DOI: 10.12957/demetra.2016.22501

I have a fat body, what now? Experiences of obese women following a multidisciplinary, non-prescriptive intervention, based on the Health at Every Size® approach

Eu tenho um corpo gordo, e agora? Relatos de mulheres obesas que participaram de uma intervenção não prescritiva, multidisciplinar e baseada na abordagem "Health atEverySize®"

Mariana D. Ulian[1]
Bruno Gualano[2]
Fabiana B. Benatti[2]
Patricia L. de Campos-Ferraz[3]
Odilon J. Roble[4]
Bruno T. Modesto[2]
Gabriel T. de Medeiros[5]
Ramiro F. Unsain[6]
Priscila de M. Sato[6]
Ana Carolina Machado Poppe[1]
Fernanda B. Scagliusi[1]

[1] Universidade de São Paulo, Faculdade de Saúde Pública. São Paulo-SP, Brasil.

[2] Universidade de São Paulo, Escola de Educação Física e Esporte. São Paulo-SP, Brasil.

[3] Universidade de Campinas, Faculdade de Ciências Aplicadas. Limeira-SP, Brasil.

[4] Universidade de Campinas, Faculdade de Educação Física. Campinas-SP, Brasil.

[5] Universidade de São Paulo, Instituto de Psicologia. São Paulo-SP, Brasil.

[6] Universidade Federal de São Paulo, Instituto de Saúde e Sociedade. Santos-SP, Brasil.

Correspondence
Mariana Dimitrov Ulian
Departamento de Nutrição, Faculdade de Saúde Pública da Universidade de São Paulo - Av. Dr. Arnaldo, 715, São Paulo, SP, CEP: 01246-904, Brasil.
E-mail: m.dimitrov@usp.br.

Abstract

The present study qualitatively analyzed the perception of obese women on having a fat body and how they experienced and were impacted by this body condition before and after participating in a non-prescriptive, multidisciplinary intervention, based on the Health at Every Size® approach. A prospective 1-year quasi-experimental clinical trial was conducted. Initially, 30 participants were recruited; 14 concluded the intervention. Qualitative data were collected by conducting focus groups and semi-structured individual interviews. From these data, three interpretative axes were created: 1) impact of the fat body; 2) opinions on the body itself and the docility of the fat body and; 3) movement of the body. Our participants reported that the fat body had an impact on the construction of aspects of their personality, reducing, for example, possibilities of bonding and social interactions. Based on the proposed intervention stimuli, according to the perceptions of the participants, these aspects were positively affected. The participants also reported having suffered bullying and discrimination because of their bodies. After exposure to the strategies of this intervention, participants reported feeling more empowered to deal with expectations about their bodies and more comfortable with their current body condition. Finally, participants reported shifting from negative experiences associated with body movement to positive experiences, thus feeling motivated to add more physical activity into their routines, besides gaining physiological and psychological benefits.

Keywords: Obesity. Non-Prescriptive Intervention. Health at Every Size. Body Image. Qualitative Inquiry.

Resumo

Objetivou-se analisar qualitativamente a percepção de mulheres obesas sobre ter um corpo gordo e como elas vivenciaram e foram impactadas por essa condição corporal antes e depois de participarem de uma intervenção não prescritiva, multidisciplinar e baseada na abordagem "Health atEverySize®". Trata-se de ensaio clínico prospectivo, *quasi*-experimental, com um ano de duração. Os dados qualitativos foram coletados por meio da condução de três grupos focais e de entrevistas individuais semiestruturadas. Inicialmente, 30 participantes foram recrutadas; 14 concluíram a intervenção. A partir dos dados dos grupos focais e das entrevistas individuais, três eixos interpretativos foram criados: 1) impactos do corpo gordo; 2) opiniões sobre o próprio corpo e a docilidade do corpo gordo; e 3) movimentação do corpo. As participantes relataram que o corpo gordo impactou na construção de aspectos da sua personalidade, diminuindo, por exemplo, possibilidades de vínculos e interações sociais. A partir dos estímulos da intervenção proposta, segundo as percepções das participantes, tais aspectos foram positivamente afetados. Elas também relataram ter sofrido experiências de assédio moral e discriminação por causa de seus corpos. A partir da exposição às estratégias desta intervenção, as participantes relataram se sentir mais empoderadas para lidar com expectativas acerca de seus corpos e mais confortáveis com sua condição corporal atual. Por fim, relataram transitar de experiências negativas associadas à movimentação do corpo para experiências positivas com as mesmas, motivando-as a inserir mais atividades físicas em suas rotinas, além de proporcionar ganhos fisiológicos e psicológicos.

Palavras-chave: Obesidade. Estilo de Vida. Promoção da Saúde. Health at Every Size. Imagem Corporal. Análise Qualitativa.

Introduction

Constructions related to the body are malleable and shaped by cultural, social, organizational, professional and individual aspects. The body can be understood as an attribute related to culture, reflecting norms and meanings specific to a particular cultural context.[1, 2] For example, the lean body was not always the model of health (and beauty) and the construction of the health discourse about the fat body is relatively recent.

It is from the Renaissance (the period in European history, from the 14th to the 17th centuries) that feminine beauty becomes socially recognized as a predictor of a moral character that must be externalized. In the sixteenth and seventeenth centuries, fat, both in body and in food, was

perceived as healthy and a sign of social status.[3] It would be expected from women that they would be bulky. A plump body, with large hips and a large abdomen were attributes that culturally signified fertility, good health, emotional stability, and social status.[4, 5]

It is only in the late eighteenth century that there is a change in the perception of fat and smaller bodies begin to be associated with desirable attributes for women, such as delicacy and kindness.[3] It is also assumed that the fear of gaining weight is a predominantly female concern and the practice of slimming diets is automatically associated with women.[6] However, in the mid-1800s, in the Western world, body control recommendations would be aimed at male audiences. For them, a slender body would represent greater influence, political power and social privileges.

In this context, medicine began to be concerned about obesity but increased appetite and proportionality of body volumes were still more important than precisely the body size. There were no specific standards to determine obesity, which would be defined by strictly aesthetic parameters. It would not be the individual who would self-classify as sick, but others, by comparison to a socially recognized standard of beauty. Short of a standard for normality, which was possible only with quantitative medicine and still nonexistent, the recognition of obesity resided in physicians' ability to identify the natural and the unnatural.[7]

With the rise of scientific rationality, knowledge and power became intertwined, for knowing implied holding power over men,[8] investing in quantification as a means for the development of the notion of health anchored in normality.[9] Thus, statements by Flemyng (1760, apud[7]) and Brown (1788, apud[7]) would be contrasted with previous definitions by the substitution of aesthetic connotations by a bio-pathologizing discourse, seeking to extract from it the whole range of aesthetic or moral questions.[7]

Under such point of view, it can be seen that the pathologization of the fat body occurred through a continuous process, culturally and historically dated.[7, 10] With this change in expectations for the body, for the female audience restrictives diets became a popular practice around the year 1920. Social pressure for women to follow the new ideal of beauty grew, while the negative messages addressed to the body with excess weight increased, relating such physical condition to immorality, lack of control and discipline.[11]

Nutritional discipline and control of the body were seen as a means for women to achieve influences and privileges equal to those of men. Thus, dieting can be seen as a multifaceted practice, which not only subjects the body to cultural norms but simultaneously allows privileges and rights to individuals.[11] Diet has become a moral issue, involving the individual's ability to control, resulting in deprivation and depletion of physical and emotional energy.[12, 13]

For many people, especially women, managing body weight has become a continuous project.[14] According to the latest research from the *National Health and Nutrition Examination Survey*

(NHANES), conducted between 2003 and 2008, three in five American citizens have wished to lose weight, and 57% of women and 40% of men have engaged in some type of diet in the previous year.[15]

Currently, according to research in Europe and North America, it is estimated that 25 to 65% of women and 10 to 40% of men are engaged in any diet aimed at weight loss.[16] However, evidence has been showing that this is sustained by only a small portion of people and many gain even more weight than before the diet [17-19].

Siahpush et al.[19] have longitudinally examined the association between dieting and body weight and body mass index (BMI). Those who have dieted once, more than once and always, when compared with those who have not dieted, have had, respectively, 1.9, 2.9 and 3.2 times more opportunities to develop obesity. In this way, the interest for other care strategies is crucial and has been gaining attention.

The other care strategies differ from traditional interventions aimed at fat people since they focus on body, emotional and individual acceptance as a means to improve such people's physical and emotional health (when and if necessary), without focusing on body weight control.[20] Among them, the "Health at Every Size"® (HAES®) approach is highlighted, a name coined by the *Association for Size Diversity and Health* (ASDAH 2013[20]).

HAES® aims to encourage healthy behaviors for people of all body sizes and loss of body weight is a consequence or not of this process. Its principles include: 1) Recognizing that health and well-being are multidimensional and include emotional, physical, spiritual, and intellectual aspects; 2) Encouraging the building of a positive body image; 3) Accepting and respecting the diversity of body sizes and shapes; 4) Promoting a diet that balances individual nutritional needs, besides aspects such as hunger, satiety, appetite and pleasure; and 5) Promoting pleasurable and sustainable physical activities.[20]

Provencher et al.[21] and Gagnon-Girouard et al.[22] have observed the impact of an intervention based on the HAES® on psychological variables and body weight of overweight and obese women. This lasted four months and participants were randomly assigned into three groups: HAES®, social support and a waiting list. At the HAES® group, lectures were conducted in order to increase participants' attention and knowledge about biopsychosocial aspects involving health and body weight. The social support group had the same format as the first one but participants were not instructed and discussions were not directed. The last group was instructed to maintain its usual habits and had no contact with the research group. At the end of the follow-up period, the latter received the same guidance as the HAES® group.

All groups showed improvements during the intervention, which were related to changes in quality of life, body dissatisfaction and binge eating, evaluated through questionnaires and statistically analyzed. However, only the HAES® group maintained them during the follow-up

period and only in this group the maintenance of body weight in the 12 months of follow-up was related to psychological improvements resulting from the intervention.

In the long run, changes in the HAES® group were maintained or continued to improve, which did not happen in the other groups. Borkoles et al.[23] have proposed an intervention based on the HAES® approach for a population of women with class III obesity. Participants underwent three months of intervention followed by nine months of follow-up. The intervention had as strategies approaches aimed at the practice of physical activity and changes in eating behavior and the control group was instructed to maintain their current habits. Modest, although statistically significant, changes were observed in the body weight of participants in the intervention group. During the follow-up period, no further changes were observed in this variable but the participants in the intervention group showed a significant improvement in psychological variables and sedentary behavior, differently from the control group.

Studies have shown that interventions based on HAES® seem to improve aspects such as self-esteem, body dissatisfaction, eating behavior and body composition[21, 22, 24-28]. Although one of the principles of HAES® is to encourage the construction of a positive body image, no interventions were found that assessed participants' perceptions about their body condition after being inserted into interventions based on this approach. Considering the historical construction of the body as a predictor of moral character and the strengthening of scientific rationality to classify the body, this investigation proves important, since it brings the perspective of these individuals, whose bodies are often classified and pathologized by the gaze of others, be it aesthetic or pathophysiological.

The objective of this article is to qualitatively analyze the perception of obese women about having a fat body and how they experienced and were impacted by this body condition before and after participating in a non-prescriptive, multidisciplinary intervention based on the "Health at Every Size®" approach.

Methods

Study design and participants

This was a prospective, quasi-experimental, one-year clinical trial. Thirty women were selected, participants in the "Health and well-being in obesity" intervention, whose design and main results have already been described by Ulian and collaborators.[29-32] The inclusion criteria were: a) Being females; b) Being between 25 and 50 years old; c) Having a BMI above 30 kg/m²; d) Being literate; e) Having no diabetes mellitus 1 and 2; f) Carry out no nutritional monitoring outside the intervention; g) Using no weight loss pills. Of the 30 participants initially selected, 14 completed the intervention.

All signed an Informed Consent Form (ICF). The project was approved by the Research Ethics Committee (REC) of the Brazilian Federal University of São Paulo and the study was registered on clinicaltrials.gov under no. NCT02102061.

Characteristics of the intervention

The intervention consisted of physical activities three times a week (for one hour), philosophical workshops, a total of five during the intervention, and individual nutritional services fortnightly. Every four months, focus groups, blood tests, anthropometric assessments, and completion of scales and self-administered questionnaires would be carried out.

Physical activities included leisure activities in circuit, focusing on the development of aerobic and anaerobic capacities, strength, proprioception and flexibility. In the workshops, topics were discussed that find discussion in philosophy and are part of the universe that involves the issue of obesity. Among the topics, one can mention the mechanism of desire and boredom, restriction and health, moralization of the body and health, freedom and anxiety.

Nutrition intervention was based on nutritional counseling. It is "a meeting between two people to examine carefully, to look with respect, and to deliberate with prudence and correctness about the eating habits of one of them."[33] The main strategies used during nutritional counseling are: self-monitoring, goal setting and food planning. Self-monitoring was performed by means of a daily food consumption record. This includes notes about the time, place, company and duration of meals, feelings and related thoughts, whether it was a planned, pleasurable consumption, and notes on hunger and satiety.

From the diary, one could see what needed to be worked out in order of importance and urgency and food planning would be done. In a simplified way, this was used to help participants plan what and how much food to eat. In addition, nutritionists sought to increase participants' attention to signs of hunger and satiety, for emotional or environmental triggers that could lead to automatic eating behaviors and to encourage them to build an external support network to the intervention. Individual nutritional appointments were 45 minutes long.

Data collection and analysis

An experienced anthropologist conducted three focus groups throughout the intervention. In addition to this, an observer noted expressions, gestures, and other nonverbal marks from participants. Both were members of the research team but not the intervention team.

Each group had a questionnaire drawn up by all the intervention professionals. Such scripts have not been pretested and were different in each focus group as some activities and reflections were inserted at different times throughout the intervention and therefore would not fit if they would be addressed in all focus groups. In this sense, some initial questions would not fit if presented at the end of the intervention and vice versa. With different questionnaire scripts in each focus group it was possible to observe the evolution of the intervention and the participants, besides allowing changes in the strategies used, when necessary.

Although focus group discussions have covered all areas involved, this paper shall review those related to body reports. Participants were invited to participate in focus groups. The invitation would be done personally and individually, at which time the purpose of the encounters would be explained. Seven to eight women were expected to make up the focus groups but, foreseeing absences, ten were invited, except for the last one, in which all were included. Each focus group was attended by seven women.

Sampling was done as follows: in the first focus group, once the intervention had a larger number of participants, a raffle would be carried out to ensure that invitations would be randomly provided. In the second one, the women present in the first group were invited again and new invitations, also established through raffling, were extended to other participants. In the last focus group, participants from the first and second focus groups were also invited again. One of them had withdrawn from the intervention and therefore, due to the withdrawals, only one participant would not be included because she had not participated in any group. Thus this one was also invited.

Considering the three focus groups conducted, 12 of the 14 participants were present in them. Of these, two participated in the three focus groups, five in two, and five in a focus group. The duration of the meetings ranged from 80 to 100 minutes. All were recorded by two digital recorders and transcribed by a member of the research team. In the transcripts, the observer's notes were included, although they did not make up the final analysis. With them it was intended that the team observed the groups progress and the participants' engagement in them. The analysis of the data collected in the focus groups was returned to the participants at the end of the intervention.

In addition to the focus groups, one participant in the intervention conducted individual interviews with all participants at the start of the intervention. The interviews aimed to investigate the life trajectory and how the participants understood and developed eating and body practices. They were asked to report past and current habits covering such topics, as well as reflect on their life trajectory. Participants were encouraged to recognize important moments, individually or collectively, as well as changes in their lifestyle and family structure. The duration of the meetings ranged from 60 to 120 minutes.

The interviews were recorded by two digital tape recorders and transcribed. Later, life history narratives were constructed by structuring each participant's reports, taking care in emphasizing their historical perception on the construction of life habits, their cultural and family influences, and the identification of symbols, values, beliefs and behaviors involved, according to theoretical and methodological frameworks by Lima & Gualda,[34] Paulilo[35] and Thompson.[36] After this step, the narratives were returned to the participants so they could suggest changes to them if they felt the need. Of the 14 participants who completed the intervention, eight gave consent to use their life histories.

From the data of the focus groups and the individual interviews careful readings of the transcribed materials were carried out. During this process, important elements present in each report were highlighted and reflections about them were separately noted. Subsequently, elements similar, complementary or referring to the same category were organized in interpretative axes, which were not established beforehand but named in accordance with the sense sprouted. These interpretative axes shall be presented in the results and discussion section and be articulated with theoretical references of the literature on HAES® and on non-prescriptive approaches. In order to preserve the participants' anonymity, they are identified as participants (P).

Results and Discussion

Table 1 shows the participants' demographic characteristics. Of the 30 participants who started the intervention, 16 left before its end. Three moved from town, three had no time available, one became pregnant, four claimed personal reasons and five claimed health reasons. The interpretive axes constructed from the focus groups and individual interviews are presented below.

Table 1. General characteristics of participants in a multidisciplinary and non-prescriptive intervention based on the approach "Health at Every Size"® (n = 14). São Paulo, 2013.

Characteristic	Mean (standard deviation)	%
Age (years)	45 (7.1)	
Education		
Completed secondary school		28.6
Completed higher education		71.4
History of weight gain		
Childhood		35.7
Adolescence		7.1
Adulthood		57.2
Occupation		
Professor		21.4
Homemaker/retired		28.6
Student		7.1
Self-employed		14.3
Civil servant		7.2
Outsourced worker		21.4
Marital status		
Single		35.7
Married		42.9
Divorced		14.3
Widow		7.1

Values expressed as averages (SD) and percentages (%)

Impacts of a fat body

Psychological impacts for those having fat bodies can be built by physical and social processes.[37] Social aspects include negative messages about having a fat body which, when systematically expressed, are reflected in the construction of environments and discourses that discriminate and do not tolerate that body. These are evident in institutions and in everyday speech, resulting in discrimination and stigmatization of those who have a fat body.[37]

It his work, Goffman[38] describes stigmatization as a process that tends to discredit an individual who is considered "deviant." According to the author, stigmatization is the result of social interactions that label "deviant" the ones who move away from those who are supposedly considered "normal." Once attributed, the stigmatizing characteristic justifies a series of social discriminations or more or less severe exclusions.

Goffman[38] also proposes the idea of *main status* to reflect the reduction of an individual to the target characteristic of stigmatization, remaining with other qualities in the background. This is why obese people are often characterized by their weight than by other social or personal attributes.[38] In addition to the psychological problems resulting from discriminatory and stigmatizing behaviors, these also appear to have implications for maintaining body weight.

In a longitudinal study, participants who suffered discrimination due to body weight were approximately 2.5 times more likely to become obese. And those who were obese and discriminated were three times more likely to remain obese when compared with persons who had not been discriminated against.[39]

Our participants reported impacts related to their bodily condition. Some brought accounts from childhood or adolescence. In one of the life history interviews, a participant mentioned her personality transition. While in childhood she considered herself an extroverted child, in adolescence negative experiences related to her body condition caused a change in that characteristic. She reported that she became more introverted and less interested in participating in social situations:

> I remember being much more extroverted in my childhood than I am today. In adolescence I feel that I went on losing this extroversion along the way, a little due to obesity. [...] I remember that my nickname at school was "chubby." At the time I swallowed it and I did not even say it at home but deep inside it hurt me. (P1).

Another participant told that, because she had been an overweight teenager, she had difficulty with love relationships. As an alternative, she turned to individual activities:

> Between the ages of 12 and 15 I think I was pretty chubby and having quite some difficulty in terms of relationships. Therefore, all the girls would date and I, the chubby one, would not. But I was always very interested in reading, music... Thus I would always find in art a refuge to live well. (P10).

Impacts of fat bodies in these life cycles could also be observed in the study by Puhl & Luedicke.[40] The authors observed that high school students who reported having negative emotions due to harassment undergone from being overweight would be more likely to avoid physical activities and would also respond to this confrontation by increasing food intake.[40]

At the beginning of the intervention proposed in this paper the speech by some participants suggests that the fat body still remained as an obstacle to new relationships or more involvement in social situations:

> Today I'm single. That's another thing that obesity really messes up with. I do not think I'm ugly but I do not find myself attractive either. (P1).

Similarly, P10 reported in her life history interview that her perception was that her relationships would end up being undermined because of her bodily condition:

> I go out much less than before. It's a matter of acceptance. I do not accept myself that way. I do not feel like going out, being in a group of friends, being in certain places. It's a matter of feeling beautiful, attractive, maybe feeling accepted, right? I do not feel it. (P10).

The same perception was maintained in P11's speech. In contrast, P2 reported having no relationship difficulties and having an extensive network of friends: "[...] I have many friends, many indeed. And they are good. Friends indeed, not just colleagues."

Impacts of a fat body can also be seen in the study by Degher & Hughes.[41] The authors qualitatively analyzed how overweight individuals interacted with themselves and with others and what the consequences of these interactions on their identity were. Research participants reported that they were often confronted with stressful and emotionally draining situations and would circumvent them by responding negatively to considerations about their physical condition or by agreeing with negative considerations to be better accepted.

It seems plausible to assume that for many of our participants their body condition at the beginning of the intervention was a limiting factor for their greater social and affective involvement. One of HAES® principles recognizes that health and well-being are multidimensional and include emotional, physical, spiritual and mental aspects, and that individual experiences with body weight and health are part of a complex interaction of such factors.[20] From this principle, throughout

the intervention these aspects were respected and taken into account in the development of the participants' care strategies.

Among the strategies used in nutritional care, it is important to establish goals. Although this involved mainly aspects related to the participants' nutrition, it was not limited to this facet. It could include, for example, questions such as: 1) Who can help the participant in a certain aspect? 2) What aspects of their routine can be changed so that a goal can be more easily practiced? 3) How can the participant increase self-care?

In the philosophical workshops it was possible to highlight the moralization of the body as an important tool to cover and discuss individual experiences with the participants' body condition. As a reflection, early in the intervention some participants reported that they already felt more motivated to make their daily lives more active, as highlighted in the following lines:

> [...] I would just stay home. Therefore I have to go out Mondays, Wednesdays and Fridays to come here. [...] It's a preparation, it's a different thing, it's something I like, I feel good with. They [family members] also think that I have improved a lot, mood, everything. (P6).

> [...] They [family members] can see that I am happy, that I am going out more. I think they are happy for me. (P7).

It is also interesting to notice some change of attitude from the participants in relation to their bodies. At first, they said they were more comfortable with the current rhythm of their bodies and less concerned about weight loss alone, suggesting a change from their previous expectations:

> Maybe my body works slower today and that's okay. Now I just take care of not speaking, "Ah, it did not work today, then it is over." (P10).

Halfway through the intervention, this perception remained in force:

> [...] What got stronger is: it's okay for you to be in a body situation that you don't accept, but that's not the end of the world. And I want to change but I do not need to be neurotic either. I can accept myself the way I am while I am achieving what I want. (P7).

In the last focus group conducted, ideas in this sense also stood out, as illustrated in P9's speech:

> I used to look and feel fat, which bothered me. I haven't put off so much weight, but I feel good. I look at myself and I like it. I've learned to like myself again, to give myself some time. And that was very good.

P10 reported that she was "satisfied with the process" and said that she learned to respect her rhythm and herself:

> I have to respect myself and I think the intervention has helped me say, "You are not satisfied but that is no reason to not doing anything, not taking care." (P10).

The same participant reported that she was discovering positive attributes in her ("It is an exercise in perceiving beautiful things in me."). The speeches highlighted show the participants' active positioning in seeking changes that made sense to them at different moments of the intervention, suggesting that such changes were a growing and constant movement throughout the follow-up. These statements also appear to be different from those reported at the time of the initial intervention, in which the fat body appeared to be something that "hindered" the participants from seeking other activities and relating to other people.

A possible "benefit" of the stigmatization of fat people has been debated since this could motivate the loss of weight and its maintenance.[42] The health effects and the ethical impacts of such an approach are strongly questioned. As highlighted in the study by Sutin and Terracciano,[39] the discrimination of the body was directly related to the weight gain or maintenance of the fat body. In addition, according to our participants' reports, negative attitudes about the body also seemed to impinge on them and prevent them from pursuing activities that captivated them and from building affective bonds.

Understanding about body image thus seems to be important to specify personal, social and psychological experiences of having a fat body and also to think of new care strategies for people with such body condition.

Opinions about the body itself and the making the fat body docile

During the individual interviews, some participants reported opinions that others expressed about their bodies. P1 reported that her sister insisted that she seek medical treatment:

> I remember that my older sister commented that I needed to eat less, that I needed to lose weight. When I was 16, she insisted so much with my mother that she took me to an endocrinologist and it was the first time I started having a treatment.

The same participant reported the doctor's addressing, in which he expressed his opinion about her body:

> [...] He would say to me, "Today you are 22. You will see, by the time you are 25, it is going to be much harder for you to lose weight." By the time I was 25, he said, "When you are 28, it is going to be much more difficult." And then, "The day you are a mother, it is going to be even harder."

Only P9 reported a positive experience with her body: "[...] My husband loves me, he says he likes his chubby one, he does not want me to lose much weight."

Impacts of stigmas suffered by people with fat bodies can also be observed in the study by Lewis et al.[43] The authors have carried out a qualitative study in which, through semi-structured interviews, they have investigated how obese adults would describe the different types of stigma they had suffered, how they responded to it, and how this experience impacted their health and well-being. One participant reported a stigma experience at work:

> […] My manager would say that I had to lose weight because it was affecting my job. I work creating websites for people with physical disabilities. My weight is completely irrelevant.

Other participants in the study by Lewis et al.[43] reported that they often felt that they did not belong to some places, such as in clothing stores, in which they reported how the clerks would make them feel ashamed for simply looking at fashion items. Some participants also reported embarrassing experiences in doctors' offices:

> When I go to doctors' offices I can not sit in the chair because the moment I do it I get stuck in them. This is annoying and embarrassing.

One can understand these reactions in view of the fat body when it is assumed that at the end of the eighteenth century the body would be valued as a production force, becoming a focus of great investment.[44] It is in such context that idleness assumes a negative connotation[45] and the body becomes a biopolitical reality endorsed by medicine.[46] The same medicine which, according to Foucault,[46] turns to the relation body/labor force only in the last moment of constituting the medical power, being configured as a biopolitical strategy. And this would be understood as: "This attempt, starting from the 18th century to rationalize the problems posed to governmental practice by phenomena characteristic of a set of living beings forming a population: health, hygiene, birthrate, life expectancy, race" (2008, p. 431[47]).

Once the body is understood as a productivity agent, the fat body receives social representations as slow, unproductive, lazy and pernicious[45] and begins to be scrutinized by medicine. Research

such as the ones by Cori, Petty & Alvarenga[48] and Swift et al.[49] show fairly discriminating attitudes from the general population toward fat people, including health professionals, as pointed out in the statements above. The first study has aimed at identifying nutritionists' attitudes regarding obesity. The results showed that there are important stigma and prejudice against obese people. Characteristics cited by these professionals included: glutton (67.4%), unattractive (52.0%), clumsy (55.1%), without determination (43,6%) and lazy (42,3%).[48]

Allied with capitalism, medicine makes possible a greater exploitation of the workforce and making bodies docile, more malleable[44] in the search to increase its useful force through exercises, surveillance and inspections.[50] Subject to medical discourse forces, the body had been worked and subjected to a relation of docility-utility, which Foucault[51] has called "discipline." Then, as pointed out by Novaes,[52] women freed themselves from their corsets and began to be contained "in the tightness of their measurements" (p. 39). In this way, the torture of the corset was replaced by the medical discourse, which, seeking to ensure health, subjected the body to new sacrifices.

The body begins to be molded by gymnastics and, intriguingly, the most used term is "to work out," as if forging iron, carving(again), repairing, modifying every part of the body.[44] Such construction incorporates symbolic connotations of success, self-control, class and competence into the ideal body image: lean, young, white, and middle-class. To its negative aspects are incorporated others such as lack of willpower, laziness and weakness.[3] In this context that links thinness to a moral virtue – as stated in P8's speech, "One has to feel ashamed." – Dirce de Sá Freire[53] points to the substitution of the need for confession of sins by the act of stepping on a weighing scale, accountable to society.

As a reflection of the constant pressures on the body, participants in the present study reported resorting to different strategies for weight loss, such as hiring personal trainers, having therapeutic and medical follow-up, endeavoring to engage in physical activities without professional supervision and excessively, taking drugs to lose weight and following different diets. On the latter strategy, the attempts reported by them were diverse:

> [...] I have already followed the macrobiotic diet. I have already followed that diet to detoxify. Eight days eating only brown rice. I have already eaten garlic too. Every day I would eat a small piece of garlic [...] (P2).
>
> […] I've eaten passion fruit flour, bean flour, and I've had tea to drink for weight loss (P4).

Some participants reported having followed commercial diets. P12, for example, reported that she had used the (American company) Weight Watchers International diet plan but she did not adapt to the portions and quantities proposed. P13 reported that her last attempt had been the (low-carbohydrate diet promoted by American physician and cardiologist Robert Atkins) Atkins

Diet. And P3 had for many years (meal replacement) weight loss health shakes. It is seen that the pain and sacrifice of physical exercise not only shape the body, but the character, being then accepted, as P12 presented: "I had never performed physical activity and I thought it was not the worst thing in the world. It may not be the best, but I need it."

The symbolic and social construction around the body creates a relation of power over such a body, which can be classified, named and typified. However, for Foucault, this power is diffuse and non-repressive, produced at all levels and relations.[45, 54]

The speeches highlighted at the beginning of this section indicate the appropriation of the medical discourse about the body in the family space and the relation with morality (here associated with punishment only to those who need to lose weight). The same idea was repeated when the participants were already engaged in the intervention, when they mentioned third-party expectations about their bodies. For example, for P3 her family members would present surveilling and critical attitudes, demanding weight loss and not supporting the changes she was about to make:

> They talk like that, "You're the one who is on a diet. You're the who has to lose weight. You can not punish us into eating diet food because we do not need this."

This exercise of continuous power, which makes bodies docile, is also internalized by the participants themselves, as pointed out in speeches by P8 and P10:

> [...] I noticed that we ourselves talk bad about ourselves because we are overweight or obese (P8).

> [...] I'm aware of what I want and need and that I will feel happier if I lose more weight (P10).

At the beginning of the intervention, some participants showed a different view of their bodies when seeing themselves in photos or their images in mirrors:

> [...] I look at the photos and I say, "Wow! How can that be? Such an awful thing" [...]. Today I'm 247 pounds but I do not have that image of my body. I look in the mirror and I do not think I'm the same as the girl in the picture (P1).

In addition, all participants reported negative feelings about their bodies at the intervention initial stage, such as: "I'm not satisfied" (P1); "I'm not well with my body." (P10 e P12); "With my body... I think it's bad." (P11); and "I feel bad about my body, bad indeed." (P14).

Some participants shared how they related their body condition to changes in their lives. P10 reported as follows:

> I've had several medical examinations to see if it had anything to do with the thyroid and it didn't [...]. I felt such a sense of relief but also frustration because it meant that it was myself, that it was not my organism.

P14 reported that she related her bodily condition to "shamelessness" on her part: "[...] It's rather naughtiness, it's all psychological. I'm not hungry like this. I eat just because." And P13 said that she had already tried "everything." But completed: "[...] Everything in quotation marks because if I had tried everything I would have succeeded."

In these statements it is emphasized that the fault for the "failure" in the process of weight loss is always attributed to the participant's failure and not to the strategy chosen, which, unfortunately, is not even questioned. Other responses regarding their current weight included emotional aspects such as anxiety (P1, P2, P9, P12) and to letting themselves go while taking care of other people (P10).

In order to question and provoke discussions about the social construction of the fat body, this intervention seemed to allow greater appropriation and affirmation of their bodies. Our goal with the intervention proposed was to promote changes considering the participants' current weight and that we would not prescribe a diet or any other prescription to them. We would be anchored at the HAES® principle which states that moving towards a healthier lifestyle shall in time result in a more adequate body weight (when and if necessary).

Some participants said it was a relief that the intervention would have a nonprescription diet plan and that they had no expectations about it ("I was relieved, I said, 'Thank God, no one has a great plan for me'" – P10). As for the first focus group, conducted at the beginning of the intervention, some participants showed some change from previous expectations. They noticed that although they had not had some great weight loss, they felt more motivated to continue with the intervention:

> [...] I did not see a big difference in the weighing scale. But on the bright side I realize that I have more courage, more desire to continue it (P13).

Participants also appeared to have more realistic expectations regarding their bodies, which also seemed to have impacted their motivation to remain in the intervention. After a few months of intervention, the participants mentioned that the image in the mirror still would not fit the image they had of their body, as highlighted in the following speech:

> [...] When I see a photo, a video, I say... Folks! I do not believe that I'm that size! Because there in the mirror it does not seem like it, it seems I'm smaller (P5).

Still, in the last focus group participants mentioned that although they were not completely satisfied with their current body condition, they did in fact change some of the previous paradigms and matured their opinions:

> [...] I'm satisfied with the process because I know it's a slower process. I have to respect my rhythm and not say, "Ah, since I'm like that then let it go." (P10).

During the intervention, discussions involving the subject of body image were addressed in the three spheres involved (nutritional counseling, physical activity and philosophy). It seems that one of the contributions of addressing this issue was in helping participants understand how the body image-building process takes place, which empowers them to cope with the various expectations about the body and also helps them to be more comfortable with their current body condition.

Moving the body

Regarding the practice of physical activities, some participants reported having been very active children or adolescents, showing themselves as engaged in sports activities at school, clubs or even as part of daily childhood games: "When I was young I loved to run, no one would match me, I loved running [...]" (P2). Or else, "Until I was 16 I would play sports. Therefore I would practically live at the club. I would go to school, then to the club and back home at night." (P9).

Over time, increased responsibilities made these moments no longer a priority. They reported activities that they started and enjoyed but did not continue, such as dancing, performing Pilates, walking in parks, going to the gym. However, at the beginning of the intervention there were few participants who reported routinely engaging in physical activities in addition to those proposed in the research.

P2 reported, for example, that her bodily movement away from the activities on sports courts would involve household chores. P1 reported that she was very fond of dancing but over time he lost the pleasure in performing this activity and consequently lost interest in going out for it. As for P8, she reported that although she was very fond of dancing, she should highlight her body condition as a reason to discontinue the activity:

> [...] I used to be skillful in dancing. Today I have no such skills whatsoever and that weighs on me. My belly weighs me down, my legs weigh me down, my breathing is difficult, these things I do not have anymore.

Moreover, experiences of judgment and criticism from professionals seemed to discourage participants from joining new activities. P8 highlighted some perceptions about the environment at gyms:

> […] When you go to a gym, those people are not affectionate towards you. They look like, "That fat woman, you know, she can not lift even three kilos."

This central idea highlighted an experience of judgment and criticism about the participants' body condition and physical capacity:

> I started doing gymnastics and the coach would make comments like... That I could not reach, that I was too slow... The trauma that I already have about this kind of increased, you see? (P3).

Alvarado, Guell and Murphy[55] have conducted a qualitative study to identify barriers to physical activity and explore aspects facilitating its practice. The sample involved overweight and obese women and semi-structured individual interviews were carried out. Among the barriers mentioned by the participants, social, structural and health-related aspects were highlighted. The former were related to gender norms and associated expectations. For example, women reported that they tended to be more active with female peers and that the possibility of being active also competed with family responsibilities. The structural barriers cited included the difficulty of moving from one place to another, the limited space for physical activity at home and the limited possibility of access to paid physical activity sites. On the other hand, some activities that were highlighted as being feasible and successful included walking and engaging in low cost physical activity groups.

Toft & Uhrenfeld[56] have done a qualitative literature review to identify facilitating and limiting factors for the practice of physical activity from the experiences of class III obese adults. Eight studies were included and in all it was observed that the experiences of loss and gain of body weight had impacts on the participants. Often, physical activity had been driven by weight loss or due to being a tool for managing body weight.

For example, having body weight measured was mentioned as a necessary strategy to keep participants engaged in physical activities and also related to the participant's perception of success or failure.[56] When the weight loss was small or very low, participants' negative attitude to continue the activities would be observed. Illustratively, in one of the studies it was reported: "You can not stay engaged in physical activity if you do not see results."

The expectation of achieving a certain body weight would be related not only to an expected body pattern but also to more freedom, new possibilities and to becoming more attractive. However, excessive focus on body weight has also raised negative perceptions from some participants, such

as, for example[56]: "Having the measurements and body weight checked and hearing that you are guilty was not good."

Another factor mentioned as an obstacle to the practice of physical activity was autonomy, as highlighted in the following speech[56]: "Give me a personal trainer to get me out of bed every day and make me work out and, yes, I would lose weight."

The emphasis of physical activities offered during our intervention was on health promotion and body movement, with no focus on intensity, structure and duration of activities nor on body weight. Physical educators were prepared to deal with participants' feelings – such as fear, disappointment and shame – that might emerge in physical activities in an empathic and collaborative way. Before starting physical activities and throughout the intervention, participants would be able to express their opinion about what kind of physical activities they considered would be most enjoyable to perform. This empathic attitude from the physical educators seemed, in itself, to be a determining factor for the participants' engagement in the activities on sports courts, as highlighted in P13's speech:

> [...] I think they [the physical educators] are the base. They are always with us there and it gives us a lot of energy. Everywhere you go, they greet you... I think this is a special affection of the program like that in general.

The way physical activities were proposed also seemed to have benefited the participants:

> My biggest difficulty in performing physical activities in other places would be my body shame and here I am not ashamed because we are practically all on the same level (P3).

As a result, as the intervention progressed, participants presented speeches that seemed to show that moving the body became more present in their lives and, more importantly, it became something pleasurable and sustainable. In the last focus group, the participants self-assessed and evaluated how they would be some years ahead. They reported that they were more involved with physical activities, taking advantage of city sites:

> [...] I've ended up going out more. There are libraries, museums. I can walk and walk back, there are a lot of parks. Therefore I see myself taking more advantage of what the city offers, which also provides a better quality of life (P10).

Participants also highlighted benefits of body movement beyond weight loss, such as improved physical endurance, improved thinking (P1, P2, P3, P9, P10, P12), more agility (P2, P8, P9, P10, P12, P13, P14), improvement of chronic diseases and reduction of the use of medicines (P9, P10,

P11, P12, P13, P14), decreased stress and improved sleep quality (P8, P10, P11). It seems that physical activities as proposals in our intervention provided facilitating aspects for the inclusion of corporal practices in the participants' day to day.

Differently from the barriers observed in the literature review by Toft & Uhrenfeld,[56] body weight was not a determinant factor for our participants' adherence to physical activities. On the contrary, it seems that the distance from this expectation, as explored in previous interpretive axes, made the participants more engaged in the activities and allowed them to highlight other gains as being successful. In addition, they appeared to be autonomous to insert different physical activities in their daily lives, which probably reflects the difference between this approach and another one, more prescriptive, upright and passive.

It is evident that moving the body is vital to enable health enhancement and quality of life. It is known that it is important to be active but it seems important to look at how it is approached and how such body movement is proposed. Strategies traditionally proposed – often focused solely on energy expenditure and performance – appear to have had no sustainable effects. On the other hand, it seems that proposing activities that encourage body movement and retrieve the pleasure of moving the body is more effective and even stimulates the insertion of new activities in the routine, as was seen with our group of women.

Conclusion

The objective was to qualitatively analyze obese women's perceptions about having a fat body and how they experienced and were impacted by this body condition before and after participating in a non-prescriptive, multidisciplinary intervention based on the "Health at Every Size®" approach.

Participants reported that the overweight had an impact on their personality, making them less susceptible to social interactions and relationships in earlier life cycles and also into adulthood. From the stimuli of the intervention, they reported being more motivated to build new affective relationships. They also reported experiences of bullying and discrimination on their bodies, such as from doctors and family members, which pressured them to seek different ways of losing weight.

On the other hand, the different strategies used in the intervention, according to the participants' speeches, have made them more empowered to deal with expectations about their bodies, helping them to feel more comfortable with their current body condition. Finally, while at the beginning of the intervention participants reported negative experiences associated with physical activity and were resistant to them, at the end of the follow-up period they were motivated to insert more physical activities into their routines and reported physiological and psychological gains arising from increased body movement.

It was possible to see that there was a symbolic and social construction on the body, establishing a relation of power over it. This construction is influenced by several discourses, which in turn contribute to making the body docile. It seems possible to conclude that understanding the body strictly by biological optics has been increasingly a limiting and reductionist strategy, restricting the possibilities of health care.

The HAES® approach overcomes such limitation, since it has as its principle to encourage the construction of a positive body image. However, studies that were based on such approach did not report evaluating the participants' perception about their body condition, reducing the possibility of observing the potentiality of such a strategy. In the present study, we have seen that encouraging this principle seems to be a possibility for questioning the moralization of the fat body, contributing to the construction of a more positive body image and overcoming social representations usually associated with such body condition (such as slowness, lacking productiveness, laziness).

Ultimately, it seems that the format proposed in this intervention has not reinforced the mechanism of making fat bodies docile and has contributed to the empowerment of people who once experienced such a mechanism. Moving towards a broader understanding of this body condition, as highlighted in this paper, seems to contribute to the construction of new possibilities for interventions and lead to the change of people who have a fat body.

Acknowledgments

The authors would like to thank the participants for their trust and collaboration during the study and the scholarships granted by Foundation to Support Research of the Brazilian state of São Paulo (*Fundação de Amparo à Pesquisa do Estado de São Paulo*; FAPESP, in the Portuguese abbreviation) (numbers 2012/12035-0 and 2015/12235-8), Brazilian National Counsel of Technological and Scientific Development (*Conselho Nacional de Desenvolvimento Científico e Tecnológico*; CNPq, in the Portuguese abbreviation) (numbers 309121/2012-4 and 311357/2015-6) and Brazilian Coordination of Improvement of Higher Education Personnel (*Coordenação de Aperfeiçoamento de Pessoal de Nível Superior*; CAPES, in the Portuguese abbreviation).

References

1. Chapman GE. From dieting to healthy eating: an exploration of shifting constructions of eating for weight control. In: Sobal J, Maurer D. Interpreting weight: the social management of fatness and thinness. New York: Aldine de Gruyter; 1999. p. 73-87.
2. Sobal J. Social and cultural influences on obesity. In: Bjorntorp P, editer. International textbook of obesity. New York: John Wiley & Sons; 2001. p. 305-322.

3. Vasconcelos NA, Sudo I, Sudo N. Um peso na alma: corpo gordo e mídia. Revista Mal-Estar e Subjetividade 2005; 4:65-93.

4. Stearns PN. The turning point. In: Stearns PN, organizer. Fat bodies: bodies and beauty in the modern west. New York: New York University Press; 2002. p. 3-24.

5. Scagliusi FB, Lourenço BH. A ditadura da beleza e suas consequências no discurso nutricional. In: Alvarenga M, Scagliusi FB, Philippi ST, organizadoras. Nutrição e transtornos alimentares: avaliação e tratamento. Barueri: Manole; 2011. p. 59-83.

6. Bell K, McNaughton D. Feminism and the invisible fat man. Body & Society 2007; 13(1):107-131.

7. Santolin CB, Rigo LC O nascimento do discurso patologizante da obesidade. Movimento: Revista da Escola de Educação Física da UFRGS 2015; 21(1):81-94.

8. Birman J. A biopolítica na genealogia da psicanálise: da salvação à cura. História, Ciências, Saúde 2007; 14(2):529-548.

9. Canguilhem G. O normal e o patológico. Rio de Janeiro: Forense; 1995.

10. Poulain JP. Sociologie de l'obésité. France: Puf; 2009.

11. Vester K. Regime change: gender, class, and the invention of dieting in post-bellum America. Journal of Social History 2010; 44(1):39-70.

12. Fischler C. Food, self and identity. Social Science Info 1988; 27:275-92.

13. Kessler DA. The end of overeating: taking control of the insatiable American Appetite. New York: Rodale Books; 2009.

14. Sobal J, Maurer D. Interpreting weight: the social management of fatness and thinness. New York: Aldine de Gruyter; 1999.

15. Yaemsiri S, Slining MM, Agarwal SK. Perceived weight status, overweight diagnosis, and weight control among US adults: the NHANES 2003-2008 Study. Int. J. Obes. 2011; 35(8):1063-1070.

16. Montani J-P, Schutz Y, Dulloo AG. Dieting and weight cycling as risk factors for cardiometabolic diseases: who is really at risk? Obes. Rev. 2015; 16 (Supl. 1):7-8.

17. Curioni CC, Lourenço PM. Long-term weight loss after diet and exercise: a systematic review. Int. J. Obes. 2005; 29(10):1168-1174.

18. Rolland C, Johnston KL, Lula S, Macdonald I, Broom J. Long-term weight loss maintenance and management following a VLCD: a 3-year outcome. Int. J. Clin. Pract. 2014; 68(3):379-387.

19. Siahpush M, Tibbits M, Shaikh RA, Singh GA, Kessler AS, Huang TT-K. Dieting increases the likelihood of subsequent obesity and BMI gain: results from a prospective study of an Australian national sample. Int. J. Behav. Med. 2015; 22(5):662-671.

20. Association for Size Diversity and Health. ASDAH [Internet]. [acesso em: 15 abr. 2016]. Disponível em: https://www.sizediversityandhealth.org/

21. Provencher V, Bégin C, Tremblay A, Mongeau L, Corneau L, Dodin S, et al. Health at every size and eating behaviors: 1-year follow-up results of a size acceptance intervention. J. Am. Diet. Assoc 2009; 109(11):1854-1861.

22. Gagnon-Girouard MP, Provencher CBG, Tremblay A, Mongeau L, Boivin S, Lemieux S. Psychological impact of a "Health-at-Every-Size" intervention on weight-preoccupied overweight/obese women. J. Obes. 2010; 1-12.

23. Borkoles E, Carroll S, Clough P, Polmand RCJ. Effect of a non-dieting lifestyle randomised control trial on psychological well-being and weight management in morbidly obese pre-menopausal women. Maturitas 2016; 83:51-58.

24. Bacon L, Stern JS, Van Loan MD, Nancy L, Keim NL. Size Acceptance and intuitive eating improve health for obese, female chronic dieters. J. Am. Diet. Assoc. 2005; 105(6):929-936.

25. Leblanc V, Provencher V, Bégin C, Corneau L, Tremblay A, Lemieux S. Impact of a health at every size intervention on changes in dietary intakes and eating patterns in premenopausal overweight women: results of a randomized trial. Clin. Nutr. 2012; 31:481-48.

26. Humphrey L, Clifford D, Morris MY. Health at Every Size college course reduces dieting behaviors and improves intuitive eating, body esteem, and anti-fat attitudes. J. Nutr. Educ. Behav. 2015; 47(4):354-360.

27. Dalen J, Smith BW, Shelley BM, Sloan AL, Leahigh L, Begay D. Pilot study: Mindful Eating and Living (MEAL): weight, eating behavior, and psychological outcomes associated with a mindfulness-based intervention for people with obesity. Complementar Ther. Med. 2010; 18(6):260-264.

28. Bacon L, Aphramor L. Weight science: evaluating the evidence for a paradigm shift. Nutr. J. 2011; 10:9-21.

29. Ulian MD, Gualano B, Benatti FB, Campos-Ferraz PL, Roble OJ, Modesto BT, et al. "Now I can do better": a study of obese women's experiences following a non-prescriptive nutritional intervention. Clin. Med. Insights: Women's Health 2015; 8:13-24.

30. Ulian MD, Benatti FB, Campos-Ferraz PL, Roble OJ, Unsain RF, Sato PM, et al. The effects of a 'Health at Every Size' based approach in obese women: a pilot-trial of the 'Health and Wellness in Obesity' study. Front. Nutr. 2015; 2(34):1-12.

31. Ulian MD, Scagliusi FB, Sato PM, Modesto BT, Benatti FB, Gualano B, et al. Saúde e bem-estar na obesidade: paradoxo ou possibilidade? Rev. Cul. Ext. 2015; (14):123-131.

32. Ulian MD, Gualano B, Benatti FB, Roble OJ, Campos-Ferraz PL, Unsain RF, et al. Strategies for the care of obese: a non-prescriptive nutritional perspective. In: Entrena-Duran F, organizer. Food production and eating habits around the world: a multidisciplinary approach. New York: Nova Publishers; 2015. p. 73-88.

33. Motta DG. Aconselhamento nutricional. In: Motta DG, organizador. Educação nutricional & Diabetes tipo 2. Piracicaba: Jacintha; 2009. p. 27-33.

34. Lima A, Gualda DMR. História oral de vida: buscando o significado da hemodiálise para o paciente renal crônico. Rev. Esc. Enferm. USP 2001; 35(3):235-241.

35. Paulilo M. A pesquisa qualitativa e a história de vida. Serviço Social & Sociedade 1999; 2:135-48.

36. Thompson P. A voz do passado: história oral. Rio de Janeiro: Paz e Terra; 1992.

37. Schwartz MB, Brownell KD. Obesity and body image. Body Image 2004; 1:43-56.

38. Goffman E. Stigma. Notes on the management of spoiled identity. London: Penguin; 1968.

39. Sutin AR, Terracciano A. Perceived weight discrimination and obesity. PLoS ONE 2013; 8(7):e70048.

40. Puhl R, Peterson J, Luedicke J. Fighting obesity or obese persons? Public perceptions of obesity-related health messages. Int. J. Obes. 2012; 37(6):774-82.

41. Degher D, Hughes G. The adoption and management of a "fat" identity. In: Sobal J, Maurer D, organizers. Interpreting weight: the social management of fatness and thinness. New York: Aldine de Gruyter; 1999. p. 11-27.

42. Bayer, R. Stigma and the ethics of public health: not can we but should we. Soc. Sci. Med. 2008; 67(3):463-472.

43. Lewis S, Thomas SL, Hyde J, Castle D, Komesaroff PA, Warwick Blood R. "I don't eat a hamburger and large chips every day!": a qualitative study of the impact of public health messages about obesity on obese adults. BMC Public Health 2010; 10:309.

44. Araújo EMN, Meneses JR. Histórias do corpo e do feminino no Brasil do tempo presente. Anais do XXVI Simpósio Nacional de História; jul. 2011; São Paulo: ANPUH-SP, 2011; 1:1-12.

45. Silva TMG. O corpo feminino sob tirania na pós-modernidade. Rev. Unifarmma 2013; 12(1):41-54.

46. Foucault M. Microfísica do poder. 8 ed. Rio de Janeiro: Graal; 1989.

47. Foucault M. Nascimento da biopolítica: curso dado no Collège de France (1978-1979). São Paulo: Martins Fontes; 2008.

48. Cori GC, Petty MLB, Alvarenga MS. Atitudes de nutricionistas em relação a indivíduos obesos: um estudo exploratório. Ciênc. Saúde Coletiva 2015; 20(2):565-576.

49. Swift JA, Hanlon S, El-Redy L, Puhl RM, Glazebrook C. Weight bias among UK trainee dietitians, doctors, nurses and nutritionists. J. Hum. Nutr. Diet. 2013; 26:395-402.

50. Nespoli N, Novaes JV, Rosa CM. O corpo na cultura: obesidade como doença, biopolítica e normalização. Desafios: Revista Interdisciplinar da Universidade Federal de Tocantins 2015; 1:149-168.

51. Foucault M. Vigiar e punir: nascimento da prisão. 14 ed. Vozes; 1996.

52. Novaes JV. Com que corpo eu vou? Sociabilidade e usos do corpo nas mulheres das camadas altas e populares. Rio de Janeiro: Ed. PUC/Pallas; 2010.

53. Freire DS. Com açúcar, sem afeto. In: Del Priore M, Amantino M, organizadores. História do corpo no Brasil. São Paulo: Editora Unesp; 2011. p. 453-476.

54. Berg R. Medicina, Freud e obesidade: diálogos multidisciplinares sob a perspectiva de Foucault. Ágora: Estudos em Teoria Psicanalítica 2011; 14(2):183-196.

55. Alvarado M, Guell C, Murphy M. Barriers and facilitators to physical activity amongst overweight and obese women in the Caribbean: a qualitative study. International Journal of Behavioral Nutrition and Physical Activity 2015; 12:97.

56. Toft BS, Uhrenfeldt L. The lived experiences of being physically active when morbidly obese: a qualitative systematic review. Int. J. Qual. Stud. Health Well-being 2015, 10: 28577.

Received: April 15, 2016
Reviewed: August 3, 2016
Accepted: August 17, 2016