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# Interfaces between *fatphobia* and the professionalization in nutrition: an essential debate

# Interfaces entre a *gordofobia* e a formação acadêmica em nutrição: um debate necessário

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## Abstract

The study proposes to reflect on how nutrition training is likely to reproduce *fatphobia*, and the risks imposed on fat people by this oppression. *Fatphobia*, as a discrimination against fat individuals, resulting from stigmatization, translates into inequalities in the most diverse environments, affecting biological, psychological, social and economic levels. The hierarchy between populations considered to be more or less healthy, based on the medical-statistical logic polarized between normal and pathological, supports the predominance of physiology in the study of health sciences, consolidating practices of intervention and control over deviants, as preventive measures. The theoretical formation, as a definition of the practice, presents dilemmas creating a trend of pathological action, directing the Courses of Nutrition to prioritize economic interests to the detriment of social demands. This pathologization contributes to the maintenance of the health model that corroborates the incessant search for the ideal body type, favoring the commodification of health practices. The conceptual and theoretical debate is essential for the discussion of the practical approach, since the belief in obesity as a reflection of the moral qualities of individuals has important social consequences. Worse yet, when reproducing the stigmatization of fat people, professionals distance them from access to health services. In order to develop humanized practices, promoting health and recognizing the individual in his historicity and socialization, it is necessary to develop other concepts of health, since the clinical-biomedical approach is insufficient to perform satisfactorily before this complexity.

**Keywords**: Prejudice. Social stigma. Obesity. Risk.

## Resumo

Este estudo propõe refletir sobre como a formação em Nutrição é passível de reproduzir *gordofobia*, e os riscos impostos às pessoas gordas por essa opressão. A *gordofobia*, enquanto discriminação dos indivíduos gordos, consequente da estigmatização, traduz-se em desigualdades nos mais diversos ambientes, repercutindo nos níveis biológico, psicológico, social e econômico. A hierarquização das populações consideradas mais ou menos saudáveis, baseada na lógica médico-estatística polarizada entre normal e patológico, sustenta a predominância da fisiologia no estudo das ciências da saúde, consolidando práticas de intervenção e controle sobre os desviantes, como medidas de prevenção. A formação teórica, enquanto definidora da prática, apresenta dilemas criando uma tendência de atuação patologizante, direcionando os Cursos de Nutrição a priorizarem interesses econômicos em detrimento das demandas sociais. Essa patologização contribui para a manutenção do modelo de saúde que corrobora a busca incessante pelo tipo corpóreo ideal, favorecendo a mercantilização das práticas em saúde. O debate conceitual e teórico mostra-se essencial para a discussão da abordagem prática, uma vez que a crença na obesidade enquanto reflexo das qualidades morais dos indivíduos tem importantes consequências sociais. De forma agravante, ao reproduzir a estigmatização das pessoas gordas, os profissionais as afastam do acesso aos serviços de saúde. Para desenvolver práticas humanizadas, promotoras de saúde e que reconheçam o indivíduo em sua historicidade e sociabilização, é preciso desenvolver outras concepções de saúde, já que a abordagem clínico-biomédica se mostra insuficiente para atuar de maneira satisfatória diante desta complexidade.


**Palavras-chave**: Preconceito. Estigma social. Obesidade. Risco.

## Introduction

In the hegemonic perspectives of health, obesity and its unfoldings have been studied for some decades. In the field of Nutrition, it is pointed not only as pathology - defined as an excessive or abnormal accumulation of fat in adipose tissue - but as an important risk factor for other diseases.[1] Despite this, we lack studies that go deeper in the evaluation of the therapeutic approach to obesity and its effects.

Since before obesity entered the list of chronic noncommunicable diseases (NCDs), leaving behind concern for nutritional deficiencies and hunger, the science of Nutrition reproduces biomedical thinking.[2] The pathologization of the fat body, as something to be studied, treated and prevented, began in the period called Epidemiological Transition - between the 1940s and the early 2000s, when the causes of mortality changed. In this period, infectious diseases gave way to degenerative diseases (heart disease, cancer, metabolic diseases), also called NCDs.[3,4]

The increased levels of obesity (and decreased levels of malnutrition) experienced in the last 40 years as a consequence of changes in the population's way of life - industrialization, urbanization, sedentary lifestyle and changes in eating habits - is also known as Nutritional Transition.[5]

According to the Family Budgeting Survey (Pesquisa de Orçamentos Familiares - POF), more than 50% of the Brazilian population was overweight, and about 16% of the adult population was in some degree of obesity in 2009.[6] In order to solve the problem, as well as the other professions of Health, the science of Nutrition began to focus on the study of obesity, reproducing traditionally biomedical thinking, starting from the assumption of this as a disease that must be treated from a biological-nutritional point of view and as a risk factor for other diseases.[7] In the last two decades, the World Health Organization (WHO) has considered the existence of an "obesity epidemic", which influences the increase of public policies aimed at weight loss.[2]

So, obesity is commonly and simplistically defined as a disease resulting from a positive energy balance, i.e., higher caloric intake and lower energy expenditure. It is considered as a cause of functional disability, reduction of quality of life, reduction of life expectancy and increased mortality. Chronic conditions, such as kidney disease, cancer, diabetes *mellitus* type 2, sleep apnea and systemic arterial hypertension, are directly related to functional disability and obesity. Several epidemiological studies have led to the belief that weight loss leads to the improvement of these diseases, reducing risk and mortality.[1,8]

Many studies, however, question the causal relationship between high BMI and the risk of cardiovascular diseases and chronic noncommunicable diseases. Some of these studies also point to obesity (according to the standard established by BMI) as a possible protective factor against mortality, emphasizing the need to develop and use other methods of risk prediction to replace BMI.[9] In addition, reports of patients considered obese indicate that health professionals are an important source of prejudice.[10] International studies found negative attitudes to obesity among physicians, nurses, psychologists, physical educators and nutritionists.[11] There was evidence of significant implicit prejudice, including by obesity specialists.[12]

If on the one hand we can identify ways of reproducing *fatphobia* and normativity, on the other hand we find an absence of possibilities and techniques of performance that use a concept

of health broader than the hegemonic one. This work explores these shortcomings and presents the challenge of developing new approaches and tools for action in Nutrition.

The construction of this object of study, as Bosi[13] points out, "represents a dynamic process that occurs at the interface of the academic with the existential, understanding the political-ideological aspects implied therein". That is, it was not defined in a "neutral or disinterested" way, but well positioned in terms of the material and subjective reality presented. In this way, the present study deals with basic / fundamental, qualitative and exploratory research. The theoretical rescue was based on the sociological and historical analyzes of Bourdieu[26] and Poulain[2,3] about obesity, articulating them with the normal and pathological conception of Canguilhem[14] and the debates on stigma and risk promoted by Goffman[20] and Caponi[21,24]. In addition, the studies of Bosi[13,38] were the basis for the analyzes on the professionalization in Nutrition. Based on these theoretical assumptions, a bibliographical review was carried out on the most commonly used databases in health areas, seeking to recognize the current debates on health conceptions, *fatphobia* and professionalization in Nutrition.

## Discussion

### Normality or variability

The health sciences are dedicated to developing and improving the knowledge necessary for the therapeutic process of what is recognized as pathological. As Canguilhem[14] cites, "To act, one must at least locate it." Thus, with the characterization of the disease, it is believed to recover health, that is, "to restore, in the desired standard, the organism affected by the disease". This means that, when treating pathology, we will conceptualize it as something heterogeneous to health: normal and pathological, as opposing and unrelated conceptions.

As a concept, one can define with certain precision, according to the use of physiology and medicine, the normal as a judgment of value, not of reality, defining the maximum physical capacity of a being. The equivocal confusion of normality with the average of a characteristic of a species was facilitated by the realistic philosophical tradition, which gives an ideal type value to a common character.[14]

An example that illustrates this significance to the term are the studies of Quêtelet, which are the basis of anthropometry and give rise to biometrics, especially the screening tool currently used for nutritional assessment: body mass index (BMI) . Quêtelet, when studying the variability of man's stature, attempted to prove man's submission and regularity to divine laws, thus differentiating the arithmetic median mean from the true mean.[14] That is, the basis of the anthropometric parameters was made in the search for evidence of the natural character of human physical characteristics.

According to WHO, Ministério da Saúde (Ministry of Health) and Sociedade Brasileira de Cirurgia Bariátrica e Metabólica (Brazilian Society of Bariatric and Metabolic Surgery) guidelines, the criterion most used to define an individual's body fat level is BMI, obtained by the ratio between weight and height squared value (BMI = Weight / Height$^2$). Although there are other methods such as waist circumference and skinfolds, the use of BMI is the majority due to its ease of application, agility and low cost.[1]

The problem of a model constructed from a statistic is to disregard the specificities of each group studied, since what is understood as a "deviation to the norm" is, in fact, an inseparably biological and social phenomenon and is directly related with the perspective (worldview) of the observer in relation to the observed subject.

The use of the means hides "the essentially oscillatory and rhythmic character of the functional biological phenomenon",[14] as well as suppresses anthropological variations (i.e., it disregards the cultural context and possible biological variations that may be due to the different cultural patterns that exist, and which will not necessarily be considered "out of the norm" of normality in other cultures) of the same.[2 a]

In this context, the human body becomes the result of social norms, that is, normality would be the product of a normalization between functions and organs whose synthetic harmony is the result of defined conditions. The view of the health professional in relation to the individual considered obese, therefore, is conditioned by a certain social-biological view on how a "healthy" individual should be, based on the belief that the patient should be disciplined and persevering in the treatment, following prescriptions in order to achieve the ultimate goal: weight loss.[15]

The problem of the pathologization of anomalies in search of a homogeneous normality is serious, because it reduces the comprehension of the multifactoriality of obesity to a behavioral factor, contributing to the maintenance of a health model that corroborates the incessant search for a corporeal type seen as ideal, favoring the commercialization of health practices.[3]

Moreover, in a more profound way, by reducing illness to symptoms and complications without considering the context in which it is inserted, we distance ourselves from the perception that the pathology depends on the totality of an individual behavior,[14] that is, we become more distant from an integral understanding of the individual.

In Brazil, for example, despite being counter-intuitive, hunger and overweight are not opposites, but they are related. The food insecurity scenario determined by poverty can induce families to

a Sahlins[16] chronicles life in pre-Columbian Hawaiian societies, where people who, according to Western scientific standards today, would be considered obese, were in fact not just people who were considered healthy, but who were synonymous with beauty, status and power (political leaders).

choose foods with high caloric density associated with low cost. Neuroscience corroborates this assertion in that it reveals neurological mechanisms in which anxiety and stress associated with involuntary food restriction increase the risk of eating disorders characterized by high consumption of high-calorie foods.[17] In addition, there is ample evidence today of metabolic adaptations in response to long and recurrent periods of fasting during life and in the intrauterine period. That is, the absence of food substrate leads to adaptations for energy savings, again increasing the risk of weight gain or metabolic disorders such as diabetes and hypertension.[17]

Evidence from people considered to be metabolically healthy obese has been presented in several studies. Flegal et al.[18] identified the absence of a positive association between obesity grade 1 and mortality, and a negative association between overweight and mortality. The diagnostic method determined by BMI, therefore, presents questions and risks by its generalization, categorizing individuals through a tool originally formulated to health assessments at the population level.[3] In this way, individuals who are not necessarily ill, but who deviate from the criteria of normality established by BMI, are classified as having obesity, understood in this context as a pathology to be treated.

The way we consider variability - as a threat to normativity or as a path to a new form - will define how we will see the living being carrying a new characteristic. Therefore, the conceptual and theoretical debate is essential to discuss the practical approach in health.

The theory of Canguilhem[14] defends the capacity of self-preservation and adaptation of the human being, the biological normativity being incapable of accompanying this process. The obese individual would then be anomalous, not abnormal, because, in general, he/she expands his/her own standards of compatibility with life.[19]

At the moment when the norms adopted hegemonically by the health area are questioned, questions arise about the limits of the practice in health, the consequences of this process and the relationships of this with the professional practice. And the practical result for individuals who deviate from this normative health is the experimentation of stigma.

## Stigma and prejudice

Stigma is defined by Goffmann[20] as a process that tends to devalue individuals considered "abnormal" or "deviant", who are classified as such by other individuals. And, from the moment a particular pattern is termed as deviant, this classification alone would justify discriminatory and excludable attitudes to a greater or lesser degree.

The concept of biopolitics also provides explanations for the hierarchy of populations considered more or less healthy. In the context in which biopolitics establishes itself as a

"government over life", based on the medical-statistical logic of polarization between normal and pathological, an overlapping of the vital to the political is seen, sustaining the inequalities between population groups.[21]

The anticipation and prevention of all forms of possible dangers would be, in liberal or neoliberal society, the form of population control, raising the idea of risk "as a probabilistic quantification of everything that could represent a danger or threat to the life of the populations". That is, the State exercises power over the population in the name of security and through the mechanisms of risk-security.[21]

The exclusivity given to biological facts secondarily reflects the political dimension of existence, as well as the capacity for reflection and argumentative dialogue, social bonds and affections.[21] Biopolitics, therefore, becomes a way of managing and administering the populations, reducing the citizens to the body-species existence, because:

> [...] the safety devices allow treating the population as a set of living beings that have particular biological and pathological features, which correspond to specific knowledges and techniques. To manage this population, policies will be created to reduce child mortality, prevent epidemics and endemics, and intervene in living conditions, with the aim of modifying them and imposing norms on food, housing, urbanization, etc.[21]

The stigmatization of fat people reduces this population to its corporal or behavioral characteristic considered as abnormal, and discriminates by it, thus establishing a collective control over its body and limiting its action in the political sphere. These mechanisms result in the belief that obesity is a reflection of the moral qualities of individuals, especially the lack of control, although it is not only characterized by criticism to the individual but by a series of interactions of a wider order that demean them and turn them into a culprit for their devaluation.[2]

As summarized by Silva and Ferreira:[19]

> The body considered fat suffers a stigma before the society by its moral bankruptcy, as well as a pathologization by certain corporal dimensions defined biologically inadequate by the biomedical reference.

The consequences of stigma are the exclusion and oppression of the group in question. Among several other illnesses, fat stigma affects the self-esteem of fat people, with important social consequences, such as reducing the chances of indication for job vacancies, worsening of psychosomatic disorders and stress-induced diseases.[22]

The failure to conform to the established norms of identity has a direct effect on the psychological integrity of the individual, since the rules lead one to believe that the simple will would solve a "deviation" that is actually the result of a social construction.[20] In addition, social relations and the relationship with one's own body are significantly affected by this search for health and aesthetics, since they ground personal identity and the sense of belonging to a particular social group. The prejudice experienced in affective relations presents the definition of the fat body as a result of laziness, failure or neglect.[19]

Stigma then generates a cycle of oppression, as it presents a range of norms and value judgments - emitted by the media as well as by the health professionals themselves - about how the fat individual must build his/her personal identity, health, and behaviors. And dissatisfaction with one's own identity, in turn, feeds a marketing component that promises to "correct" his/her appearance with slimming ideals.[23]

Practically, in reproducing the stigmatization of fat people, health professionals distance individuals from access to health services - because it extends this suffering to a social space of vulnerability of the subject as a patient - which makes them even more vulnerable because they have neglected other health / disease factors to the detriment of their stigma.[3]

Therefore, it is necessary to question the present hegemonic health model, and consequently, the health conception that underlies it. Caponi[24] states that:

> Health does not belong to the order of calculations, it is not the result of comparative tables, laws or statistical means, and therefore, its study is not exclusive to biomedical investigations, whether quantitative or not.

However, at present, academic health education is still "absolutely biological": the disease is studied, not health.[25] In an aggravating or even causal way, the scholar of the health area is least interested in the meaning of the words "health" and "illness".[14] Thus, the predominance of physiology in the study of health sciences[14] simplifies and fragments human beings, distancing them from their social context, reinforcing the problematic of pathologization and stigmatization mentioned above and allowing the consolidation of intervention and control practices on deviant forms as prevention and safety measures.[21]

Despite the frequency with which the term "obesity" appears in the scientific literature as a chronic disease, it is understood that "much more than an organic condition, obesity is a social fact".[23] And more than a fact, obesity is a social construction. To be considered a disease, it was necessary the context of the nutritional transition, associated to the change in the symbolic values of corporality. Therefore, when we understand these contexts as social processes, the biomedical clinical approach is insufficient to act satisfactorily in the face of such a complex phenomenon.

The conception of the social determination of the process of construction of health and illness allows us to analyze the possible process of illness that people may suffer beyond the biological dimension.[19] Understanding health-disease as a social process means recognizing the existence of conditioning social structures, which act coercively on individuals and their choices. More than that, it recognizes a hierarchy among the factors that promote illness, for example, not putting "lifestyles" on the same level as "socioeconomic condition", but rather the first as subordinate and acting under conditions imposed by the latter.

It is also important to recognize that choices and tastes are not only personal, but a negotiation between the *habitus* and the field,[26] that is, a construction from all the individual conceptions constituted from the history of the subjects in which their subjectivity is constantly re-signified in contact with their personal experiences in relation to the social world. Thus, understanding the health-disease binomial as a broader social process is essential for us to remove the "guilty" gaze over individuals, as if it were enough for them to have "willpower" and "initiative" to change their daily practices, in order to improve their health condition.

## Fatphobia

In the case of people considered obese, in addition to trying to understand the interactional complexity that leads people to gain weight, it should be considered that the statistical-biomedical premise of weight loss for achieving a healthy life can be, in itself, detrimental to social inclusion and political recognition of that person seen as "abnormal."

Considering the above, it is evident the importance of the debate about *fatphobia*. The scarcity of studies on the subject in the scientific bibliography, especially in Brazil, makes it difficult to construct this debate from its conception.[11] The scientific approach found, for the most part, comes from the organization of social groups (Movimento Gordo [b]) that demand strategic actions to combat it.

According to Arraes,[27] cordel literature author and militant of the fat and black causes, it is possible to define *fatphobia* as:

> [...] a form of structured and disseminated discrimination in the most varied sociocultural contexts, consisting of the devaluation, stigmatization and harassment of fat people and their bodies. Fatphobic attitudes generally reinforce stereotypes and impose degrading situations with segregationist purposes; therefore, *fatphobia* is present not only in the most direct types of discrimination, but also in the daily values of people.

b The Movimento Gordo emerges as an attempt to overcome stigma, playing an important role in the acceptance of fat people by society, through structured actions.[5]

Besides that, the *fatphobia* is closely associated with *lipophobia*. The difference between *lipophobia* and *fatphobia* is that the former is characterized as discrimination against fat individuals and their bodies, stigmatizing them in the most diverse possible associations: lack of control, sloppiness, laziness, incapacity, illness, inadequacy, non-belonging.[28] The second is the systematic aversion to "fat in itself," that is, the person's own fear of becoming fat.[29]

*Fatphobia* translates into inequalities in workplaces, health care and education institutions, often because of the generalization of negative stereotypes that overweight and obese people are lazy, unmotivated, undisciplined, less competent and sloppy.[11,22] It has direct consequences in psychological (depression, anxiety, self-image and eating disorders), social and economic levels;[30] in addition to indirect consequences, such as the difficulty of access to health services (promotion, prevention and treatment),[29] reversing in higher costs for the SUS, in the long term. It is, therefore, the consequent marginalization of stigmatization, and the materialization of the biopolitics of obesity, where body mass control is a form of body control.

When biopolitics places life as the object of study of the biological sciences and as a space for governability, it constitutes a scientific and political technology that exerts itself on the anomalous populations, and whose immediate concern is to anticipate the risks. The security mechanisms established for each risk or danger play roles similar to disciplinary mechanisms, maximizing productive forces with diminished political capacity.[21] Thus, the "security pact" that links the State and population of liberal societies not only legitimizes intervention in anticipation of all risks as a compromise - which will not be seen as an excess of power, authorizing the execution of extralegal interventions - but it also creates a collective understanding that subjects themselves are responsible for surveillance and control of risks as a moral duty, since liberalism propagates the idea that anyone is able to anticipate risks if properly informed.[21]

It is this organization that makes the fat body become an object of control both of society and of itself, creating mechanisms of adequacy in the name of preventing risks of complications, i.e., in the name of its safety. In addition, characterization and understanding of *fatphobia* outweigh the subjective aspects, since the issue of accessibility is also an obstacle, materializing in the field of health through the lack of equipment and qualified professionals to attend.

Recognizing, however, the existence of oppression against people considered obese is insufficient, since a broad understanding requires the recognition of social markers (intersectionalities) corresponding to the different factors that demarcate specific territories of experiences in the life of each subject and / or group.[31] Therefore, an important cut-off to be made is the discussion of gender, conceiving it as a historical and cultural construction.[32]

Studies that identify greater vulnerability of women to the pressures of socio-cultural, economic and esthetic standards point to this fact as an aggravating risk for the development of eating disorders.[33]

For the female segment, the requirement of lean bodies is characterized as synonymous with normality.[34] In addition, studies have shown that body image is a predictive factor for the practice of diets, and the frequency of these practices is a risk factor for the development of eating disorders.[33]

When we return to the discussion brought by biopolitics - that control of bodies distances the individual from the political, legal and social environment - it is possible to understand what Wolf says,[35] when stating that: "[the] dietary habit is the most potent political sedative in female history. A quietly hallucinated population is more docile."

This overlapping of control mechanisms causes the overweight women to suffer a peculiar oppression: in addition to the discrimination experienced in social relations, veiled or not, constant vigilance, blame and charging for initiatives that fit the hegemonic aesthetic pattern, they face a battle against themselves, presenting self-disapproval, guilt and greater risk of development of psychological and alimentary disorders.[36]

It is important to understand that this excessive preoccupation with one's own appearance does not come about by chance, but is the consequence of an objectification of the woman who emphasizes appearance as the main aspect of her existence. That is, much of her feelings and identity depends on how the woman sees herself and is seen by others.[36]

## The academic background of the health professional nutritionist

The profession of nutritionist is permeated by gender meanings in its historical constitution, although an inexpressive approach to the subject is identified in the studies about training and practice in Nutrition.[32] The feminization of jobs not only preserves the hierarchy of powers and roles, but also subjects the category to oppressions that weaken performance.

Currently, some studies point to the presence of dilemmas in training / professional performance in Nutrition in Brazil: essentially technical, biologistic, generalist and non-specific.[37]

One of the main Brazilian authors on the subject, Maria Lúcia Bosi,[38] describes us as "essentially technical" professionals, with an emphasis on "biological knowledge" and specialized / fragmented within the area of performance. In addition, Bosi[33] also points to the problem of a broad, superficial and non-specific training.

On the other hand, Costa[39] - that also analyzes the predominant curricular structure in the courses of Nutrition in Brazil, the professional profile and the service to the labor market - argues that the courses of Nutrition are directed primarily to meet economic interests and the labor market, rather than meeting social demands. In addition, it points out the tendency of the Nutritionist to act biologistically, from the perspective of the disease, reducing it to a "deviation", of a purely individual character.

Besides that, it is noted that "nutritionist training is flawed in counseling strategies, behavioral change and body image approach".[11] In other words, in addition to presenting limited goals in therapeutic management, these are predominantly not achieved.

A study carried out by Cori et al.[11], whose objective was to identify nutritionist attitudes towards obesity, found a strong stigmatization of obesity and prejudice against the obese person, attributing to the same characteristics such as: gluttonous, unattractive, clumsy, without determination, lazy and dishonest. Among the most important factors pointed out by the professionals as cause of obesity, there were: emotional and mood changes, food addiction or dependence, sedentary lifestyle and low self-esteem. It should be noted that other factors, such as metabolic-hormonal changes, financial and social situation, and frequent dietary intake were not considered as important by professionals.

The study argues that this simplification of the etiological factors of obesity can lead to the culpability of the individual, neglecting the interaction between genetic inheritance and socioenvironmental factors. In addition, we also discuss the problem of the frequency with which professionals mentioned "lack of awareness" or lack of information as reasons for obesity, which emphasizes individual blame.[11]

An interesting point of the study draws attention to the vigilance of health professionals themselves, who should maintain their "proper weight", as they should be examples, according to the professionals' answers. The disagreement that "obese people can be as healthy as those of normal weight" was also another point discussed.[11]

Considering the theoretical formation as something that defines and conforms the practice of the nutritionist professionals, reflecting in their professional identity and professionalization,[13] it is essential to carry out an analysis of this formation as a fundamental part of the construction of a collective identity and, consequently, of a certain understanding of the category by society.

## Final considerations

Knowing the complexity of factors - media, society, physiology, economy, food, physical activity, infrastructure, development, biology, medicine - that determine what is called "obesity", circumscribe the therapeutic action and approach of the health professional only in biological terms is not only insufficient,[29] but also can be irresponsible.

The discussion of this work is so complex because the control over the fat body happens subtly, though in all spheres of life. Stigmatization distracts the subjects from the determinants of diseases that are present in their everyday territories, moving people away from understanding the need for social organization to cope with them. Besides that, the professional's posture according to the patient's BMI, in addition to stigmatizing and fat-phobic, further undermines this subject, reinforcing the predisposition of these individuals to physical and psychological problems, promoting alienation.

Therefore, it is necessary to have a health education that encourages professionals to be engaged with their knowledge, with the subjects and their living territories, capable of analyzing the social determinants that reinforce the production of inequalities, violations of rights and non-humanization of certain groups.[31]

A theoretical and practical approach to stigma and biopolitics, allowing a critical view on the concepts of normality and pathology - themes that are not limited to obesity and allow the inclusion of diversity in health studies - are fundamental for the training of health professionals who promote universal, integral and equitable assistance, and that are critical and sensitive to the construction of humanized assistance.

Specifically in the field of Nutrition, it is urgent and essential that the "diet mentality" - "defined as social control and consequent malaise that crosses experience with food and the body"[7] - is deconstructed since it interferes in food choices, disempowering and generating loss of autonomy.

Believing in the association of pleasure with eating to the development of obesity - viewed as opposed to the concept of health - not only causes a distortion of this concept, as it does an association of guilt to the act of eating, completely distorting the possibility of exploitation and qualification of the relationship of the body with food, disregarding all other factors involved in this process (taste, memory, culture, availability, among others). Another very common mistaken association attributes to "lack of self-esteem" and "low self-esteem" a cause function of obesity, whereas, in fact, these are consequences of stigmatization.

Even when it is aimed at weight loss, the professional must perform the service with care and attention, with an understanding of the social and cultural vulnerability to which this subject is submitted. Person-centered care - not illness - encompasses the possibility that the individual may develop life re-signification strategies, including eating and exercising.[19] It is not a question of seeking a training that solves social inequities or disease determinants, but rather understanding that social bonds and autonomy renew the senses of healthy living and the supposed hegemonic ideals of beauty.

Expanding the concept of health during academic training allows a broadening of understanding and criticality, in this case, regarding obesity, thus avoiding the displacement of the problem to a psychological sphere[11] as a solution to the feeling of incompetence to approach the subject.

One of the great limits to fight against *fatphobia* is the denial of the existence of the oppression preventing the realization of the self-criticism on the part of the professionals and students, aggravating the persistence of the reproduction of the prejudice during the academic formation in Nutrition. In addition, considering the importance of gender in the construction of the Nutrition profession, it is necessary to recognize that authority and power in the field of Science, in the area of Nutrition, are being exercised with greater expression by the masculine gender.[32] In this way, the inclusion of feminism is strategic for the qualification of training, since feminist critique has deepened the debate about eating disorders, broadening the psychopathological approach to the dimensions related to socialization, besides recognizing the primary and causal role of culture and gender, emphasizing social causes to the detriment of the factors seen as individual in the standard medical model. That is, feminism is also an important foundation for questioning the clinical value of normative / pathological duality, including for the analysis of eating disorders.

Understanding social determination in the multidimensionality of eating behavior disorders, including the perception of one's own body, is essential for clinical management in which the impacts of weight loss on people's health are considered. Therefore, the discussion about cultural and economic pressure exerted on the body is of great value, considering the multiplication of concepts and practices related to body and food, and the detection and management of disorders in the professional experience in Nutrition.

Another consequence of these qualifications in training may be a decrease in the moralization of the body and its relations, which lead to veiled discrimination, even casting doubt on the intellectual and practical capacity of professionals of the area who are not in the normal parameters of normality.

It should be noted that the breakdown of paradigms about the approach to obesity in Nutrition demands the development of studies and research that are still incipient, as well as the questioning and relativization of some certainties and truths brought by biomedical science. On the one hand, this is reflected both in the performance of health professionals who are hegemonically stigmatizing

and *fatphobic* and, on the other hand, in the proposals of Public Health Policies, in which an approach that does not work the intersectoriality predominates (and, in this way, does not work determinant factors of the health-disease process), but focuses on educational approaches that end up reinforcing individuals' accountability for their health status and their consequent blame.

It is necessary to redirect attention to the real determinants of health, to the detriment of guilty attitudes. Health sciences need to recognize their privileged place of articulation between knowledge and government interventions on individuals and populations.[21] This means, ultimately, the adoption of biopolitics that are able to minimize the negative impacts of modernity that have led to the explosion of chronic degenerative diseases in recent decades, such as respecting human diversity and the multiple forms of experience that must be accepted and worked, without stigmatization.

Throughout this work, we perceived the need for dialogue between the knowledge of nutrition and other areas of knowledge, such as Sociology and Anthropology, in order to eliminate simplistic visions about body and health, and to qualify professional training and practice.

The approach of the professional nutritionist should reflect a socio-historical understanding of the individual, avoiding the naturalization of the pathologization of the fat person - bringing the individual closer to access to health - and avoiding the transformation of care into a risk factor, increasing the resolution to the actual factors of illness.

Undoubtedly, there is still much to deepen in the subject of *fatphobia*, specifically in the formation of the professional nutritionist. It is not a question of following the same paths, but of proposing points of reflection and searching for new routes that allow the construction of practices and knowledge that expand the limits of historically consolidated approaches in the area of Nutrition.

## Contributors

Silva BL and Cantisani JR have participated in all steps from designing the study to reviewing the final version of the article.

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