THE DAILY EFFORT TO SAY NO TO "GOOD LIFE": A CASE STUDY WITH OBESE PEOPLE WHO RECEIVE NUTRITIONAL COUNSELING

O ESFORÇO COTIDIANO DE DIZER NÃO ÀS "COISAS BOAS DA VIDA": UM ESTUDO DE CASO COM PESSOAS OBESAS QUE RECEBEM ACOMPANHAMENTO NUTRICIONAL

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Abstract

Obesity is a condition of excessive accumulation of generalized or localized fat that can compromise the health of the individual. The etiology of obesity is a multifactorial process involving genetic, environmental and individual aspects, which makes more difficult the action on their determinants. The treatment of obesity may involve different components such as body practices, medicine and psychological support, but nutritional practices are essential to ensure increased health and vitality. The objective of this study was to understand some meanings attributed by obese people, certain nutritional practices. We carried out a qualitative socio-anthropological case study and empirical analysis, in which the greatest methodological concern was with the description, understanding and interpretation of observed phenomena in a specific group of obese participants. Open interviews were made in depth and concluded that the low-calorie diet can be understood as a necessary strategy for weight control but also as the deprivation of pleasure and joy of eating.

Key words: Obesity. Nutritionalpractices. Deprivationofpleasure.

Resumo

A obesidade é uma condição de acúmulo excessivo de gordura generalizada ou localizada que pode comprometer a saúde do indivíduo. A etiologia da obesidade é um processo multifatorial que envolve aspectos genéticos, ambientais e individuais, o que torna mais difícil a ação sobre seus determinantes. O tratamento da obesidade pode envolver componentes variados, como práticas corporais, medicamentos e suporte psicológico, mas as práticas nutricionais são fundamentais para se garantir aumento da saúde e da vitalidade. O objetivo deste estudo foi compreender alguns sentidos atribuídos, por pessoas obesas, a certas práticas nutricionais. Foi realizado estudo de caso qualitativo socioantropológico de natureza empírica e analítica,

no qual a preocupação metodológica maior foi com a descrição, compreensão e interpretação dos fenômenos observados em um grupo específico de participantes obesos. Foram realizadas entrevistas abertas em profundidade e concluiu-se que a dieta hipocalórica pode ser compreendida como estratégia necessária de controle ponderal, mas também como privação do prazer e da alegria de comer.

Palavras-chave: Obesidade. Práticas Nutricionais. Privação do Prazer.

INTRODUCTION

Definition and prevalence of obesity

Obesity is a condition of excessive accumulation of generalized or localized fat, which can compromise the health of the individual. It can be defined as body mass index (BMI) higher than 30kg/m2, although in some cases high BMI does not mean obesity. BMI is a useful variable both epidemiological and quotidian that classifies obesity in overweight and obese grade I, II or III (WHO, 1998).

Both overweight and obesity are consequences of excessive energy intake compared to energy expenditure. Thus, the successful weight control is based on the negative energy balance (MAHAN et al., 2005).

The etiology of obesity is a multifactorial process involving genetic, environmental and individual aspects, which makes it difficult to act on its determinants (PINHEIRO et al., 2004). Among the variety of etiological factors associated with the development of obesity are: nutritional imbalance, physical inactivity, neuroendocrine changes, prolonged use of certain drugs, among others (ANDERSON; KONZ, 2001).

This chronic, expensive, high-risk and repeated disease affects about 300 million people worldwide, also in developed countries. It is estimated that currently more than 115 million people suffer from problems related to obesity in developing countries. In addition to the cases of overweight, the number of people affected could reach 1 billion and 700 million (DEITEL, 2003; WHO, 2002).

In Brazil, comparing current research with less recent ones, the progressive increase in prevalence of overweight and obesity over the past decades is clear. The Ministry of Health informed in 1993 that 15% of the population had overweight, and that 6.8% of this population was already considered obese. Four years later, in the 1997 survey, those numbers rose to 38.7% of overweight and 9.7% of obesity (MONTEIRO; CONDE, 1999).

Comorbidities and nutritional transition

Obesity is a nutritional health problem associated with high incidence of diseases

such as cardiovascular, type 2 diabetes, hypertension, diseases of the locomotor system, among others, and is an important risk factor for major causes of morbidity, mortality and disability in Brazil (MONTEIRO; CONDE, 1999).

Recent alterations introduced in lifestyle over time, stemming mainly from urbanization and industrialization, included significant changes in dietary patterns of the population, and are among the main causes for the alarming prevalence of obesity today. In modern eating habits, there is greater consumption of sugar, fat, and industrialized and refined foods, eggs, dairy products, with simultaneous decrease in the consumption of whole grains, legumes, roots, tubers, fruits and vegetables (ROBERTS; BARNARD, 2005).

Excessive fat, animal protein and refined carbohydrates, along with a shortage of low-glycemic carbohydrates and fiber, reduced the quality of nutritional standards, making it also responsible for the visible and worrisome increase of overweight and obesity (ANDRADE et al., 2003).

The current scenario is a nutritional transition, i.e., continuous decrease of cases of malnutrition and increasing prevalence of overweight, a consequence of changing patterns of eating behavior of the population, coupled with reduced energy expenditure in physical activity (PINHEIRO et al., 2004).

According to the World Health Organization (WHO, 2002), 60% of recorded deaths worldwide are caused by diseases related to poor diet and lack of physical activity.

Obesity today: obesity and lifestyle

The abundant consumption of energy-dense foods and beverages was appointed by the International Obesity Taskforce (IOTF) as the cause of the obesity epidemics, along with sedentary lifestyle (STUBBS; LEE, 2004). According to Pereira et al. (2005), frequent fast food consumption has strong association with weight gain and insulin resistance, suggesting that these foods increase the risk of obesity and type 2 diabetes.

The benefits of regular physical activity and healthy eating go beyond the administration of body weight, and both should be recommended together, combined or not with other forms of treatment, in order to improve the health of the population, especially of those with excessive weight (STUBBS; LEE, 2004).

Studies that combined an exercise program with a balanced reduced-calorie diet resulted in significant reduction in body weight and minimized risk factors for chronic diseases for at least one year, thus suggesting better control of hypertension and type 2 diabetes (AVENELL et al., 2004). Obese non-diabetic individuals undergoing diet and physical activity showed increased insulin sensitivity, accompanied by a reduction in

visceral fat (SHADID; JENSEN, 2003). Small weight losses, about 50% to 10% of initial weight, are able to substantially improve the health of obese patients and modify their cardiovascular risk factors (FEIGBAUM et al., 2005).

Treatment consisting of diet and physical activity, with or without the administration of Orlistat (medicine indicated for weight loss), resulted in significant reduction in triglycerides of 225 obese patients under study (FEIGBAUM et al., 2005). In the study be Lindström et al. (2004), intensive intervention on lifestyle in one year made participants gain several beneficial changes in diet, physical activity, blood glucose and lipid concentrations, and also resulted in large reduction of the incidence of type 2 diabetes. These changes in clinical characteristics of obese happened regardless of the modest weight reduction observed.

It is speculated today that changes in lifestyle, regardless of the success in weight loss, would be beneficial to the health of obese patients, in order to control possible existing comorbidities and prevent the development of other (ROBERTS; BARNARD, 2005). Changes in lifestyle of sedentary obese with poor eating patterns, although difficult, are necessary and should be implemented, mainly in the long term, so as to sustain behaviors that encourage healthy lifestyles (PINHEIRO et al., 2004). Regardless of other forms of treatment, the recommendation of a balanced and healthy diet, able to provide the energy and nutrients needed for survival and health maintenance, combined with regular physical activity, is always recommended to fight obesity (PRICE, 2005).

Strategies for weight loss and more importantly, to keep that loss, involve changes in behavior, and results depend on patient compliance to specific forms of treatment applied to it. Prevention and treatment of chronic diseases such as obesity require changes in lifestyle that are characterized by poor patient compliance in the long term. There are a number of aspects that may influence compliance with dietary prescription and motivation to adopt a desirable standard of feeding behavior (ASSIS; NAHAS, 1999; HARPER; PETERSON, 2004).

A recent study investigating the efficacy of physical exercises performed at home, combined with mild energy restriction for 12 months in 203 women, showed that significant weight reduction achieved in the first six months was reversed over the others. Therefore, future benefits of weight loss could not be observed (MEDIANO et al., 2010).

Some methods can be applied to assist in the successful treatment of obesity by long-term behavioral change. Good choices include telephone calls, electronic mail or group educational sessions, to assist the effectiveness and continuity of treatment (WADDEN et al., 2005).

Although the change in individual behavior and lifestyle is fundamental, the social, economic and cultural contexts in which the behavior is inserted must also be analyzed. It is essential to improve the economic and social conditions, and to encourage public policies to create environmental media that promote active lifestyles and health eating behaviors (COUTINHO et al., 2008).

Nutritional treatment of obesity

The treatment of obesity may involve different components such as exercise, medication and psychological support, but nourishing education is fundamental to provide adequate health conditions (MONTEIRO et al., 2004; SNOW et al., 2005). In general, all diets for weight reduction are designed to minimize the caloric intake of the individual. Several studies have been conducted so as to determine the best dietary behavior to reduce and control body weight (MAKRIS; FOSTER, 2005).

Changes in the nutritional composition of diets for weight reduction led to different dietary behaviors. There is a need for further research on the effectiveness of diets and recommend how to handle the amount of macronutrients – for example, high protein diet like Atkins, South Beach and Zone Diet, and high-carbohydrate diets like Ornish; diets that alternate energy density over time; diets based on the type of carbohydrate, such as the diet with low glycemic index, among others (KLEIN et al., 2004).

In the last twenty years, the main focus of the diets was a reduction in fat intake, in order to reduce the risk of chronic diseases, strongly linked to the consumption of saturated fats. Low-fat diets (LFDs) produced significant weight reductions in the long run, and brought benefits for blood pressure, lipid profile and glucose (AVENELL et al., 2004; LINDSTROM et al., 2004).

According to energy restriction, diets can be classified as low-calorie diets (LCDs), with 1,000 to 1,500 daily calories, which promote reduction of about 8% of initial weight in 3 to 12 months treatment, and very low-calorie diet (VLCDs), with less than 800 daily calories, reaching an average reduction of 13.4 kg in 12 months and that are usually composed of special liquid formula. The latter is not recommended for the treatment of weight loss, since it is nutritionally inadequate because of the large energy deficit (GANS et al., 2002).

This paper aims to present some meanings that overweight or obese participants attributed to the practice conducted with the extension program “Physical Activity Adapted for Obese People”, coordinated by the Laboratory of Physiology Applied to Physical Education (LAFISAEF), of the Institute of Physical Education and Sports (IEFD), of Rio de

Janeiro State University (UERJ)[1].

MATERIAL AND METHOD

Methodological strategy

The extension program "Physical Activity Adapted for Obese People", coordinated by the Laboratory of Physiology Applied to Physical Education (LAFISAEF), of the Institute of Physical Education and Sports (IEFD), of Rio de Janeiro State University (UERJ) comprises weekly physical exercises (on Mondays, Wednesdays and Fridays, from 2:30 PM to 3:30 PM), medical, nutritional and psychological supports specifically designed for overweight or obese people. The project "Physical Activity Adapted for Obese People" was created in 2005, and this research was conducted for 24 months (2007-2008).

Thirteen students, between 33 and 64 years of age (52 ± 9.0), three men and ten women, were seen. Eleven live in Rio de Janeiro city, one in Nova Iguaçu and one in São Gonçalo, cites in Rio de Janeiro state. Regarding education, four have college degrees, four have completed basic education, two have completed elementary school and three have not completed elementary school. The requirement for participation in the activities offered – physical exercises, psychotherapy, and diet therapy, in addition to the overweight condition – was to have a minimum age of 18 years, performing a stress test with a cardiologist and submit a report attesting physical conditions to practice therapeutic physical exercises monitored by physical education professionals.

It is a qualitative socio-anthropological case study of empirical and analytical nature, with ethnographic field in which the greatest methodological concern was describing, comprehending and interpreting phenomena in a specific group of obese participants. As a qualitative research, this investigation is directed to search the meanings attributed to health practices, from the description and understanding of the cultural reality of this group of overweight or obese participants. The concern of this research was not the representativeness of the studied group – using a sample to search generalization, but with a case study, interpretation of a specific group, seeking to learn actions and social interactions. We did not develop a predictive and / or explanatory research, nor quantitative. This research, therefore, was not to determine the meaning of "true" or "validity" of the analysis objects, such as positivist science, based on the explanatory paradigm.

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The understanding we seek in our research is that proposed by Weber (1991, 2005), that is, understanding to interpret social actions. It is clear that understanding must achieve maximum verifiability, but Weber himself warns us that the most verifiable interpretation will never be causally valid, but only a particularly plausible hypothesis of what is real.

The social behavior of social actors offers a large field susceptible to an understanding by the social researcher. The ability to understand will allow us to interpret without the intention of establishing universal laws, for the social sciences are comprehensive, historical, and guide themselves to the culture. Unlike the social sciences, in which we can only grasp the regularities observed by means of propositions of mathematical form and nature, the understanding method proposed by Weber focuses on the interpretative understanding of human action, i.e., the subjective sense that the actors attach to what they do or do not do.

In this sense, the goal of interpretative and comprehensive sociology in this research was to investigate the sense of the motivations of the subjects and to interpret them, even if the motivations are not part of the conscious action of individuals involved in social actions. When we refer to subjects' motivations, we mean connections of meanings that, for the observer's eyes, can reveal the basis for studied and observed behaviors.

The strategy was to describe and reveal the meanings evoked by the subjects, in order to understand and interpret the reasons that made them seek and remain in the extension project, linking them with the nutritional practice developed within the connections between diet and culture.

In-depth interviews

Open in-depth interviews were conducted and recorded, with all participants of the overweight or obese groups and the health care team. All signed a consent form, agreeing to participate. The research was also submitted to and approved by the Ethics Research Committee[2] of the Institute of Social Medicine, Rio de Janeiro State University, to ensure the correct preparation of all ethical procedures involving human subjects.

The open interviews were not characterized by the development of a script. Respondents were free to express themselves, with the least possible interventions during the interview. The participants were asked to speak freely. In the interviews, we sought to find a way that allowed us to understand what people say about what they do. These

[2]Certificado de Apresentação para Apreciação Ética (CAAE): 0013.0.259.000-07; National Committee for Research Ethics (CONEP): FR – 152142

interviews also helped us to collect information about the personal history inside and outside the extension project, their motivations, their desire to lose weight.

The interviews always began with a conversation about life before the extension project. The initial approach was intended to make the student less constrained and more willing to talk. The student talked about his sedentary past and failed attempts to follow restrictive diets. Interviews with health professionals (and trainees) engaged helped us understand the nutritional practice used and its interface with the engagement of students in the diet.

In the analysis of the interviews, we privileged the symbolic content of the speeches of the subjects, because we understand that words hold symbols and refer to representations. In-depth interviews were analyzed through the Content Analysis procedure. According to Bardin (1977), Content Analysis can be conceptualized as a set of techniques of communication in order to obtain, by systematic and objective procedures to describe the content of messages, (quantitative or qualitative) indicators that allow the inference of knowledge on the conditions to produce messages.

Initially, we focused on the content produced in the speeches of the surveyed ones, compared to their manifestation during utterance, and then we extracted the core of meaning that make up the utterance of speakers. Bergson (1979) states that, under the words and phrases, there is something much simpler than a sentence and even a word: the meaning. Our effort was to capture these meanings.

The content analysis procedures reconstruct representations in two main dimensions: syntactic and semantic. We did not analyze the frequency of words and their ordering, vocabulary, and word types. The purely descriptive analysis of word frequency was not a methodological option. We prefer the semantic encoding that favors human encoder and not the mathematization or use of software.

Nutritional counseling and therapeutical practice in the Extension Project "Physical Activity Adapted for Obese", UERJ

In general, when the individual seeks a nutritionist, he has tried numerous strategies: diet prescribed by doctors, use of drugs for weight loss programs, Weight Watchers, etc. Nutritional monitoring arises at this point as another opportunity to try to lose weight and not as priority health practice. That is, the search for a nutritionist becomes one of the latest strategies for weight loss.

If we take our readings of the formation of a citizen in ancient Greece, Plato highlights the importance of adequate feeding for the guardians. In the Greek *paideia*, the concern with diet was more important than medical and hygienic care. Exercise and

proper diet would be necessary for the health of the body, as well as music for the health of the soul. Harmony between these elements could produce what we now call health (JAEGER, 2003; MATTOS et al., 2010; PLATON, 2002).

Throughout the in-depth interviews with obese people, it was possible to understand that diet focuses on behavioral change. That is, diet is effective only if the individual changes his behavior towards food, even if he needs psychological support in the context of multi or inter-disciplinary teams. For the participants, diet gets two senses:

- Diet is behavior change: participants recognize that it takes a new way of dealing with food and it goes through shifts in attitudes and behaviors.
- Diet is deprivation of pleasure, joy and “the good things of life”.

We intend to discuss these meanings attributed to diet in order to understand how nutritional strategies become a therapeutical practice for obese people.

Consultations take about 50 minutes, when personal data and information about eating habits, hydration, bowel function and diseases are collected. After the interview, a clinical feature, a “24-hour recall” is drawn. That is, a set of information about eating habits, in order to highlight the main mistakes made by the participants. Then one explains the strategy of the low-calorie diet to be followed aiming at food re-education and weight loss.

During the clinical approach, we recognize that many participants are looking for something other than weight loss. Some begin to talk about their problems, especially family ones. The reception, care and ties become key elements for compliance with treatment. Without recognition of the individual who suffers, acceptance of the low-calorie diet tends to be weak.

Because of the social isolation in which these people live, sociability is very important, as the obese have the chance to be in a place where people are alike and have the same limitations. In gyms and weight training, they know they are isolated, in addition to being censored by the gaze of others (DURET; ROUSSEL, 2003; MATTOS; LUZ, 2009).

Obesity impairs health, aesthetic and social life. Moreover, it is accompanied by serious psychological factors (BRITZ et al., 2000; CARPENTER, 2000; CARR; FRIEDMAN, 2005; ONYKE et al., 2003). In most cases, there are subjective issues beyond the desire to eat (GASPARD; DOUCET, 2009), so it is difficult to deal with obesity only with low-calorie diets. There are compulsive crises, episodes of depression and anxiety. Obesity, in our experience, is associated with anxiety and frustration.

Several studies have shown strong correlation between obesity and anxiety, anguish, depression and all kinds of suffering. This fact is mainly due to the stigma of fat,

since obese people see themselves as excluded, discriminated, humiliated and even abandoned. Moreover, they feel more socially disadvantaged and less professionally favored (ANDREOLETTI et al., 2001; CARR; FRIEDMAN, 2005; EAGLY et al., 1991; FRIEDMAN et al., 2002; ONYIKE et al., 2003).

Many obese eat too much, even without hunger. And psychotherapy is fundamentally important for the nutritional strategy of removing excessive sugar from the diet of these people. Women reported that, when they become anxious, they tend to eat candies. When psychotherapy emphasizes the differences between gluttony, lust and hunger, nutritional treatment greatly improves. When the student can combine psychotherapy with diet therapy, he can lose weight.

The nutritional consultations within the extension project are individual, monthly or bimonthly, and there are weekly collective lectures that last from 10 to 15 minutes and always address any topic related to nutrition. The goal is the behavioral change and health education.

Other professionals from the extension project also recognize that changing habits is essential for obese students, although they know it is very difficult. The corporal *habitus* (BOURDIEU, 1984, 1997; BOLTANSKI, 1971) acquired by the obese students with regard to food is one of the biggest barriers to failure in complying with low-calorie diets.

> Most do not follow the diet. It is very hard for you to drop things you like. The more you convince people that they should not eat chocolate, they always try it because they like chocolate and it makes them happy. Even though it will make you get fat, you keep eating because it makes you happy. (23 years old, extension project trainee).

> Diet? Most drop it out. Some have told me. Some give up indeed. In the beginning it is very difficult, you've got eating habits. And the nutritionist cuts them, even softly. And those people who survive keep the diet. And those who do not survive cheat, lie saying that they are still on a diet. [...] I believe food is an escape. It is like a drug. And then you get depression. And to get out of depression you eat more. It is a vicious circle. (46 years old, physical education teacher, extension project).

The obese participants recognize that eating habits are very difficult to be modified and account for the current overweight condition. The presence of large quantities of candies, fried foods, pizzas and fast-food within the family contribute to an unbalanced eating pattern. The changes with respect to food, when they receive support from the family, tend to be successful.

> Everyday at home we used to have a lot of soft drink, pizza, chips,

> cake. Then my daughter and I cut everything. When I feel like eating, I eat and go for a walk in the street. Now I eat vegetables, because I ate too much meat, pasta, pork, fries... Now I eat much chicken and fish. (61 years old, extension project participant)
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> Diet? Restriction is very hard to do. You create habits for a lifetime and now it is more difficult to change. I eat a lot of tidbit. I like candies and chocolate and cannot eat them anymore. I already know what to eat and not to eat. I am very greedy. This is the problem. At home everybody likes candies. And what do you do? Leave? (51 years old, extension project participant).
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> I used to eat sandwich, chips, soft drink [...] I do not know what is to be in double digits for decades; 99 kg was a luxury of a teenager. Now we just live in three digits. (39 years old, extension project participant).
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> My husband brings *quindim*[3], candies, etc. After eating I remain thoughtful. But eating is a pleasure, ins't it? I tried to compensate and did not have dinner. I had a tea and went to sleep early. (52 years old, extension project participant).

Even with the difficulties to change eating habits, many participants consider nutrition as an important tool that helps them develop new meanings for food, meals, and even the choice of food. Then they fell healthier, regardless of the degree of weight loss.

> My passion has always been pies and candies. Fattening foods, you know. The nutritionist's lectures helped me. Hydrogenated fat, refined sugar, rice. All that I've been learning and lead me to change things at home. Now I know. Once I went to shopping-centers and ate those pies. Now I avoid them. I know the evil those tartlets make to me. Cholesterol, glucose. (56 years old, extension project participant).
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> Nowadays I control myself because the nutritionist gives me orientation. I did not stop eating anything, just reduced the quantity. Sometimes we eat food we do not know whether they are good or bad, And now I avoid certain things. Fat, fries, I reduced them. (56 years old, extension project participant).
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> Sometimes I skip meals, schedules. I do silly things, like eating what I should not eat. But now I believe I am right. I do not eat candies. I really stopped. Whole wheat pasta only. Brown rice too, it is wonderful. Now I discovered brown rice. I used to eat a loto f bread, now I eat less. I used to eat a lot of cheese, too, and now I eat less because I found out that cheese is fatty. Now I eat ricotta, which is better. (64 years old, extension project participant).

In order to help participants change their eating habits, one of the strategies used is to establish nutritional goals. Individual goals are established. Sometimes the goals are

[3] A high-calorie candy made of sugar and egg yolks, very popular in Brazil.

simpler and have educational character. There are, for example, participants who do not even drink a glass of water per day. They are taught to drink about two liters a day. Most also do not know that meals need to be fragmented, and erroneously make three meals a day, in large quantities. They learn that the number of meals should be larger, in small portions. From these simple tips, there are significant improvements in health, regardless of weight loss.

In nutrition counseling, one needs to make good survey of eating habits, so that goals can be consistent with the possibilities of the body. The most obese people do not report everything they eat because they feel ashamed. The higher the weight, the more they distort information during consultations. They feel ashamed to admit that food is a great pleasure, although they know it may harm their body. Obese students are those who actually speak less about their eating habits, remaining silent or directing their speech to other topics. When they are urged to talk about diet, they show certain rejection.

> That diet is horrible, it is. Tasty things are imoral and fattening, right? And you always say no to delights of life. My husband comes with chocolates, candies. Will I be just looking? It can't be. That's terrible. It is temptation. (52 years old, extension project participant).

> There's benn years I do not go to the theater, to the movies, I don't go to parties, dances or sambas. Something I have to do, right? To eat. At least one beer. What I miss more is beer. This was the most difficult thing, the worst sacrifice. (51 years old, Eetension project participant).

One patient reported dissatisfaction with the presence of candies and snacks after the bodily practices held in the Extension Project. For her, it is absurd that the students have permission to have that kind of food after class. It is contradictory to have a snack after physical activities, as students are there to lose weight.

> I mentioned this, right? People snacking. And there are people who snack after class. They bring peanuts, coconut candy and so on. This worried me. To what extent does this person want to lose weight? And they said each one is another one. I don't agree, I don't think it is reasonable. Then there are people here who do not fit. I do not agree. It is illogical. (Gisele, 52 years old, extension project participant).

The dissatisfaction of the participant, even her anger, coincides with Durkheim (2008) when he argues about the need for sharing beliefs. Beliefs, religious or not, are only active when shared. One can certainly hold them for some time for an entirely

personal effort, but that is not how they are born or acquired. In fact, obese patients, who have a true faith / confidence in the practices of the Extension Project, feel the need to experience it with their peers. To do so, they get out of isolation, come close to others, seeking to convince them and strengthen them.

Conclusions

By joining the Extension Project, the participants must gradually adopt an ascetic behavior towards food. They must abstain from certain foods if they want to lose weight. To abstain is to impose sacrifices to oneself. It is necessary to elicit changes in the attitudes of participants toward food and introduce them soon in the circle of healthy food and get them in touch with it. They are separated from the profane food (candies, soft drinks, snacks, fast food) and this is accompanied by multiple denials and a system of prohibitions. Deprivation of certain foods means that they broke some of the ties that bind them to profane food. This relationship of the sacred and the prohibition against food is crucial for new senses and meanings about health. Changing feeding is changing life, is changing history.

We therefore conclude this discussion by pointing out the importance of a multidisciplinary team in the treatment of overweight and obesity. The nutritional treatment for obesity is not characterized only by the implementation of a restrictive diet plan, but also by changes in eating habits and lifestyles, in order to avoid episodes of compulsive food intake. Much more than a well-planned low-calorie diet, it is necessary to rethink the feeding process in the establishment of harmony and balance in health. Henceforth, we know that the assignment of new meanings to food contributes to the construction of new values and representations of the fat body today.

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