | Nursing at the extremes: navigating the emotions of care**
Professor Pam Smith, Professorial Fellow in Nursing Studies, the School of Health in Social Science, University of Edinburgh, United Kingdom

11.00 - 11.30 *Strathblane Hall* — **Refreshments, exhibition viewing, poster judging/viewing**

11.30 – 12.55 Concurrent session 1

	11.30 - 11.55		**12.00 - 12.25**		**12.30 - 12.55**
1.1 Action research Room: Fintry (level 3) Chair: Ruth Northway	1.1.1 Abstract number 142 **Working Together: action research with service users to improve person-centred care** *Dr Juliet MacArthur, NHS Lothian, United Kingdom*	**5 minutes transitional break**	1.1.2 Abstract number 199 **In search of improved pressure injury risk assessment for patients admitted to hospital: evaluation of a clinical-judgement-based tool** *Professor Lin Perry, University of Technology Sydney, Australia*	**5 minutes transitional break**	1.1.3 Abstract number 400 **Shared Outcomes in Neurorehabilitation - supporting person centred care and multi-disciplinary working - the Neurorehabilitation Outcomes Management System (NROMS).** *Dr Carina Hibberd, Stirling University, United Kingdom*

Page 1

Programme version 11

	Poster number 34 **The development of the Chinese Health Improvement Profile (CHIP) for improving the physical health of people diagnosed with severe mental illness** (Abstract number 6) *Dr Daniel Bressington, The Hong Kong Polytechnic University, Hong Kong*
Poster tour H **Public health** Leaving registration at: 13.30 Led by: *Dr Julie McGarry, University of Nottingham, United Kingdom*	Poster number 35 **The impacts of a health education programme on primary school teacher's knowledge and attitudes towards Type 1 Diabetes Mellitus in children in Saudi Arabia** (Abstract number 266) *Buthaina Aljehany, University of Salford, United Kingdom*
	Poster number 36 **Healthy Conversation Skills: an intervention to improve the nursing workforce's skills in supporting behaviour change** (Abstract number 334) *Julia Hammond, University of Southampton, United Kingdom*
	Poster number 37 **Binaural beat technology: Can it really affect cardiovascular stress response?** (Abstract number 378) *Lieutenant Colonel Melisa Gantt, Landstuhl Regional Medical Center, Germany*
	Poster number 38 **Exploring type 2 diabetes, alcohol use and lifestyle modifications: a systematic literature review** (Abstract number 323) *Christine Mantzouka, United Kingdom*
	Poster number 39 **An integrated literature review to explore the factors which facilitate and impede the implementation and reach of lay health worker programmes aimed at promoting influenza vaccination** (Abstract number 324) *Dr Sherrill Snelgrove, Swansea University, United Kingdom*
Poster tour J Primary and community care Leaving registration at: 13.30 Led by: *Professor Austyn Snowden, Edinburgh Napier University, United Kingdom*	Poster number 40 **How community nurses perceive the use of health plans in the communication of health needs of children and young people with learning disabilities** (Abstract number 244) *Lucy Riggs, United Kingdom*
	Poster number 41 **Promotion of oral health in elderly residential care: a review of the literature** (Abstract 457) *Brendan Garry, Guy`s and St Thomas' NHS Foundation Trust, United Kingdom*
	Poster number 43 **How prepared are informal carers of patients with advanced COPD and what are their support needs?** (Abstract number 364) *Dr Morag Farquhar, University of Cambridge, United Kingdom*
	Poster number 44 **Can we enable patients to express support needs in advanced non-malignant disease? Testing a prototype tool for use within a new support needs approach for patients** (Abstract number 370) *Dr Morag Farquhar, University of Cambridge, United Kingdom*

Number 3

Healthcare PGR Conference 2015, University of Leeds, Leeds, UK, 21 October 2015 “Exploring the experiences and the well-being of individuals diagnosed with type 2 diabetes and use alcohol”. (Oral presentation)

Healthcare PGR Conference 2015, University of Leeds, Leeds, UK, 21 October 2015 “Exploring the experiences and the well-being of individuals diagnosed with type 2 diabetes and use alcohol”. (Oral presentation)

School of Healthcare
FACULTY OF MEDICINE AND HEALTH

UNIVERSITY OF LEEDS

POSTGRADUATE
RESEARCH STUDENT CONFERENCE

Programme

Theme Research Impact

Abstracts and Posters

Wednesday 21st October 2015

DRIVING POSITIVE CHANGE

School of Healthcare

Postgraduate Research Student Conference

Theme: Research Impact

Wednesday 21st October 2015

Conference venue (Presentations): Baines Wing – Room 2.10
Posters – Baines Wing 3.20

9.45 – 10:15	Tea/coffee and poster viewing (Baines Wing room 3.20)	
10:15 – 10.20	Welcome and introduction	Professor Andrea Nelson (Head of School)
10.20 – 10:55	Opening presentation	Professor John Baker, Chair Mental Health Nursing, School of Healthcare
10:55 – 11:20	Presentation 1	Anadari Astuti
11:20 – 11:45	Presentation 2	Amy Hunter
11.45 – 12:10	Presentation 3	Marianne Hvistendahl-Allday
12:10 – 13:10	Lunch and poster viewing (Baines Wing room 3.20)	
13:10 – 13:35	Presentation 4	Christine Mantzouka
13:35 – 14:00	Presentation 5	Charlotte Scott
14:00 – 14:25	Presentation 6	Su Wood
14:25 – 15:15	Tea/coffee and poster viewing (Baines Wing room 3.20)	
15:15 – 15:40	Closing presentation	Dr Veronica Swallow, Associate Professor, School of Healthcare
15:40 – 16:00	Prize giving, closing remarks and thanks	Dr Paul Marshall

Number 4

Faculty of Medicine and Health Conference, University of Leeds, Leeds, UK, 23 June 2014 “Exploring patients’ and health care professionals’ perception concerning health needs of individuals with type 2 diabetes, substance abuse and depression”. (Poster)

Faculty of Medicine and Health Conference, University of Leeds, Leeds, UK, 23 June 2014 “Exploring patients’ and health care professionals’ perception with regard to health needs of individuals with type 2 diabetes, substance abuse and depression” (Poster)

Exploring patients’ and health care professionals’ perceptions with regards to health needs of individuals with type II diabetes, substance abuse and depression

What is already known?

The literature shows negative health outcomes not only between depression and diabetes type II, but also, between substance abuse and diabetes type II. Depression most often remain unnoticed and undetected by health care providers because: a) the fear of interdisciplinary team to label those who suffer from mental condition, b) the lack of time by health care professionals, c) the lack of health care providers’ knowledge on depression, d) the fact that patients emphasize on somatic symptoms and e) the lack of explicit documentation and sharing of patients’ record between health care providers (Cepoiu 2007; Smith et al., 2013).

The beginning...

According to the literature there is a multi-directional relationship between diabetes type II, substance abuse and depression (Willi et al., 2007; Nidecker et al., 2008; Shram et al., 2009).Evidence suggesting that some patients with type II diabetes ended up becoming substance abusers (Nidecher et al., 2008). Also, substance abusers diagnosed with diabetes often relapse to their previous substance abuse habits (DiClemente et al., 2008). Moreover, depression in type II diabetes can lead to substance use or to continue substance use (Mezuk et al., 2009; DiClemente et al., 2008). Hence, it is important for the interdisciplinary team to recognise the link between depression and substance abuse, and how this linkage affects their well being.

Why is this study important?

The current study is important because it will fill a gap in the literature and will inform the provision of care for diabetes type II, substance abusers that diagnosed also for depression.

What is the aim?

The aim of the study is to explore patients’ and health care professionals’ perceptions with regards to health care needs of individuals with type II diabetes and substance abuse.

How to achieve the aim?

- By identifying the health needs of type II diabetes, substance abuse and depression indivtiduals.
- By exploring the perceptions of patients with regards to their health needs, care provision and care management.
- By exploring the perceptions of health care professionals and how confident and informed they feel meeting these health needs.

How will I do it?

The methodology for the current study will be qualitative interpretive phenomenology and a purposeful sampling technique will be used. The sample will include

a) n=20 diabetic type II individuals who are substance abusers and

b) n=20 of health care professionals caring diabetes type II patients.

The data collecting method will include digitally recorded semi-structured interviews with each participant and if required follow up semi structured interviews will also be conducted.

The data analysis will include thematic content analysis.

The end...

The current evidences seem to neglect the linkage between diabetes type II, substance abuse and depression and appear to care for each condition separately rather than caring for this in unison. Furthermore, substance abusers and depressive individuals are usually stigmatised and marginalised and therefore provided with sub optimal care for their diabetic situation.

Finally, the aim of the current study is to understand the health needs of these individuals.

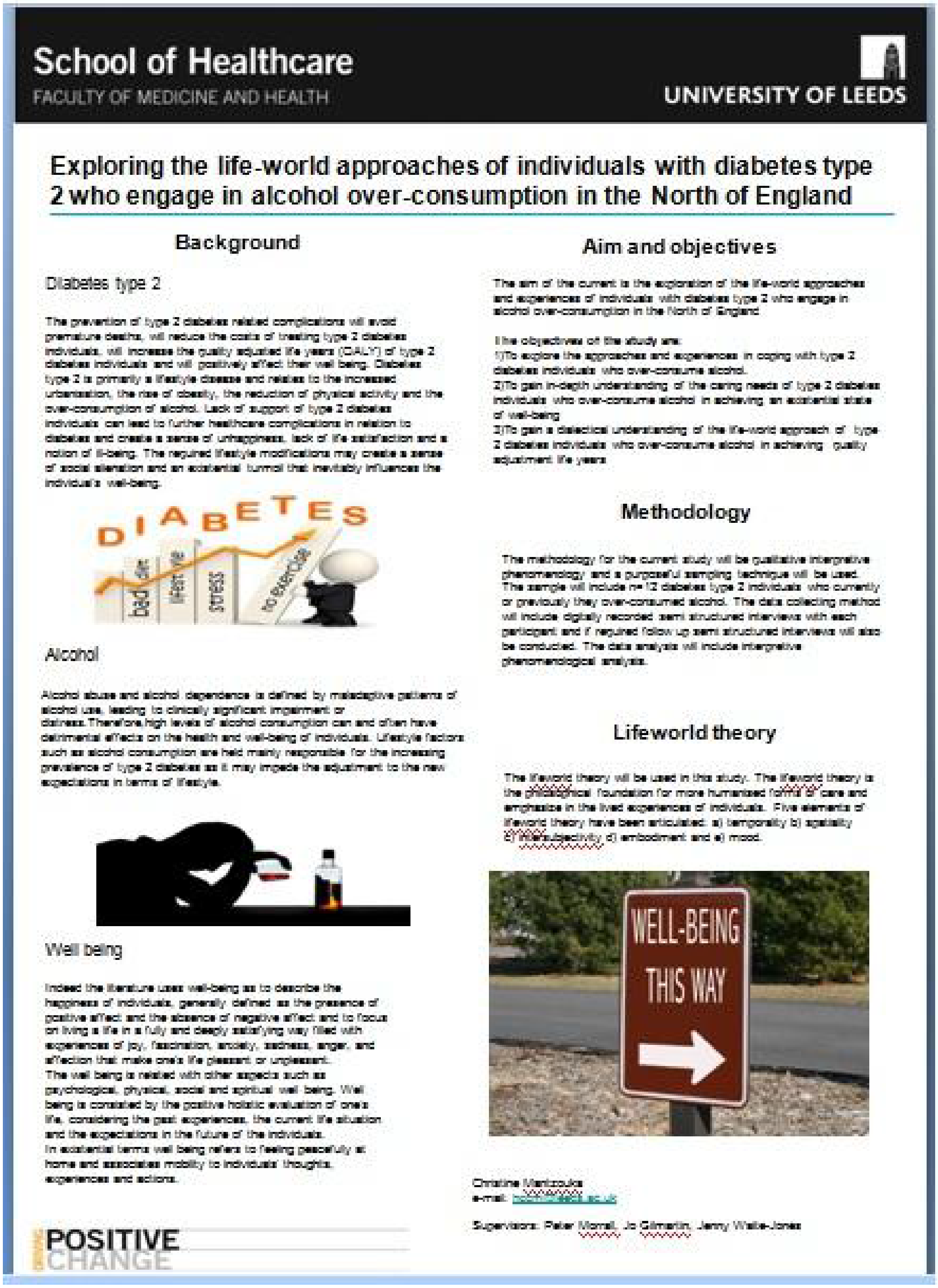
Reference List

Christine Mantzouka | hccm@leeds.ac.uk
UNIVERSITY OF LEEDS
Supervisors: Peter Morrall, Jo Gilmartin & Jenny Waite-Jones

<u>Number 5</u>

Healthcare PGR Conference, University of Leeds, Leeds, UK, 24 October 2014
“Exploring the life-world approaches of individuals with diabetes type 2 who engage in alcohol over-consumption in the North of England”. (Poster)

Healthcare PGR Conference, University of Leeds, Leeds, UK, 24 October 2014
“Exploring the life-world approaches of individuals with diabetes type 2 who engage in alcohol over-consumption in the North of England” (Poster)



School of Healthcare
FACULTY OF MEDICINE AND HEALTH

UNIVERSITY OF LEEDS

Exploring the life-world approaches of individuals with diabetes type 2 who engage in alcohol over-consumption in the North of England

Background

Diabetes type 2

The prevention of type 2 diabetes related complications will avoid premature deaths, will reduce the costs of treating type 2 diabetes individuals, will increase the quality adjusted life years (QALY) of type 2 diabetes individuals and will positively affect their well being. Diabetes type 2 is primarily a lifestyle disease and relates to the increased urbanisation, the rise of obesity, the reduction of physical activity and the over-consumption of alcohol. Lack of support of type 2 diabetes individuals can lead to further healthcare complications in relation to diabetes and create a sense of unhappiness, lack of life satisfaction and a notion of ill-being. The required lifestyle modifications may create a sense of social alienation and an existential turmoil that inevitably influences the individual's well-being.

Alcohol

Alcohol abuse and alcohol dependence is defined by maladaptive patterns of alcohol use, leading to clinically significant impairment or distress.Therefore,high levels of alcohol consumption can and often have detrimental effects on the health and well-being of individuals. Lifestyle factors such as alcohol consumption are held mainly responsible for the increasing prevalence of type 2 diabetes as it may impede the adjustment to the new expectations in terms of lifestyle.

Well being

Indeed the literature uses well-being as to describe the happiness of individuals, generally defined as the presence of positive affect and the absence of negative affect and to focus on living a life in a fully and deeply satisfying way filled with experiences of joy, fascination, anxiety, sadness, anger, and affection that make one's life pleasant or unpleasant.
The well being is related with other aspects such as psychological, physical, social and spiritual well being. Well being is consisted by the positive holistic evaluation of one's life, considering the past experiences, the current life situation and the expectations in the future of the individuals.
In existential terms well being refers to feeling peacefully at home and associates mobility to individuals' thoughts, experiences and actions.

POSITIVE
CHANGE

Aim and objectives

The aim of the current is the exploration of the life-world approaches and experiences of individuals with diabetes type 2 who engage in alcohol over-consumption in the North of England

The objectives of the study are:
1)To explore the approaches and experiences in coping with type 2 diabetes individuals who over-consume alcohol.
2)To gain in-depth understanding of the caring needs of type 2 diabetes individuals who over-consume alcohol in achieving an existential state of well-being
3)To gain a dialectical understanding of the life-world approach of type 2 diabetes individuals who over-consume alcohol in achieving quality adjustment life years

Methodology

The methodology for the current study will be qualitative interpretive phenomenology and a purposeful sampling technique will be used. The sample will include n= 12 diabetes type 2 individuals who currently or previously they over-consumed alcohol. The data collecting method will include digitally recorded semi structured interviews with each participant and if required follow up semi structured interviews will also be conducted. The data analysis will include interpretive phenomenological analysis.

Lifeworld theory

The lifeworld theory will be used in this study. The lifeworld theory is the philosophical foundation for more humanised forms of care and emphasise in the lived experiences of individuals. Five elements of lifeworld theory have been articulated: a) temporality b) spatiality c) intersubjectivity d) embodiment and e) mood.

Christine Mantzouka
e-mail: [illegible]

Supervisors: Peter Morrall, Jo Gilmartin, Jenny Wallis-Jones

APPENDIX III

Table of full text articles assessed using Hawker's appraisal framework - chapter 2

APPENDIX III

Hawker's appraisal framework - initial search

Articles	Abstract	Introduction and aims	Method and data	Sampling	Data analysis	Ethics and bias	Results	Transferability or generalisability	Implications and usefulness	Total score
Baliunas et al., 2009	Good (4)	Fair (3)	Good (4)	Good (4)	Fair (3)	Fair (3)	Good (4)	Poor (2)	Fair (3)	30
Wu et al., 2011	Good (4)	Good (4)	Good (4)	Good (4)	Good (4)	Good (4)	Good (4)	Good (4)	Fair (3)	35
Yalcin et al., 2008	Good (4)	Good (4)	Good (4)	Good (4)	Fair (3)	Poor (2)	Fair (3)	Good (4)	Fair (3)	31
Gorter et al., 2011	Good (4)	Good (4)	Good (4)	Fair (3)	Fair (3)	Poor (2)	Fair (3)	Good (4)	Good (4)	31
Breton et al., 2013	Poor (2)	Good (4)	Good (4)	Good (4)	Fair (3)	Fair (3)	Fair (3)	Fair (3)	Fair (3)	29
Kneck et al., 2012	Good (4)	Good (4)	Good (4)	Good (4)	Fair (3)	Good (4)	Good (4)	Good (4)	Good (4)	35
Kalda et al., 2008	Good (4)	Fair (3)	Good (4)	Good (4)	Fair (3)	Fair (3)	Fair (3)	Good (4)	Fair (3)	31
Manderson and Kokanovic, 2009	Fair (3)	Good (4)	Good (4)	Good (4)	Good (4)	Fair (3)	Good (4)	Fair (3)	Fair (3)	32
Johansson et al., 2009	Good (4)	Good (4)	Fair (3)	Good (4)	Good (4)	Fair (3)	Good (4)	Fair (3)	Fair (3)	32
Ahlin and Billhult, 2012	Good (4)	Good (4)	Good (4)	Good (4)	Fair (3)	Fair (3)	Fair (3)	Fair (3)	Fair (3)	31
Handley et al., 2010	Good (4)	Good (4)	Good (4)	Good (4)	Poor (2)	Fair (3)	Good (4)	Good (4)	Fair (3)	32
Grado, 2013	Good (4)	Good (4)	Fair (3)	Fair (3)	Good (4)	Poor (2)	Good (4)	Fair (3)	Fair (3)	30
Malpass et al., 2009	Good (4)	Good (4)	Good (4)	Good (4)	Fair (3)	Fair (3)	Fair (3)	Good (4)	Fair (3)	32
Jansink et al., 2010	Good (4)	Fair (3)	Fair (3)	Fair (3)	Good (4)	Fair (3)	Good (4)	Fair (3)	Fair (3)	30
Collins et al., 2009	Good (4)	Fair (3)	Fair (3)	Fair (3)	Fair (3)	Fair (3)	Good (4)	Fair (3)	Fair (3)	29

Gorter et al., 2011	Good (4)	Good (4)	Fair (3)	Fair(3)	Fair (3)	Fair (3)	Good (4)	Fair (3)	Fair (3)	30
Turner, 2008	Fair (3)	Good (4)	Good (4)	Good (4)	Good (4)	Fair (3)	Good (4)	Fair (3)	Fair (3)	32
Dutton et al., 2013	Good (4)	Good (4)	Good (4)	Good (4)	Fair (3)	Fair (3)	Fair (3)	Good (4)	Fair (3)	32
Schulman- Green et al., 2012	Good (4)	Good (4)	Good (4)	Good (4)	Fair (3)	Fair (3)	Good (4)	Good (4)	Good (4)	34
Lamers et al., 2010	Good (4)	Good (4)	Good (4)	Good (4)	Good (4)	Fair (3)	Good (4)	Fair (3)	Good (4)	34
Vassilev et al., 2011	Good (4)	Good (4)	Good (4)	Good (4)	Fair (3)	Fair (3)	Fair (3)	Fair (3)	Fair (3)	31
White et al., 2009	Good (4)	Good (4)	Good (4)	Good (4)	Poor (2)	Fair (3)	Good (4)	Fair (3)	Fair (3)	31
Shiotz et al., 2011	Good (4)	Fair (3)	Good (4)	Good (4)	Good (4)	Poor (2)	Good (4)	Good (4)	Fair (3)	32
Nash et al., 2014	Good (4)	Fair (3)	Good (4)	Good (4)	Fair (3)	Fair (3)	Good (4)	Fair (3)	Fair (3)	31

Hawker’s appraisal framework - follow-up search

Articles	Abstract	Introduction and aims	Method and data	Sampling	Data analysis	Ethics and bias	Results	Transferability or generalisability	Implications and usefulness	Total score
Boehm et al., 2015	Good (4)	Good (4)	Good (4)	Fair (3)	Fair (3)	Fair (3)	Fair(3)	Poor (2)	Fair (3)	29
Johansson et al., 2016	Good (4)	Good (4)	Good (4)	Good (4)	Good (4)	Good(4)	Good (4)	Poor (2)	Poor (2)	32
Benavides et al., 2017	Good (4)	Good (4)	Good (4)	Fair(3)	Fair (3)	Poor (2)	Good (4)	Poor (2)	Poor (2)	28

APPENDIX IV

Table of full text articles assessed using Tyndall’s checklist - chapter 2

APPENDIX IV

Tyndall's checklist for appraising the grey literature

Articles	**Authority**	**Accuracy**	**Coverage**	**Objectivity**	**Date**	**Significance**
Shield et al., 2014	The authors are qualified (PhD, MSc and work in Centre for Addiction and Mental Health; University of Toronto)	Credible sources and documents, present similar results as studies in this similar field	Limitations were clearly presented	It is balanced and includes opinions of experts	Up to date literature and includes important material	It strengthen a current position, it is meaningful and representative
Saucedo, 2013	The author is qualified (MD, MPH, PhD c), presented by the World Health Organisation	Credible sources and documents, summarize similar results as studies in similar field	Presentation of limitations	It is balanced, published in WHO organisation and includes opinions of experts	Up to date literature including important literature	It is meaningful, and enriches to the current research
Katon, 2008	The author is qualified (MD Department of Psychiatry and Behavioral Sciences, University of Washington)	Credible sources and documents, concludes similar results and clearly states methodology	Clear presentation of limitations	It is balanced, published in American Journal of Medicine and includes opinions of experts	Up to date literature and important materials are included	It is meaningful and strengthen a current position
Min et al. , 2010	The author are qualified (Alice Lee Centre for Nursing Studies, Yong Loo Lin School of Medicine, National University of Singapore: A Collaborating Centre of the Joanna Briggs Institute)	Credible sources and documents, concludes similar result to similar studies and clear statement of methodology	No clear presentation of the limitations of the article	It is balanced and include opinions of experts in the field	Up to date literature and inclusion of important material	It is meaningful and enriches to the current research
Hicks, 2010	The author is qualified Nurse consultant in diabetes, in Enfield Community Services, London	Credible sources and documents and similar results to similar studies	No clear presentation of the limitations of the paper	It is balanced, published in Nursing Standards and includes opinions of experts	Up to date literature that includes important material	It is meaningful and enriches to the current research

APPENDIX V

Initial Interview Schedule (prior the piloting)

APPENDIX V

INTERVIEW SCHEDULE

i. Introduce myself
ii. Build rapport (allow the participant and the researcher to connect and feel comfortable)

ACTION QUESTIONS

1) Tell me about your experiences with type 2 diabetes?
    a) Can you tell me how you deal with type 2 diabetes?
    b) How have you fitted type 2 diabetes condition with your daily life routine?
    c) What is this routine for you? – Could you please give me an example?
2) What were you required to do as to deal with type 2 diabetes
    a) How would you describe the support received in dealing with type 2 diabetes
3) What would say has changed in your lifestyle after the diagnosis with type 2 diabetes? – Give me an example.
4) How has type 2 diabetes affected the levels of alcohol intake for you? – Give me an example.

    a) Can you tell me if you feel that modifying your alcohol patterns affected your social life? And in what ways
5) What kinds of support and resources have been most helpful to you in managing lifestyle modifications?
6) How is the relationship between you and the health professionals developed since the diagnosis and onwards?
7) How is your relationship with colleagues, friends, family, and neighbours?

KNOWLEDGE QUESTIONS

1) What do you know about type 2 diabetes and alcohol use?

   a) *Can you expand (prompting)*
   b) *How many units or glasses of alcohol did you drink per day and how many do you drink now (prompting)*
2) In what ways do you think your life has been affected by the diagnosis of type 2 diabetes
3) What do you think of the healthcare support you received in managing lifestyle changes for:
   a) type 2 diabetes
   b)moderate alcohol?
4) What challenges have you experienced with the changes with regards to lifestyle? / What do you think are the possible solutions to these challenges?

PERSONAL PHILOSOPHY QUESTIONS

1) Do you think that type 2 diabetes has changed you as a person
   a) *If yes, in what ways (prompting question)/ example*
2) To what degree (extent) do you feel that you have come to terms with the lifestyle changes required from type 2 diabetes
3) How do you feel with your current lifestyle
4) What are your plans for the future? How do you believe that lifestyle changes will affect these plans?
   - Anything else you would like to add
   - Thank the participant for the time and the sharing of information and experiences.

APPENDIX VI

Participant Information Sheet

APPENDIX VI

UNIVERSITY OF LEEDS

Faculty of Medicine and Health
School of Healthcare

Christine Mantzouka
PhD student
Baines Wing,
School of Healthcare,
University of Leeds,
Leeds, LS2 9UT
1th June 2015

Participant Information Sheet

Exploring the experiences and the well-being of people diagnosed with type 2 diabetes and who have or do use alcohol (not matter in what quantity).

You are invited to take part in the above named study but before you decide. The following information to help you decide whether or not you will be willing to participate in this research:

What is the purpose of this study?

The purpose of the study is to explore the experiences of people who have been diagnosed with type 2 diabetes and used or still use alcohol.

The aims of the study are to explore:

(1) the experiences of the treatment and support individuals who have been diagnosed with type 2 diabetes received from health care professionals

(2) how people live with diabetes and the challenges in adapting any lifestyle changes relating to potential alcohol use.

Who is doing the study?

The study will be undertaken by Ms. Christine Mantzouka as part of fulfilling her PhD degree requirements at the School of Healthcare, University of Leeds. The researcher will be supervised by Dr. Peter Morrall, Dr. Jo Gilmartin and Dr. Jenny Waite-Jones from the School of Healthcare, University of Leeds.

Why have I been asked to participate?

You have been invited to participate in this study because you are considered to have relevant knowledge and experiences as you have been diagnosed with type 2 diabetes for over six (6) months and asked to quit or moderate alcohol consumption.

What will be involved if I take part in this study?

If you choose to participate in the study, you will be invited to a single interview which will last approximately 60 minutes and will be audio-recorded. The interview will take place at a time convenient to you at the diabetes support group venue (or alternative suitable venue in the University of Leeds).

What are the possible advantages and disadvantages of taking part?

You will be asked questions about your experiences with regards type 2 diabetes and lifestyle changes in relation to alcohol consumption.

There is no direct benefit to you for taking part in this study, other than providing an opportunity to share your views and insights on the topic and providing insights that will assist health care professionals in determining the potential changes that might be needed in supporting lifestyle changes among people with type 2 diabetes.

Do I have to take part?

Your participation in this study is totally voluntary and it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.

Can I withdraw from the study at any time?

You are free to withdraw from the study without having to give a reason for withdrawing and with any consequences to you for your withdrawal. Even after the completion of the interview the participants can request up to 2 weeks post the interview to withdraw part or all data collected. Furthermore, you will have an opportunity to discuss the study with the researcher who will provide you with the opportunity to ask any questions and queries after you have read the information sheet.

Will the information obtained in the study be confidential?

All information obtained from you will be kept strictly confidential and stored according to the data protection act. Your name will be removed from all interview transcriptions, which means only the researcher will know what you have said. The audio recording will be done using a digital device that has password protection and the password will be known only by the researcher (Christine Mantzouka) and supervisors. If requested you will have access to the interview data for the purpose of verification of transcription and analysis. The digitalised record of your interview will be deleted after transcription and the transcript held in a password protected secure network of the University of Leeds for a period of five years, after which, it will be deleted from the device on which it is stored. You will remain anonymous and only the researcher or the representative will know your personal information. You have the right to withdraw from the study up to two weeks after the interview. Furthermore, you will retain the right to withdraw from the study at any point during the interview without any consequences and you can also withdraw parts or all of the data you have provided during the interview for up to two weeks after the completion of the interview. Finally, your name will be removed from all the gathered information as to maintain anonymity in all cases.

What will happen to the results of the study?

Your responses and that of other participants will be analysed. Some quotes will be used from all participants' responses to illustrate the views of participants. However, these quotes will not be associated with your name but the researcher will use pseudonymous that will assure your confidentiality. The results of this study will be part of researcher's PhD thesis and will also be published in relevant scientific journals and be presented at conferences.

Who has reviewed this study?

Ethical approval has been granted by the School of Healthcare Research Ethics Committee *(state project reference number and date).*

If you at any point during this study become uncomfortable with any aspect of it, feel free to let me know and the interview will be terminated. Also, it is important to remember that you will not have to answer any question you do not want to. Also, in the rare case you may require support following the interview please contact community diabetes service (Shaftesbury House, 480 Harehills Lane, Leeds LS9 6NG Tel: 0113 843 4200, Monday to Friday 8.30am to 4.30pm).

If you agree to take part, would like more information or have any questions or concerns about the study please contact
Ms. Christine Mantzouka
PhD Student,
School of Healthcare, Baines Wing, University of Leeds,
LS2 9UT, Leeds, UK.
Tel: 07543 380468 or email: hccm@leeds.ac.uk

Dr. Peter Morrall
Lecturer,
School of Healthcare, Baines Wing, University of Leeds,
LS2 9UT, Leeds, UK.
Tel: 0113 3431184 or email: p.a.morrall@leeds.ac.uk

Dr. Jo Gilmartin
Nursing Lecturer,
School of Healthcare, Baines Wing, University of Leeds,
LS2 9UT, Leeds, UK.
Tel: 0113 3431254 or email: j.gilmartin@leeds.ac.uk

Dr. Jenny Waite-Jones
Psychology Lecturer,
School of Healthcare, Baines Wing, University of Leeds,
LS2 9UT, Leeds, UK.
Tel: 0113 3431255 or email: j.m.waite-jones@leeds.ac.uk

Finally, if you agree to participate, please sign the attached informed consent form. A copy will remain with you.

Thank you for taking the time to read this information sheet.

APPENDIX VII

Information Poster

UNIVERSITY OF LEEDS

Have you been diagnosed with type 2 diabetes at least 6 months ago?

Have you or do you use alcohol (no matter in what quantity)?

Do you want your opinions about type 2 diabetes and alcohol use to be heard?

Do you want to help us improve care?

Take part in our research study. It provides an opportunity to talk and share experiences and you'll be helping to present insights about type 2 diabetes experience and improve care and health policy!

Contact: Ms. Christine Mantzouka
PhD Student,
School of Healthcare, Baines Wing, University of Leeds,
LS2 9UT, Leeds, UK.
Tel: 07543 380468 or email: hccm@leeds.ac.uk

APPENDIX VIII

Modified Interview Schedule

Interview Guide	Study Objectives Addressed
ACTION QUESTIONS 1) Tell me about your experiences with type 2 diabetes? a) Can you tell me how you deal with type 2 diabetes? b) How have you fitted type 2 diabetes condition with your daily life routine? c) What is this routine for you? – Could you please give me an example?	Study objective 2 and 3 addressed
2) What were you required to do to deal with type 2 diabetes a) How would you describe the support received in dealing with type 2 diabetes	Study objective 1 and 3 addressed
3) What would say has changed in your lifestyle after the diagnosis with type 2 diabetes? – Give me an example.	Study objective 2 and 4 addressed
4) How has type 2 diabetes affected the levels of alcohol intake for you? – Give me an example. a) Can you tell me if you feel that modifying your alcohol patterns affected your social life? And in what ways	Study objective 1, 4 and 5 addressed
5) What kinds of support and resources have been most helpful to you in managing lifestyle modifications?	Study objective 4 and 5 addressed
6) How is the relationship between you and the health professionals developed since the diagnosis and onwards?	Study objective 2 and 3 addressed
7) How is your relationship with colleagues, friends, family, and neighbours?	Study objective 2 and 5 addressed
KNOWLEDGE QUESTIONS 1) What do you know about type 2 diabetes and alcohol use? *a) Can you expand (prompting)* *b) How many units or glasses of alcohol did you drink per day and how many do you drink now (prompting)*	Study objective 1 and 2 addressed
2) What kinds of support and resources have been most helpful to you in managing lifestyle modifications?	Study objective 3, 4 and 5 addressed
3) What do you think of the healthcare support you received in managing lifestyle changes for: a) type 2 diabetes b)moderate alcohol?	Study objective 3 and 5 addressed
4) What challenges have you experienced with the changes with regards to the lifestyle? / What do you think are the possible solutions to these challenges?	Study objective 4
PERSONAL PHILOSOPHY QUESTIONS 1) Do you think that type 2 diabetes has changed you as a person *a) If yes, in what ways (prompting question)/ example*	Study objective 2 and 4
2) To what degree (extent) do you feel that you have come to terms with the lifestyle changes required from type 2 diabetes	Study objective 4 and 5
3) How do you feel with your current lifestyle	Study objective 2 and 4
4) What are your plans for the future? How do you believe that lifestyle changes will affect these plans? • Anything else you would like to add	Study objective 4 and 5

APPENDIX IX

Confirmation that Supervisors reviewed the data analysis and discussion sections

Number 1

Confirmation letter from my main Supervisors Dr Peter Morrall that he has reviewed and provided feedback/ comments on the analysis of the findings section and the writing of the discussion section, and that the researcher responded to these feedback/ comments.

UNIVERSITY OF LEEDS

Healthcare Studies
University of Leeds

17th July 2020

To whom it may concern,

I can confirm that within my capacity of PhD supervisor for Ms Christine Mantzouka during her PhD studies at the University of Leeds, that I have provided extensive reviews, and provided oral and written feedback on the analysis of her data and on the discussion of her findings for the study entitled "*Exploring the lifeworld experiences, lifestyle changes, and well-being of individuals with type 2 diabetes who consume alcohol*".

I can also confirm that Ms Christine Mantzouka acted upon the provided review and feedback, and constructively used it to finalise the analysis and writing of the study's findings.

[redacted]

Dr Peter [redacted]

[redacted]

Number 2

Email exchanges confirming supervisors reviews and provided feedback/ comments on the analysis of the findings section and the writing of the discussion section, and the researcher's responses to these feedback/ comments.

Re: First 4 analysis !

Peter [redacted]

Thu 03/11/2016 10:57

To: Christine Mantzouka <hccm@leeds.ac.uk>; Jo [redacted]

Thank you Christine. We can talk about this today when we meet but at first glance the coding looks promising [redacted] Peter

Dr Peter [redacted]

Number 3

Email exchanges confirming supervisors reviews and provided feedback/ comments on the analysis of the findings section and the writing of the discussion section, and the researcher's responses to these feedback/ comments.

Re: Feedback Analysis3

From: Jo [redacted]
Sent: 01 February 2018 11:40:53
To: Christine Mantzouka
Cc: Peter [redacted]
Subject: Feedback Analysis3

Hi Christtne, T [redacted]

Points to consider;

1. [redacted]
4. You still avow personality changes & I think you have very weak evidence to support such an inference (see feedback comments attached).
5. [redacted]
6. Some of the quotes are very good & others are weak & do not fit with the characteristics avowed in the aforementioned text.
7. [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted], Jo

[redacted]

APPENDIX X

Two coded transcripts (*Interviewee B and Interviewee C*)

Number 1

Coded transcript from interviewee B

KEY:

Interview B= InB, Line 1= L1, Codes 1= C1

Researcher= R

Study participant= SP

Text	**Coding I** **1st cycle coding**	**Coding 2** **2nd cycle coding** *What is this about?* *What does it mean?* *What is happening?* *What are the assumptions?* *(make abstract-touch test)*
R: Tell me about your experiences with Type 2 Diabetes. SP: Well I was supposed to inject (name of drug) once a day and take a B12 pill and a statin and...what's the other one...(name of drug) I think. I'm trying to diet down. Diet so I can get rid of this weight. So at the moment I'm just trying to find another job. As regards Diabetes I'm just trying to get as much exercise as I can and get rid of this weight, I've let it slip. I got diagnosed 10 years ago, 9th May 2006. I got my weight right down to 16 stone but it's crept back, so I've got to creep it off again.	1) Well I was supposed to inject (name of drug) once a day and take a B12 pill and a statin and...what's the other one 2) I'm trying to diet down. Diet so I can get rid of this weight. 3) I'm just trying to get as much exercise as I can and get rid of this weight 4) I got my weight right down to 16 stone but it's crept back, so I've got to creep it off again.	1+2+3+4 = lifestyle changes in type2 diabetes are difficult and require continuous effort (InBL1C1)
R: So what were you required to do to deal with Type 2 Diabetes? SP: The initial input was lose this weight and take the pills but initially I had got a lot of issues with the drugs to start with. My key area now is to get rid of this weight which has crept back again. You could do with something better than I've been doing because it's come back again and in 2006 I got it right down to 16 stone. The thing was I didn't feel very well, I was cold all the time and I think that's a lot to do with the drugs I was taking back then. So basically that's...and I used to inject a drug called	1) The initial input was lose this weight and take the pills 2) I had got a lot of issues with the drugs to start with 3) My key area now is to get rid of this weight which has crept back again... it's come back again and in 2006 I got it right down to 16 stone.	1+2+3+4+5+6 = Type 2 diabetes has significant impact in the way people live and feel (InBL2C1)

(name of the drug) and taking these three pills and trying to get my weight down and trying to do as much exercise as I can. It's exercise and diet are the key ones with this one.	4) The thing was I didn't feel very well, I was cold all the time and I think that's a lot to do with the drugs I was taking back then. 5) I used to inject a drug called (name of the drug) and taking these three pills and trying to get my weight down and trying to do as much exercise as I can 6) It's exercise and diet are the key ones with this one.	
R: Do you have any support? SP: I went and saw the nurse at...when I went to the thing and saw the nurse...the trouble...the issue of having the nurse thing is effectively you come out with a healthy plate with a little bit of like a pie chart of the different stuff you've got to eat. Have you seen the healthy plate? And you get told...when you see the nurse it's a bit vague and general and so in general you get an idea of what you should be eating and what you shouldn't be eating and so instead of 3 pork chops you have one pork chop and you cut the rind off and all the rest of it. Then if you compare it with what's in the media and what's coming out from a number of sources it's sometimes difficult to be clear what is the best way because fats and saturated fats have had a very bad press until recently and recently with....they've honed it more on trans-fats, certain kinds of fats. Years of going in one direction seem to be changing, appear to be changing, Dieticians appear to be changing direction a little bit. When I first got diagnosed I went on that expert course in 2006 where you saw the nurse, one or two nurses, to give me...the expert course, and there was a lot of dietary stuff involved in that but on Monday night, I think you'd gone by then, a Dietician came and she was going on about everything being up in the air and they've been told about four new diets and digging their heels in and not clear of the evidence and all this kind of thing. So I think the actual dietary things...there's an awful lot of stuff about your guts and your internal bacteria that seems to be in the media as well at the moment so....I'm really off the point here. The only person I've seen is this nurse recently and they just	1) the issue of having the nurse thing is effectively you come out with a healthy plate with a little bit of like a pie chart of the different stuff you've got to eat... The only person I've seen is this nurse recently and they just come out with the healthy plate and don't have too many calories and balance it with what's on the healthy plate and don't....keep off biscuits, chocolate and ice cream and cakes. 2) I haven't had one fizzy drink since 2006 but that's one thing I've been fantastic at, I've cut out all fizzy drinks. And well alcohol...a pint of lager is worse than a mars bar. 3) And you get told... 4) when you see the nurse it's a bit vague and general and so in general you get an idea of what you should be eating and what you shouldn't be eating 5) Then if you compare it with what's in the media and what's coming out from a number of sources it's sometimes difficult to be clear	1= Lack of follow up education and support from nurses (InBL3C1) 2= Understanding the detrimental of alcohol consumption (InBL3C2) 3+4= Lack of empowerment and clarity of type 2 diabetes individuals from health education (InBL3C3) 5= Mass media provide mixed messages in order to support consumption rather healthy lifestyles (InBL3C4) 6+7=Initial education is not sufficient to support people in undertaking lifestyle changes (InBL3C5)

come out with the healthy plate and don't have too many calories and balance it with what's on the healthy plate and don't....keep off biscuits, chocolate and ice cream and cakes. I haven't had one fizzy drink since 2006 but that's one thing I've been fantastic at, I've cut out all fizzy drinks. And well alcohol...a pint of lager is worse than a mars bar.	what is the best way because fats and saturated fats have had a very bad press until recently 6) Years of going in one direction seem to be changing, appear to be changing, Dieticians appear to be changing direction a little bit 7) When I first got diagnosed I went on that expert course...and there was a lot of dietary stuff involved in... a Dietician came and she was going on about everything being up in the air and they've been told about four new diets and digging their heels in and not clear of the evidence and all this kind of thing. So I think the actual dietary things...there's an awful lot of stuff...	
R: How much would you say you drink alcohol, how much maybe per day, per week? SP: Two or three pints every two or three days something like that. No doubt it will be too much shortly when they reduce the limit to nothing.	1) Two or three pints every two or three days something like that 2) No doubt it will be too much shortly when they reduce the limit to nothing.	1+2= Alcohol use remains part of lifestyle of type 2 diabetes (InBL4C1)
R: Has this changed since you've been diagnosed with Type 2 Diabetes? SP: Before I got diagnosed I drunk more. Then when I got diagnosed it went right down to next to virtually nothing. I think that helped. That got rid of the weight. Since I've been out of work it's crept up a bit, being out of work. You're so cheesed off being out of work, being out of work doesn't help. It helps in one way that you can get exercise rather than sat at a desk all day so it's fantastic for that but 8 hours sat at a desk is no good for you. On the other hand it's stressful relaxing sometimes thinking when I am going to find a job.	1) Before I got diagnosed I drunk more 2) Then when I got diagnosed it went right down to next to virtually nothing. I think that helped. 3) That got rid of the weight 4) Since I've been out of work it's crept up a bit, being out of work. You're so cheesed off being out of work, being out of work doesn't help. 5) It helps in one way that you can get exercise rather than sat at a desk all day so	1+2+3+4+5= Concurrent personal or professional issues affects the control of alcohol use (InBL5C1)

	it's fantastic for that but 8 hours sat at a desk is no good for you. On the other hand it's stressful relaxing sometimes thinking when I am going to find a job.	
R: How has the diagnosis with Type 2 Diabetes affected or changed at all your relationships with other SP: It doesn't make much difference I don't think. I drink a lot less now than I used to drink before I got diagnosed but I think it's still a bit too much. It's crept up again with the weight that's partly, not the whole thing.	1) It doesn't make much difference I don't think. I drink a lot less now than I used to drink before I got diagnosed but I think it's still a bit too much. 2) It's crept up again with the weight that's partly, not the whole thing.	1+2= Inability to self-regulate alcohol consumption (InBL6C1)
R: What kind of support do you think you would need in order to change your life-style SP: One thing is when I was up in the Midlands I tried joining Weight Watchers. There was about 50 women and 3 blokes so you felt totally swamped by millions and millions of...so if you go it's not very balanced. And so every week you'd pay £5 and they weigh you and if it's good... and they've got this general scheme on how to lose weight. From one week to the next I went down 7lbs and I thought crickey that's fantastic so I made another appointment and she said keep a food diary and you think if there's some nifty way of keeping a food diary that didn't involve.....if you could bar code everything you flipping ate into some gadget...you're right you keep a food diary for a bit but after a bit you thought it's a bit more laborious trying to remember every single thing you've had but....the resource you'd have...a free version of Weight Watchers where you all turn up and get weighed or say what you've eaten or...I think food if you got a daily food pack or something and that daily food pack had all you could eat...is everything in this food pack....this food pack had got 1900 calories in it and you think fantastic, the trouble is you wouldn't be able to go out and have a drink.	1) I tried joining Weight Watchers. There was about 50 women and 3 blokes so you felt totally swamped by millions and millions of...so if you go it's not very balanced. 2) And so every week you'd pay £5 and they weigh you and if it's good... and they've got this general scheme on how to lose weight. 3) From one week to the next I went down 7lbs and I thought crickey that's fantastic so I made another appointment and she said keep a food diary 4) if you could bar code everything you flipping ate into some gadget...you're right you keep a food diary for a bit but after a bit you thought it's a bit more laborious trying to remember every single thing you've had but 5) a free version of Weight Watchers where you all turn up and get weighed or say what you've eaten or...I think food if you got a daily food pack or something and that daily food pack had all you could eat...is everything in	1= Support groups need to be well thought and balanced in order to be successful (InBL7C1) 2= The financial cost of seeking support can become a deterrent in lifestyle changes (InBL7C2) 3+4= Daily routine erodes efforts for change (InBL7C3) 5= Crying out for help (InBL7C4)

	this food pack....this food pack had got 1900 calories in it and you think fantastic, the trouble is you wouldn't be able to go out and have a drink.	
R: How is the relationship between you and the Health Care developed since the diagnosis? SP: It's changed a bit. Before I got diagnosed you think doctors....but when I got diagnosed I was a bit unusual that I'd moved so the first the doctor saw of me was the day of this diagnosis so the first thing he gives you is a thing saying...so you fill the form in and get free prescriptions and then you get the NHS booklet which crushes all hope. You read that and you think right life's over. It's that bad is that little NHS booklet. I was reading the booklet thinking I think I'll become a monk and just give up. You feel that bad reading the NHS...I don't know if you've ever seen the NHS booklet? And you think this is awful, this is it, life's over. You really think...and the doctor said...because I had all these drugs (named the drugs) and he said you'll have to take these drugs for the rest of your life because you can't control this with diet and so I ended up having a very rough time with the drugs a rough time with (name), the second week I was diagnosed I was in Crete and he changed the (name of drug) another one and I didn't start taking it and I thought it was going to finish me off so I went to the local medical aid thing and he put me on a heart monitor and I said I think it's this drug I've just started taking. And you read the insurance thing and you find out you can't change your medication without telling them before and you think oh god is this drug finishing me off I won't be insured. But the doctor said well try taking half of one each day and he sent me to the hospital because my foot was going numb. So I went to this hospital, that was a grim experience because you read the NHS booklet about amputations, blindness, kidney disease all the horrors you can get from it and in one of the wards there was this woman laying on a bed with the sheet going flat off the end of her legs. That woman in that bed has got no feet. Oh god, it was a grim experience because they x-rayed my foot when we came back to the UK and....because I had trouble with these drugs in 2006 and I thought at one point these	1) first the doctor saw of me was the day of this diagnosis so the first thing he gives you is a thing saying...so you fill the form in and get free prescriptions and then you get the NHS booklet which crushes all hope. You read that and you think right life's over...I was reading the booklet thinking I think I'll become a monk and just give up. You feel that bad reading the NHS... And you think this is awful, this is it, life's over... he said you'll have to take these drugs for the rest of your life because you can't control this with diet and so I ended up having a very rough time with the drugs a rough time... this booklet from the NHS which destroys all hope 2) that was a grim experience because you read the NHS booklet about amputations, blindness, kidney disease all the horrors you can get from it and in one of the wards there was this woman laying on a bed with the sheet going flat off the end of her legs 3) because I had trouble with these drugs in 2006 and I thought at one point these drugs are just going to finish me off, so I was not getting anywhere with the doctor 4) they give you an anti-depressant drug and you feel the anti-depressant knocking you	1= Unfriendly reading material can crash hope and make the future unliveable (InBL8C1) 2=Shock of diagnosis (InBL8C2) 4+5+8= The medical profession tries to solve unsuccessfully type 2 diabetes with medication (InBL8C3) 3+5= The organisational structure of care for type 2 diabetes individuals is doctor centered and insufficient for lifestyle changes (InBL8C4) 6= The dominant culture is to blame the individual for now following the rules in order to change rather than the organisational structure (InBL8C5) 7= Taking responsibility for change leads to hope for better future (InBL8C6)

drugs are just going to finish me off, so I was not getting anywhere with the doctor, they give you an anti-depressant drug and you feel the anti-depressant knocking you out, but you think it's just one drug to knock out to make you unaware of what the other drugs are doing! I remember he gave me these (name of drug) and said you won't notice any affect with these for two weeks with these drugs and I noticed an affect with the first pill and so during that time ultimately I rang the Samaritans and NHS Direct and all the rest of it and everybody sits on their hands, no one will tell you anything, all they'll say is go and see your doctor. So all routes lead to your doctor, and your doctor is just saying oh well you'll get used to these pills. First of all they say it'll take a week, you come back after a week oh it'll take a month, you come back in a month oh it might take a few months, so after about three months I thought if I don't do something I feel as though these drugs are going to...and so I thought....I tried stopping taking it once and the day after I felt even worse and I thought this must be the withdrawal so I started taking it but I think what I'm going to do is I'm just going to stop taking it and get passed this withdrawal; so I stopped and it got really bad for a day or two but by the third day I started feeling a lot better again and I was monitoring my blood sugar level and I thought if it goes up I'll have to do something but it didn't go up and so I got diagnosed in May with this condition and by September I thought I had a doctor's appointment and I hadn't taken this drug for a week, I was on (name of drug) and I thought the doctor is going to kill me but I thought I don't care I'm going to tell him what I think. So I went to the doctor and said I'm not taking this drug, you know just the one thing is absolutely against the rules is to stop taking the medication and I hadn't taken it for a week so I went to see the doctor and said oh well don't take it for a month and see how you feel. And so I didn't take it for a month and for the following January about 4 months after taking...stopping all this my blood sugar levels were back down into the top of the normal range and you thought this is the doctor who said I'd have to take drugs for the rest of my life to control this and it's also the same doctor who just sat on his hands when I was about to jump off a building because I felt that bad and so at that point I started being a bit sceptical of doctors and nurses and another thing....when I say this booklet crushed all hope, one thing after I read that I started looking myself, going on the internet and looking, finding out what you can then finding out what books there are. And I remember finding one book I think it was a Harvard Medical	out, but you think it's just one drug to knock out to make you unaware of what the other drugs are doing! 5) ...ultimately I rang the Samaritans and NHS Direct and all the rest of it and everybody sits on their hands, no one will tell you anything, all they'll say is go and see your doctor. So all routes lead to your doctor, and your doctor is just saying oh well you'll get used to these pills. 6) I went to the doctor and said I'm not taking this drug, you know just the one thing is absolutely against the rules is to stop taking the medication 7) ...when I say this booklet crushed all hope, one thing after I read that I started looking myself, going on the internet and looking, finding out what you can then finding out what books there are... basically trying to find out information on what Type 2 Diabetes is all about and there's a bit in there saying that some in cases Diabetes can disappear. I thought a ray of hope! So I thought the way forward is to find out as much as you can yourself about this because doctors don't much care, or know 8) ...they've got their routine they're going to hit you with drugs because that's the cheapest for NICE and if the drugs really upset you ...then try an anti-depressant if you're still getting a bit anxious.	

book...basically trying to find out information on what Type 2 Diabetes is all about and there's a bit in there saying that some in cases Diabetes can disappear. I thought a ray of hope! That was a ray of hope after reading all this stuff...you know this booklet from the NHS which destroys all hope. So I thought the way forward is to find out as much as you can yourself about this because doctors don't much care, or know, they've got their routine they're going to hit you with drugs because that's the cheapest for NICE and if the drugs really upset you ...then try an anti-depressant if you're still getting a bit anxious. I think doctors are in general quite knowledgeable but some of them are not that clued up on things and a lot of them aren't bang up to date either. There's an awful lot of rubbish on the internet and an awful lot of pointers and things going on which...you know because one thing I got prescribed was a B12 pill which is...which can be a side-effect which can carry on if you stop taking the drugs. So this B12 pills, the last 10 years I've been taking B12 pills and the number of doctors on the way saying what are you taking B12 pills for and I'll say because he prescribed them, because he's a different doctor and he says oh right, do they do anything these pills and you're like well your colleague prescribed them!		
R: So do you prefer to change your GPs and your nurses or do you prefer to have one GP and one nurse and work with them? SP: Well at the moment it used to be rigmarole. You used to see a different doctor and a different nurse each time, just a turnover of doctors. I think....you could see one doctor if you really had a good relationship, when I first got diagnosed there was one doctor for about...right until I moved, for about 18 months and yeah I got on alright with him, that was quite good yeah because I think he was dedicated to the Diabetic lot. We built up a bit of a relationship. It's better to build up a relationship with a doctor if he's a good doctor yeah. And the nurse.	1) You used to see a different doctor and a different nurse each time, just a turnover of doctors 2) . I think....you could see one doctor if you really had a good relationship, when I first got diagnosed there was one doctor for about...right until I moved... and yeah I got on alright with him, that was quite good yeah because I think he was dedicated to the Diabetic lot. We built up a bit of a relationship. It's better to build up a relationship with a doctor if he's a good doctor yeah...	1+2= Continuity of care is beneficial for dealing with the needs of type 2 diabetes (InBL9C1)
R: How is your relationship with colleagues, friends, family, neighbours?	1) Yes I told them about it yeah 2) a few of them decided to become the food	1+2= Losing individuality and being identified by the type 2

SP: Yes I told them about it yeah. So I remember when I first....a few of them decided to become the food police for me so people were handing out biscuits in the office they were saying you can't have any biscuits. So a lot of people decided they'd take...they'd help me with my dieting so if they saw me eating anything they'd tell me off, or if they were handing something out like cakes I wouldn't get a piece of cake but after...I did lose touch with one friend and I always wondered if it was turning to Diabetes or not, I don't know. I'm not sure is some people actually thinking well it's his own fault he's been overweight for so long he's got his rewards. I don't think it should effect any of it at the moment I don't think.	police for me so people were handing out biscuits in the office they were saying you can't have any biscuits. So a lot of people decided they'd take...they'd help me with my dieting so if they saw me eating anything they'd tell me off, or if they were handing something out like cakes I wouldn't get a piece of cake but after 3) I did lose touch with one friend and I always wondered if it was turning to Diabetes or not, I don't know 4) I'm not sure if some people actually thinking well it's his own fault he's been overweight for so long he's got his rewards.	diabetes condition (InBL10C1) 3= Type 2 diabetes lifestyle changes affect social relationships (InBL10C2) 4= The prevailing of blame culture for individuals with type 2 diabetes (InBL10C3)
R: What do you know about Type 2 Diabetes and alcohol use? SP: The latest things I've heard...alcohol...when you take a drink of alcohol it hits the liver so the liver gets a little bit preoccupied with detoxifying the alcohol out of your system so...passed that we can get....you take a drink and you can take a bit of a dip in your blood sugar levels but they shoot up again. If your liver's getting a bit...	1) latest things I've heard...alcohol...when you take a drink of alcohol it hits the liver so the liver gets a little bit preoccupied with detoxifying the alcohol out of your system so... you take a drink and you can take a bit of a dip in your blood sugar levels but they shoot up again	1= Uninformed about the correlation of type 2 diabetes and alcohol (InBL11C1)
R: So how do you know about this? SP: Personal search. They said don't take a drink because your blood sugar will shoot up and you read in the books and it can just go down initially. And it goes down because your liver is otherwise occupied because part of Type 2 is your liver brining too much glucose to the party and whilst it's busy detoxifying the alcohol initially after that it goes up but you can notice it go down a bit. So I tried it because you're finger pricking, when you take a drink you can see it going down a little bit. Not 10 pints of it!	1) Personal search 2) They said don't take a drink because your blood sugar will shoot up and you read in the books and it can just go down initially	1+2= Vagueness with regard the effects of alcohol consumption and type 2 diabetes (InBL12C1)
R: Has anyone supported you in changing your life-style especially in moderating alcohol? Does anyone help you control alcohol, or managing alcohol?	1) No one’s helped.	1= Lack of professional support for lifestyle changes (InBL13C1)

SP: No one’s helped.		
R: Did they ask you, the nurses I mean? SP: They said you want to get it down a bit	1) They said you want to get it down a bit	1= Healthcare support system does not emphasise on the correlation between alcohol consumption and type 2 diabetes (InBL14C1)
R: Was it written on your healthy plate? SP: It's not on the healthy plate, no. I'm surprised they don't actually sell...have you seen the healthy plate? A plastic plate with...there's no alcohol reference on there is there. I don't know if there's any more ways to research on alcohol or the liver or the rest of your system, I'm not sure if there’s any new research on alcohol, I'm not clued up enough about it. Champagne is now coming out as quite a good thing to drink.	1) It's not on the healthy plate, no 2) I'm surprised they don't actually sell... A plastic plate with...there's no alcohol reference on there is there 3) I'm not clued up enough about it	1+2+3= Alcohol consumption is not part of the dietary consultation provided in people with type 2 diabetes (InBL15C1)
R: What challenges have you experienced with the changes with regard to life-style? SP: The challenging things were back in 2006. The challenging things were don't drink 5 pints a night anymore. So from about 5 pints a night to 2 or 3 halves. So 2006 I found difficult. Difficult keeping off Kit Kats, chocolate and cakes and all this...keeping off all those killer things and that's where I've...so I think I was good to start with and then I've slipped a little bit off the bandwagon but my diet is a lot better than it was before then. There's just still too many calories.	1) The challenging things were back in 2006. The challenging things were don't drink 5 pints a night anymore. So from about 5 pints a night to 2 or 3 halves. So 2006 I found difficult... keeping off Kit Kats, chocolate and cakes... keeping off all those killer things 2) then I've slipped a little bit off the bandwagon but my diet is a lot better than it was before then. There's just still too many calories.	1= The great difficulty in modifying lifestyle alone (InBL16C1) 2= Continuous support in order to maintain lifestyle changes is required as to avoid slippage back to old habits (InBL16C2)
R: Do you think being diagnosed with Type 2 Diabetes has changed you as a person? SP: I think it changed me in 2006 because before when I was at work I was quite sleepy and quite...when you lose a lot of weight you become more alert and alive but I think that's what I'm thinking now if I can get rid of this I'll be more alert and alive again. What else has it changed? I think in 2006 I went a bit crazy but I think it was the drugs but my view it was the drugs, in the doctor's view it was just anxious but	1) I think it changed me in 2006 because before when I was at work I was quite sleepy and quite...when you lose a lot of weight you become more alert and alive but I think that's what I'm thinking now if I can get rid of this I'll be more alert and alive again 2) in 2006 I went a bit crazy but I think it was	1= Trying to persuade oneself of the positive aspects of lifestyle changes (InBL17C1) 2+3= Medication are not a silver bullet for solving type 2 diabetes problems but can create new problems (InBL17C2)

my...like I said I told you you could be on this anti-depressant thinking well all a doctor can do is make an expert guess at what's going on inside me either it isn't these drugs...my view of myself from the field and what I feel like on the inside it does feel to be this drug because at some point you sort of felt so detached from yourself and you try coming off this drug and it gets even worse for a day and then you take it again and it's bad again but not quite as bad as ...but if you push yourself passed that, pass the couple of days and then third day you start feeling like your old self again and I thought I know what it's like to feel anxious and miserable and fed up and stressed but that was something else, it was a detached feeling, it was a detached feeling that felt like a different...but the doctor didn't particularly believe it. He eventually disappeared the doctor to get to that point because the doctor just, either didn't know or didn't care whether it was that or not...because that Summer I think I must have been the 'most wanted' poster up in surgery because I went back every 5 minutes saying I don't like this (name of drug) and the (name of drug) so I'd been through a whole basket full of drugs, they don't like me, Mr Side Effect after a bit.	the drugs but my view it was the drugs, in the doctor's view it was just anxious 3) my view of myself from the field and what I feel like on the inside it does feel to be this drug because at some point you sort of felt so detached from yourself and you try coming off this drug and it gets even worse for a day and then you take it again and it's bad again but not quite as bad as... I know what it's like to feel anxious and miserable and fed up and stressed but that was something else, it was a detached feeling, it was a detached feeling that felt like a different...but the doctor didn't particularly believe it. 4) He eventually disappeared... either didn't know or didn't care whether it was that or not...because that Summer I think I must have been the 'most wanted' poster up in surgery because I went back every 5 minutes saying I don't like this... so I'd been through a whole basket full of drugs, they don't like me, Mr Side Effect after a bit.	4= Health professionals' labelling of uncooperative individuals with type 2 diabetes affects adaptation to the condition (InBL17C3)
R: To what degree or extent do you feel you have come to terms with the life-style changes required from Type 2 Diabetes? SP: I think I did do but I lapsed and I need to come to terms with them again. I need to come to terms with them again. It would be good to have a camp on an island off the top of Scotland where there's no....you get ten tokens for the week and a token will buy you half a pint of weak beer and there's no sweet shops so there's no temptations at all and there's a whole load of you because I think if you build up a head of steam then you get through it and you get there then you have to try and stay on the wagon and I have to be honest I was....slipped off...but...	1) I think I did do but I lapsed and I need to come to terms with them again. I need to come to terms with them again 2) It would be good to have a camp on an island off the top of Scotland where there's no....you get ten tokens for the week and a token will buy you half a pint of weak beer and there's no sweet shops so there's no temptations at all and there's a whole load of you because I think if you build up a head of	1+2= The temptations as expressed in current consumerism society impede healthy lifestyles and changes for individuals with type 2 diabetes (InBL18C1)

	steam then you get through it and you get there then you have to try and stay on the wagon and I have to be honest I was....slipped off...	
R: How do you feel about your life-style at the moment? Are you happy with the life-style that you're following? SP: Not much no. I'm in limbo at the moment until I find another job. I'm cheesed off not having work.	1) Not much no. I'm in limbo at the moment until I find another job. I'm cheesed off not having work.	1= Successful lifestyle changes require personal satisfaction and gratification (InBL19C1)
R: Are you having any financial support? SP: When I left the other company in 2009/10 I had the option of kicking off the pension and all that was it pushed me out you know so I couldn't sign up for anything. So I was living like that for three and a half years it was a joke and now I've topped it up again and I'm back out so I can't sign on I'm afraid at the moment. I'm alright for this year but it's not ideal. It's only renting this crappy little room. I've got to do something. There's a financial doom lurking but not this week but there so lodging in this scrappy little room somewhere so just spending the day trawling the job opportunities and things. I actually went for a thing on Tuesday but didn't get it, I've put my name on a film extras website and they were recruiting and I was quite optimistic on the Tuesday. Over at Kirkstall they're recruiting for something...what was it called...I think it's called National Treasure they're filming and they wanted a stand in for Robbie Coltrane...that's a sure sign that I'm over weight, he's not exactly...you must...because he's Scottish isn't he. But I didn't get it because they wanted somebody who'd got stand-in experience...when they're filming and somebody stands in in-between them rehearsing that filming. But I didn't get it. they were filming next week with Julie Walters, Robbie Coltrane and Julie Walters running around Leeds next week.	1) When I left the other company... all that was it pushed me out you know so I couldn't sign up for anything... I'm alright for this year but it's not ideal... It's only renting this crappy little room. I've got to do something	1= Successful lifestyle changes require personal satisfaction and gratification (InBL20C1)

R: What are your plans for the future? What do you aim to do? SP: Plans for the future. Well an on-going wrestle to get rid of this weight and find some kind of work or employment or thing to do to reverse the money so I can live and also to get out of...I wouldn't dream...to move somewhere coastal....somewhere with a fabulous outdoor lido; Ilkley has an outdoor lido in the Summer and it's not heated. The Summer for three months it's fantastic because you go in there and I get quite a bit fitter and thinner when I get in there because it's unheated, it's quite cold so I wouldn't dream of moving somewhere coastal like Cornwall and get some kind of job, software development or anything else that might...twenty-seven years of software development I've got. I might do other things like film extra or...I do photography as well I don't know whether to get a decent camera because I've had a few cameras in the past.	1) Well an on-going wrestle to get rid of this weight and find some kind of work or employment or thing to do to reverse the money so I can live and also to get out of...I wouldn't dream...to move somewhere coastal....somewhere with a fabulous outdoor lido... get some kind of job, software development or anything else that might...twenty-seven years of software development I've got. I might do other things like film extra or...I do photography as well I don't know whether to get a decent camera because I've had a few cameras in the past.	1= Adapting to type 2 diabetes is a constant wrestle with the effects of type 2 diabetes and other life events (InBl21C1)
R: How do you believe that life-style changes will affect these plans? SP: I think the diet...I think a lot of eating is comfort eating, there's a lot of comfort eating involved. On Tuesday when I went to this thing I'd forgotten all about what I was going to have for tea...I just was thinking this is interesting, you hear about comfort eating...I think there's a lot of truth in comfort eating if you are directing yourself at something else then you forget about eating because you're engrossed in something else so I think if I got some positive way forward that would help get rid of this. the trouble with the last job was you're sat there for 8 hours a day at a desk so that's not good for you but also where it was you could only drive there so the place I was before.....when I got diagnosed one thing that changed...before I got diagnosed I always drove so I only walked a 100 yards a day so the first thing when I got diagnosed I thought right I won't bother driving there I'll go on foot and you use quite a bit of calories wandering to the bus, getting on the bus, it's not massive but it's better than just sitting in the car all day so this last job you couldn't easily get there on foot so you had to drive there. So if I get another job I have to make sure or build in a lot of exercise...if you're sat at a desk so I think it'd be good that it would take your mind off the eating but as long as there's no temptation....well if you keep off the...it's not too bad keeping off the biscuits and chocolate as long as you get some	1) I think the diet...I think a lot of eating is comfort eating, there's a lot of comfort eating involved. I think there's a lot of truth in comfort eating if you are directing yourself at something else then you forget about eating because you're engrossed in something else so I think if I got some positive way forward that would help get rid of this... So if I get another job I have to make sure or build in a lot of exercise...if you're sat at a desk so I think it'd be good that it would take your mind off the eating but as long as there's no temptation... it's not too bad keeping off the biscuits and chocolate as long as you get some exercise because the exercise is a key thing as well 2) the trouble with the last job was you're sat there for 8 hours a day at a desk so that's not good for you but also where it was you could	1= Adjusting dietary habits is difficult for individuals with type 2 diabetes due to the habit of eating unhealthy food to comfort (InBL22C1) 2+3= Modern professional lifestyle is linked to sedentary lifestyle that negatively affects type 2 diabetes condition (InBL22C2)

exercise because the exercise is a key thing as well. I think it would help with this.	only drive there so the place I was before 3) when I got diagnosed one thing that changed...before I got diagnosed I always drove so I only walked a 100 yards a day so the first thing when I got diagnosed I thought right I won't bother driving there I'll go on foot	

Number 2

Coded transcript from interviewee C

KEY:

Interview C= InC, Line 1= L1, Codes 1= C1

Researcher= R

Study participant= SP

Text	**Coding I** **1st cycle coding**	**Coding 2** **2nd cycle coding** *What is this about?* *What does it mean?* *What is happening?* *What are the assumptions?* *(make abstract-touch test)*
R: Tell me about your experiences with Type 2 Diabetes? SP: What happened was I was asked by my GP surgery to go for a general health check and I'd been treated by the GP for high blood pressure for several months before that. This was just a standard health check and I went back to the surgery and it was my GP and he just said you've got Type 2 Diabetes and I went oh right, okay. He was very helpful because the first thing he said to me was it's not your fault and I think that was so important and we had a very general discussion about life-style, about portion sizes and watching what I ate and he then said well we'll refer you to the Diabetic nurse who will give you lots more information. So that was fine but he was very good because he so reassured me and said there's absolutely no reason why you shouldn't live until you're 100 and so he was very good and reassuring. And I think he perhaps understood the impact it would have on me	1) I was asked by my GP surgery to go for a general health check and I'd been treated by the GP for high blood pressure for several months before that. This was just a standard health check and I went back to the surgery and it was my GP and he just said you've got Type 2 Diabetes 2) He was very helpful because the first thing he said to me was it's not your fault and I think that was so important and we had a very general discussion about life-style, about portion sizes and watching what I ate and he then said well we'll refer you to the Diabetic nurse who will give you lots more information. 3) …he was very good because he so reassured me and said there's absolutely no reason why you shouldn't live until you're 100 and so he was very good and reassuring. And I think he perhaps	1= The diagnosis of type 2 diabetes is an unexpected and surprising event (InCL1C1) 2+3= The initial support provided by healthcare professionals is dependent upon the individual traits of the professional rather than the structure of the organisation (InCL1C2) 4= Lack of support for the aftermath of the diagnosis in order to come to terms with the condition (InCL1C3)

before even I did because I was just in shock I guess and it was only as the days went by I sort of felt why has this happened to me or when you start hearing more about Diabetes oh I don't want to have an amputation, I don't want to have kidney problems. So it was really good that he was reassuring because I could look back on that conversation and get reassurance from it when I found out more about Diabetes.	understood the impact it would have on me before even I did because I was just in shock… So it was really good that he was reassuring because I could look back on that conversation and get reassurance from it when I found out more about Diabetes. 4) …as the days went by I sort of felt why has this happened to me or when you start hearing more about Diabetes oh I don't want to have an amputation, I don't want to have kidney problems	
R: Could you give me an example of your daily routine? Describe for me how you fit into your day your condition. SP: I'm on medication so I feel it doesn't impact too greatly on my life at the moment. It's something that I have to be aware of so I get up in the morning, get dressed and washed and everything. For breakfast I have porridge and I always have a glass of water for my tablets on the dining room table and then as soon as I've taken them I put the tablets away again so that I know that I've taken them. So I don't think oh I haven't taken them and take more by mistake. I'm lucky that I don't have to take tablets at lunchtime because that would be quite difficult because I'm never in one place at any one time because I do a lot of travelling around North Yorkshire. Then again when I come home and have my evening meal I again put the glass of water and my tablets on the table sit and eat my food and then again put the packet straight back away again. I'm also on statins and I take that before I go to bed at night. So when I'm in that routine it's fairly straightforward. The times I've forgotten to take my	1) I'm on medication so I feel it doesn't impact too greatly on my life at the moment. 2) I'm lucky that I don't have to take tablets at lunchtime because that would be quite difficult because I'm never in one place at any one time because I do a lot of travelling around North Yorkshire. 3) So when I'm in that routine it's fairly straightforward. The times I've forgotten to take my Diabetic medication is usually at the evening meal and it's either because I've gone and sat down and watched TV and I ate something and forgotten to go into the kitchen to find them at the table.	1+2+3= Medication intake is not a major lifestyle problem for individuals with type 2 diabetes (InCL2C1)

Diabetic medication is usually at the evening meal and it's either because I've gone and sat down and watched TV and I ate something and forgotten to go into the kitchen to find them at the table.		
R: What were you required to deal with Type 2 Diabetes? SP: Yeah, I think the biggest change was what I ate and cutting out snacks as well. I stopped eating as many pizzas, stopped eating Chinese take-aways, I stopped having toasted teacakes as a snack, I've added more fruit into my diet, I've cut down on bread at lunchtime, sometimes I do have a sandwich at lunchtime but I don't always, I have something else instead. It's making those changes into my diet that's been the biggest change.	1) Yeah, I think the biggest change was what I ate and cutting out snacks as well. I stopped eating as many pizzas, stopped eating Chinese take-aways, I stopped having toasted teacakes as a snack, I've added more fruit into my diet, I've cut down on bread at lunchtime... It's making those changes into my diet that's been the biggest change.	1) Dietary lifestyle changes constitute a major lifestyle challenge in individuals with type 2 diabetes (InCL3C1)
R: How would you describe the support you received? SP: In terms of support from professionals? Yeah it was important to have regular checks with the Diabetes nurse and she was very good because she was very encouraging. I felt that both my GP and the nurse had the right approach with me because they didn't try and tell me what to do because that wouldn't have worked, they made suggestions and because at the end of the day I know what's good to eat, I know what I should be eating so it's no good telling me that I already know that. It's I guess just encouraging me to keep going and also they were very practical both my GP and my nurse saying we don't expect you to not have any treats so that was very good and then I did lose quite a bit of weight and every time I went to see the nurse and I'd lost more she was	1) Yeah it was important to have regular checks with the Diabetes nurse and she was very good because she was very encouraging. I felt that both my GP and the nurse had the right approach with me because they didn't try and tell me what to do because that wouldn't have worked, they made suggestions and because at the end of the day I know what's good to eat, I know what I should be eating so it's no good telling me that I already know that. 2) It's I guess just encouraging me to keep going and also they were very practical both my GP and my nurse saying we don't expect you to not have any treats so that was very good and then I did lose quite a bit of weight and every time I went to see the nurse and I'd lost more she was really	1= Patient empowerment can achieve significant lifestyle changes in individuals with type 2 diabetes. (InCL4C1) 2= A supporting and rewarding environment is an element of successful lifestyle changes. (InCL4C2)

really encouraging and one of the things she said was I'm so proud of you and that really did boost my confidence I guess and encourage me to continue.	encouraging and one of the things she said was I'm so proud of you and that really did boost my confidence I guess and encourage me to continue.	
R: How would you say your life has changed after your diagnosis of Type 2 Diabetes? SP: I think the other change...the diet has been the biggest one definitely but then the other thing is I went to a Good to Go course which again my Diabetes nurse referred me to and during that course they told me about the healing project which I think is health, exercise, activity and....I can't remember exactly what it stands for but it was the heal project and they had a number of activities to do but they were all during the day and of course I still work but anyway one of them met me at a gym and showed me what was available and went through the gym programme and I guess showed me around the gym and I was encouraged and so I've been going to the gym for about 2 months now and I am fitting it into my life-style. It is a challenge to find the time. I think I'm quite motivated in going because I have to say I feel better after I've been to the gym; I feel more energetic. So that's been really positive, it's just sometimes when you've got a busy weekend and I haven't had time to go to the gym I feel oh no I haven't done what I should have done. That's the hardest thing, the time.	1) ...the other thing is I went to a Good to Go course which again my Diabetes nurse referred me to... 2) ...they had a number of activities to do but they were all during the day and of course I still work... 3) So that's been really positive, it's just sometimes when you've got a busy weekend and I haven't had time to go to the gym I feel oh no I haven't done what I should have done. That's the hardest thing, the time.	1+2= Supportive networks exist but are not directed to meet daily life routines of individuals with type 2 diabetes. (InCL5C1) 3= Sense of regret for not achieving what she knows she should have achieved in terms of lifestyle modifications (InCL5C2)
R: Before Diabetes did you used to drink at all or how much alcohol did you consume?	1) Did I drink, I tend...I haven't changed my drinking habits since diagnosis	1+2= Unaware of alcohol consumption habits and therefore unable to implement changes in alcohol

SP: Did I drink, I tend...I haven't changed my drinking habits since diagnosis because to be honest before I was diagnosed I didn't exactly drink a lot anyway because I only used to drink at a weekend and I'd maybe have 3 glasses each evening so I was probably say at the most 10 units a week. So I haven't altered that.	2) ...to be honest before I was diagnosed I didn't exactly drink a lot anyway because I only used to drink at a weekend and I'd maybe have 3 glasses each evening so I was probably say at the most 10 units a week.	consumption. (InCL6C1)
R: What did you find most useful in terms of support in modifying your life-style? SP: I guess the most useful thing has been the Diabetic nurse referring me to the Good to Go course because obviously they do mention...well there's a big focus on diet and they do mention alcohol and that was useful to remind me about the amount and the measures of alcohol because it's very easy to have a big wine glass isn't it so I guess I'm a little bit more conscious about not filling the wine glass quite as much but the other resource I think was obviously the Heal project and obviously going to...being a member of the Diabetes UK. I get their magazine Balance every month and that's got lots of useful information in it and lots of good recipes on their website which I've been using.	1) I guess the most useful thing has been the Diabetic nurse referring me to the Good to Go course because obviously they do mention... 2) there's a big focus on diet and they do mention alcohol and that was useful to remind me about the amount and the measures of alcohol because it's very easy to have a big wine glass isn't it so I guess I'm a little bit more conscious about not filling the wine glass quite as much... 3) ...the other resource I think was obviously the Heal project and obviously going to...being a member of the Diabetes UK. I get their magazine Balance every month and that's got lots of useful information in it and lots of good recipes on their website which I've been using.	1+2+3=Social media and volunteer support groups provide partial support in altering alcohol and dietary habits (InCL6C1)
R: How would you describe the relationship between you and the Health Care Professionals? SP: Very good yeah. I'm very pleased with the Health Professionals and I see a GP at the Priory Group Medical Centre and again he was very supportive in terms of giving me the diagnosis and reassuring me and putting it in a different view. The other thing he said is instead of	1) Very good yeah. I'm very pleased with the Health Professionals and I see a GP at the Priory Group Medical Centre and again he was very supportive in terms of giving me the diagnosis and reassuring me and putting it in a different view. 2) 'it's really important we've caught your diabetes now and I'm not having this	1+2= Support for individuals with type 2 diabetes is usually equated as early diagnosis (InCL7C1) 3= Collaborative work between nurse and type 2 diabetes patient can become a fertile environment for lifestyle modifications. (InCL7C2)

thinking oh I'm only 49 and I've got diabetes, he turned it around and said 'it's really important we've caught your diabetes now and I'm not having this conversation with you when you're 59 and you've had 10 years of undiagnosed diabetes'. And that was the other thing I felt was really positive. And again my diabetes nurse is excellent. She's very encouraging...and as I say they just know how to approach me without being bossy which wouldn't have worked with me. They're very good like that.	conversation with you when you're 59 and you've had 10 years of undiagnosed diabetes'. And that was the other thing I felt was really positive. 3) And again my diabetes nurse is excellent. She's very encouraging...and as I say they just know how to approach me without being bossy which wouldn't have worked with me. They're very good like that.	
R: Okay so you're having the same nurse? SP: Yeah, I feel that it's crucial. I mean I could...I've just got to go and have my next review soon and I really should be having it in March but I'm having it in April because I want to see (name of the nurse) so you I've made it so even though I've had to wait two weeks longer for the appointment I'd rather have the appointment with (name of the nurse) because she's seen me at the beginning of the diagnosis and she set us some goals which you know we did together and I just feel it's important that you have the same person there that you've set your original goals with and you can see them coming to fruition.	1) Yeah, I feel that it's crucial. ...so even though I've had to wait two weeks longer for the appointment I'd rather have the appointment with (name of the nurse) because she's seen me at the beginning of the diagnosis and she set us some goals which you know we did together and I just feel it's important that you have the same person there that you've set your original goals with and you can see them coming to fruition.	1= Named nurse and continuation of care is significant for individuals with type 2 diabetes empowerment and adaptation (InCL8C1)
R: How would you say the relationship is with your friends, colleagues, family since you have been diagnosed? SP: Nothing has changed, no. At home culturally it's as a taboo being diabetic is as ... being Diabetic is seen as you	1) At home culturally it's as a taboo being diabetic is as ... being Diabetic is seen as you are about to die soon... So yeah back home the diabetes issue is still not clear. So even if you would explain they would not have understood. 2) ...when I got diagnosed at first I had a	1+2= The multi-cultural reality of the UK perpetuates the stigma in relation to type 2 diabetes (InHL8C1)

are about to die soon and when I got diagnosed at first I had a relationship and the lady she didn't want to be in the relationship anymore because she saw it as I am going to die soon. So yeah back home the diabetes issue is still not clear. So even if you would explain they would not have understand.	relationship and the lady she didn't want to be in the relationship anymore because she saw it as I am going to die soon.	
R: What do you know about Type 2 Diabetes and alcohol? SP: Yeah because obviously...alcohol...does add calorie intake which if you are trying to maintain your weight doesn't help if you have a lot of alcohol. And obviously it's sugar and carbohydrate which then makes the pancreas work more so that doesn't help in terms of maintaining your diabetes level. So that's why I just stick to having some alcohol usually on a weekend, it has to be a special occasion if it's another time that I drink alcohol.	1) Yeah because obviously...alcohol...does add calorie intake which if you are trying to maintain your weight doesn't help if you have a lot of alcohol. And obviously it's sugar and carbohydrate which then makes the pancreas work more so that doesn't help in terms of maintaining your diabetes level. 2) ...having some alcohol usually on a weekend, it has to be a special occasion if it's another time that I drink alcohol.	1= Awareness of the physiological effects of alcohol consumption in type 2 diabetes (InCL9C1) 2= Unaware of the sociological effect of alcohol consumption (InCL9C2)
R: You said that the support you received was very nice. Is there anything else you might wish for from the Health Care Professionals? SP: No because I think the best thing was the Good to Go course which gave me all the knowledge. I also went on the Diabetes Information Day so in terms of my knowledge I think I know about Type 2 Diabetes, I know what to look out for in terms of potential kidney or liver...any tingling or pain in feet and fingers. I feel that I've got enough knowledge and I get enough support from the Health Professionals.	1) No because I think the best thing was the Good to Go course which gave me all the knowledge. ...went on the Diabetes Information Day so in terms of my knowledge I think I know about Type 2 Diabetes, I know what to look out for in terms of potential kidney or liver...any tingling or pain in feet and fingers. 2) I feel that I've got enough knowledge and I get enough support from the Health Professionals.	1+2= Health care professionals' support places greater emphasis on the pathophysiology rather than lifestyle changes in individuals with type 2 diabetes (InCL10C1)

R: Being diagnosed with Type 2 Diabetes has this changed you as a person? SP: I think the impact...you know at first I was shocked. I think there was a little bit of anger in terms of why me. I think the impact just makes you aware of your own mortality and you do worry because while you are thinking I'm well now and I'm managing it now it's how you manage it in the future or if you have...start to have problems in the future, that worries me. So I think that's what's changed and perhaps...I have asked to reduce my hours at work because I just feel it's...for me it's been more that I have a work/life balance.	1) I think the impact...you know at first I was shocked. I think there was a little bit of anger in terms of why me. I think the impact just makes you aware of your own mortality and you do worry... 2) ...start to have problems in the future, that worries me. 3) I have asked to reduce my hours at work because I just feel it's...for me it's been more that I have a work/life balance.	1= Initial shock of diagnosis with type 2 diabetes (InCL11C1) 2= Uncertainty for the future (InCL11C2) 3= The unavoidability of change in daily routine for individuals with type 2 diabetes (InCL11C3)
R: How many hours? SP: I work 30 which is 4 days a week and I'm wanting to just drop another afternoon. I don't know if work will let me do that yet but that's what I've requested; actually to support me going to the gym mid-week. And just you know having a bit more time for myself. It's made me think you only have one life and it's not all about work and your health is important.	1) ...and I'm wanting to just drop another afternoon. I don't know if work will let me do that yet but that's what I've requested; actually to support me going to the gym mid-week. 2) It's made me think you only have one life and it's not all about work and your health is important.	1=Type 2 diabetes diagnosis has a disruptive effect on social and professional life (InCL12C1) 2= Reassessing of life priorities once diagnosed with type 2 diabetes (InCL12C2)
R: To what degree do you think you have come to terms with the life-style changes? SP: Yeah I think I have come to terms with them. I think at the moment it's had a really positive effect being diagnosed with Type 2 because it has made me look at what I eat, I've lost a stone and a half so the health benefits of that hopefully are going to be good. So at the moment it's been quite positive and I've managed to cope with the life-style changes. I still have chocolate, I	1) Yeah I think I have come to terms with them... So at the moment it's been quite positive and I've managed to cope with the life-style changes. 2) ...a really positive effect being diagnosed with Type 2 because it has made me look at what I eat, I've lost a stone and a half so the health benefits of that hopefully are going to be good	1+2= Coming to terms with the diagnosis enables the movement towards a positive disposition on life (InCL13C1)

still have a dessert if I want one, I just maybe don't have one every....yeah I'm just very conscious if I have had a treat I try and make sure I'm good for the next two or three days afterwards or something like that.		
R: You said that you had some goals with your nurse. So do you think you have reached most of them? Are you setting new goals? SP: Yeah I have. She made me aware of the number that she wanted me to get down to in terms of the diabetes number and I've achieved that and also the blood pressure. She didn't set goals in terms of weight loss which I thought was quite good really and then my cholesterol level, now that's still got to be checked. But every time I was going to see her she would put the weight down at the side because I asked her to actually so that I could see that I was losing weight so she added that in as well which was good. So at the moment yes hopefully I'm achieving the good numbers if you like that she wants to see, so that's good.	1) Yeah I have. She made me aware of the number that she wanted me to get down to in terms of the diabetes number and I've achieved that... 2) She didn't set goals in terms of weight loss which I thought was quite good really... 3) . But every time I was going to see her she would put the weight down at the side because I asked her to actually so that I could see that I was losing weight so she added that in as well which was good. 4) So at the moment yes hopefully I'm achieving the good numbers if you like that she wants to see, so that's good.	1+2+3+4= Co-creating concrete goals with nurses leads to well adjusted condition (InCL14C1)
R: So you feel good, you seem to be achieving goals. That's nice. What are your plans for the future? Where do you see yourself in a few years? How do you see yourself in a few years? SP: Health wise, well hopefully I want to be as healthy as I am now really and I hope to maintain my weight or maybe even lose a little bit more and I want to still be going to the gym and doing some activity. I hope that I can reduce my hours if I can afford it, that's the thing. So I have some time to do work, it's a good structure to have	1) Health wise, well hopefully I want to be as healthy as I am now really and I hope to maintain my weight or maybe even lose a little bit more...I want to still be going to the gym and doing some activity... have enough time to make sure that I do eat properly, that I do exercise 2) One of the things I also do more obviously is cook for myself but again it's just fitting that into your routine.	1+2=The potential to self-care is empowering for adapting and materialising long term goals in type 2 diabetes (InCL15C1)

this being employed and useful if you've got a mortgage but have enough time to make sure that I do eat properly, that I do exercise. One of the things I also do more obviously is cook for myself but again it's just fitting that into your routine.		
R: Would you say that you prioritise your health over your job rather than working? SP: Yes. I think that's one of the things that the diagnosis of Type 2 has made me realise that you can't put work first, you've got to put yourself first.	1) Yes. I think that's one of the things that the diagnosis of Type 2 has made me realise that you can't put work first, you've got to put yourself first.	1= Rearranging of life priorities once diagnosed with type 2 diabetes (InCL16C1)
R: That's everything I wanted to ask you. Is there anything else you want to add? Or want to talk with me about? SP: No it's okay. No I don't think so. I think from reading more about Type 2 Diabetes one of the things Diabetes UK have mentioned is that there's 500,000 people still not diagnosed with it who have it. And I didn't have any symptoms of diabetes that I recognised as potential symptoms. The only thing I thought was that I was tired but I put that down to the job. There was no specific symptoms so that's why it was a shock I think but I think it would be great if the Health Service could have more ....to perhaps screen people more often with just a simple blood test rather than waiting for the health check because it's a good job the health check came through when it did or else I could have been still here today with diabetes and not knowing about it.	1) but I think it would be great if the Health Service could have more ....to perhaps screen people more often with just a simple blood test rather than waiting for the health check because it's a good job the health check came through when it did or else I could have been still here today with diabetes and not knowing about it.	1= A more proactive health care service prior the diagnosis can limit type 2 diabetes cases (InCL17C1)
R: How often do you have meetings with your GP or nurses? Is this standard or does it...?	1) ...she might put me down to a yearly review but it's 6 months since I've seen my diabetic	1= Satisfied with the nurse-client interaction (InCL18C1)

SP: It's just now down to the next time I go and see her she might put me down to a yearly review but it's 6 months since I've seen my diabetic nurse, because I don't need to.	nurse, because I don't need to.	
R: Do you think that the life-style changes...will affect your future plans ? SP: Do I don't think they'll affect me, in fact I think they will probably enhance them because I'll probably be healthier and fitter enough to do things that perhaps I wouldn't have done before so hopefully it's been really positive	1) I think they will probably enhance them because I'll probably be healthier and fitter enough to do things that perhaps I wouldn't have done before so hopefully it's been really positive.	1= A well adjusted type 2 diabetes individual can turn a negative situation into a positive one (InCL19C1)

APPENDIX XI

Ethics Committee Approval

Faculty of Medicine and Health

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UNIVERSITY OF LEEDS

14 October 2015

Christine Mantzouka
PhD student
School of Healthcare
Faculty of Medicine and Health
Baines Wing
University of Leeds
LEEDS LS2 9JT

Dear Christine

Ref no: SHREC/RP/527

Title: Exploring the experiences and the well-being of alcohol dependent type 2 diabetes individuals

Thank you for submitting your documentation for the above project. Following review by the School of Healthcare Research Ethics Committee (SHREC), I can confirm a favourable ethical opinion based on the documentation received at date of this letter.

Document	*Version*	*Date Submitted*
Ethical Review Form_ Version 3	3	14/10/2015
Poster for interviews_ Version 2	2	24/09/2015
Participant information sheet_ Version 3	3	14/10/2015
Participant Consent Form _ Version 3	3	14/10/2015
Invitation letter _ Version 1	1	24/09/2015
Interview questions _ Version 1	1	24/09/2015
Fieldwork assessment form low risk _ Version 2	2	24/09/2015
RE SHRECRP527 Supervisors support for resubmission	1	24/09/2015

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval. This includes recruitment methodology and all changes must be ethically approved prior to implementation. Please contact the Faculty Research Ethics Administrator for further information FMHUniEthics@leeds.ac.uk

Ethical approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The SHREC takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, and may be subject to an audit inspection. If your project is to be audited, you will be given at least 2 weeks notice.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

The committee wishes you every success with your project.

Yours sincerely

Kuldip Kaur Bharj

Dr Kuldip Bharj, OBE
Chair, School of Healthcare Research Ethics Committee