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Health tensions: a psychosocial approach to the social construction of obesity in the Brazilian context

Tensões em saúde: uma abordagem psicossocial para a construção social da obesidade no contexto brasileiro

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Abstract

The ways of thinking about the world and the socially adopted practices are related to the social, cultural, and historical context. This study aimed to understand the socio-representational content of obesity among people with different weight ranges. An online questionnaire was answered by 300 participants. Similarity Analyses and a Descending Hierarchical Classification were performed to investigate obesity content. Statistical analyses were used to assess unhealthy weight-control practices and other variables characterizing participants. Obesity is thought of as a difficult-to-treat physical and mental health problem. It has negative social representations, which leads to great fear of gaining weight, and obesity compromises social health. The search for acceptance and body adaptation is related to the adoption of unhealthy weight control practices, which are used by all participants, regardless of weight range.

Keywords: Body mass index; Health; Obesity; Social representations.

Resumo

As formas de pensar o mundo e as práticas adotadas socialmente estão relacionadas ao contexto social, cultural e histórico. O objetivo deste estudo foi compreender o conteúdo sócio-representacional da obesidade entre pessoas com diferentes faixas de peso. Um questionário online foi respondido por 300 pessoas. Análises de Similitude e Classificação Hierárquica Descendente foram realizadas para investigar o conteúdo de obesidade. Análises estatísticas foram usadas para avaliar práticas não saudáveis de controle de peso e outras variáveis usadas para caracterizar os participantes. A obesidade é pensada como um problema de saúde física e mental de difícil tratamento. Possui representações sociais negativas, o que leva a um grande medo de ganhar peso e a obesidade compromete a saúde social. A busca por aceitação e adaptação corporal está relacionada à adoção de práticas não saudáveis de controle de peso, que são utilizadas por todos os participantes, independentemente da faixa de peso.

***Palavras-chave**: Índice de massa corporal; Saúde; Obesidade; Representações sociais.*

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Thinking about the human body from a psychosocial perspective allows for an understanding of the ways of being and acting in the world through physical expressions materialized in social relations. These ways of being and acting in the world are related to the functioning of society and indicate how value systems are created, reproduced, and objectified through body practices and expressions. Although body experiences and knowledge are conditioned by society, they are always linked to a subjective discourse grounded in individual sensations and experiences, adding personal characteristics to socially acquired content (Jodelet, 2017).

The study of social thought is important for analyzing how different social groups share knowledge about practices adopted in daily life. Studying the body from the perspective of Social Representations makes it possible to broaden the view of this object. Social Representations (SR) are forms of thought shared in social discourse that contribute to the creation of a shared reality (Jodelet, 2001). They allow people to assign meanings to their social and subjective experiences as part of a world built through interaction with others (Fonte et al., 2019). As a social object, the body acquires visions built through an interaction between subjective and objective reality.

Regarding objective reality, it is important to consider that socio-historical and cultural contexts establish standards for how people should look and behave (Rodrigues, 2014). In Brazil, as in other Western countries, this way of perceiving and experiencing the body creates a culture of significant investment in physical fitness and, at the same time, constant dissatisfaction with appearance. These factors lead to a large number of aesthetic surgeries and create a gigantic beauty industry (Goldenberg, 2011). According to data released by the International Society of Aesthetic Plastic Surgery, 2,1 million plastic surgeries were performed in Brazil in 2023, and the country was classified as the world leader in cosmetic surgery procedures (International Society of Aesthetic Plastic Surgery, 2024).

Although socially accepted and disseminated beauty standards may have undergone variations over time, thinness standards have been dominant for decades (Gebara et al., 2022; Polli et al., 2021; Polli & Scopel, 2024). These standards, initially disseminated by traditional media and reinforced by the fashion industry, have become dominant and, in the current context, are associated not only with beauty but also with health. A thin body is seen as beautiful and healthy, while any other body shape is seen as deviant, ugly, or sick (Bennett et al., 2020; Couss et al., 2021; Polli & Scopel, 2024). Although the media and social imagination often consider a thin body synonymous with health, a thin body is not necessarily healthy. Obesity and thinness are multifactorial states, related to genetic, environmental, behavioral, and social conditions (Loos & Yeo, 2022).

Understanding socially shared knowledge on obesity can help promote health for overweight and obese people, but also for people with eutrophic Body Mass Index (BMI) (normal weight). According to the World Health Organization (WHO), the criterion for classifying an adult as obese is BMI, which is calculated by dividing weight (in kg) by height squared (in meters). A person with a BMI above 30 kg/m^2 is considered obese, and a person with a BMI between 25 and 29.9 kg/m^2 is in the overweight range. The range between 18.5 and 24.9 kg/m^2 comprises normal weight (eutrophy), and the range below 18.4 kg/m^2 is considered low weight (World Health Organization, 2021).

Obesity has a negative connotation in the Brazilian context (Couss et al., 2021; Gebara et al., 2022). It is often associated with physical comorbidities, such as cardiovascular and orthopedic problems, and a predisposing condition for various types of cancer (De Lorenzo et al., 2020). It is also strongly associated with psychological problems, such as low self-esteem, depression, anxiety, and eating disorders (Samuel & Polli, 2020). In addition, obese people have to carry a heavy social burden as they are usually victims of various forms of prejudice (Araújo, Coutinho, Alberto, et al.,

2018; Araújo, Coutinho, Araújo-Morais, et al., 2018; Pinto et al., 2020; Polli & Scopel, 2024; Sowinski et al., 2024). Obese children and adolescents are victims of bullying (Cheng et al., 2022), and obese people are generally seen as failures, sick, and ugly (Polli & Freitas, 2020; Polli & Scopel, 2024; Tarozo & Pessa, 2020).

Considering that obesity has a negative connotation in Brazilian society, this research sought to study the socio-representational content of obesity for people classified as eutrophic, overweight, and obese, according to the BMI criterion established by the World Health Organization (2021). In addition, an exploratory study was conducted to examine potential associations between certain variables and the content of obesity. The following variables were considered: gender, self-esteem, body satisfaction, body shape concerns, comparison with others' physical appearance, physical activity level, and unhealthy weight-control practices.

Method

Participants

Three hundred individuals aged 18 to 59 years participated in this study (M = 32.68, SD = 9.74). Participants were paired and divided into three groups, 100 participants in the eutrophy BMI group (Minimum = 18.52, Maximum = 24.92. M = 22.34, Md = 22.46, SD = 1.59); 100 participants with overweight BMI (Minimum = 25.14, Maximum = 29.94, M = 27.28, Md = 27.12, SD = 1.43); and 100 participants with obesity BMI (Minimum = 30.02, Maximum = 62.82, M = 34.45, Md = 32.80, SD = 4.96). Among the 300 participants, 84 were male and 216 female. The eutrophic BMI group comprised 25 males and 75 females; the overweight group, 39 males and 61 females; and the obesity group, 20 males and 80 females. Most participants were considered of middle socioeconomic status (26.7% with income between R$ 2.500,00 and 4.000,00, and 25.35% between 4.001,00 and R$ 10.000,00). The level of education was considered high, as 51.3% had completed higher education or were attending college, and 32.7% had completed their graduate studies or were graduate students.

Instruments

The questionnaire included questions about participants' characteristics, including weight and height for BMI calculations. In order to investigate the content of obesity, an open question was presented: "What does obesity mean to you?". In addition, some scales were used: The Rosenberg Self-Esteem Scale (RSES) (Hutz & Zanon, 2011), which measures global self-esteem (α = 0.90); a Body Silhouette Scale (Kakeshita et al., 2009), which assesses body shape satisfaction; the Body Shape Questionnaire (BSQ) short version, adapted from English (Evans & Dolan, 1993), which assesses body shape concerns (α = 0.87); the Physical Appearance Comparison Scale (PACS), adapted from French (Dany & Urdapilleta, 2012), which assesses the level of physical comparison with others (α = 0.79); the International Physical Activity Questionnaire (IPAQ) – short version, adapted from French (IPAQGroup, 2005), which assesses physical activity levels (α > 0.80).

Participants were also asked whether they had used unhealthy weight-control methods in the past 12 months. The questions were adapted from the questionnaire used by Yager and O'Dea (2009) and Yager et al. (2017). The methods mentioned were: fasting, use of weight-loss medications, inducing vomiting after meals, and use of laxatives (Tshililo et al., 2016).

Procedures

The study was approved by the Human Research Ethics Committee of a University in Southern Brazil (Protocol nº 3.698.187). Data were collected between July 2020 and April 2021 via a questionnaire developed in Google Forms and distributed on social media. Individuals who digitally signed an Informed Consent Form were given access to the questions.

Data Analysis

The data collected through the questionnaires were subject to descriptive and inferential statistical analyses, using the chi-square and Analysis of Variance (ANOVA) tests to assess potential differences among participants of different BMI ranges. The data on what participants think about obesity were analyzed using the IRaMuTeQ software (Ratinaud, 2009). Two complementary analyses were carried out to investigate the socio-representational content in different ways.

To understand the organization of key elements and the content shared by participants regarding obesity, a Similarity Analysis was performed (Bouriche, 2003). For this analysis, the connections between elements are taken into account, considering the strength of the statistical relationship between two elements of the content that emerged from the question presented. Using the chi-square test, the most frequent elements are associated with one another, and these associations can be visualized in a graphical presentation.

To determine potential differences between groups, a Descending Hierarchical Classification (DHC) was performed to identify oppositions among themes. In DHC, it is possible to insert variables for each participant and observe whether class content is associated with the variables. In this analysis, the following variables were used: gender, obesity classification (eutrophy, overweight, obesity), self-esteem classification, body satisfaction, body shape concerns, physical activity level, comparison with others' appearance, and adoption of unhealthy weight-control practices.

For the analysis of the Rosenberg Self-Esteem Scale, which consists of 10 items with four response options, scores were summed, and self-esteem was classified as: low (between 10 and 19 points), medium (between 20 and 29 points), and high (above 30 points) (Hutz & Zanon, 2011). In order to analyze the data from the Silhouette Scale (Kakeshita et al., 2009), the difference between the number of the silhouette that the participant considers real and the one they consider ideal was calculated, and participants were classified as downward dissatisfied (they would like to be fatter), satisfied, or upward dissatisfied (they would like to be thinner). The differences between the ideal and actual silhouettes can reach up to 14 points, as the scale comprises 15 images. The classification was dichotomized into "dissatisfied" or "not dissatisfied" for being fat, to be used with the explanatory variable in DHC. To assess body shape concerns, participants' BSQ scores were categorized as follows: free from body dissatisfaction – below 19 points; mild dissatisfaction – from 19 to 25 points; moderate dissatisfaction – from 25 to 33 points; and severe dissatisfaction – equal to or above 33 points.

To assess Physical Appearance Comparison (PACS), participants are considered to have low comparison with others if scores are below 9; moderate if scores are between 9 and 15; and high if scores are above 15. Regarding physical activity, participants who do more than 300 minutes of physical activity per week are considered very active, those who do between 150 and 299 minutes per week are considered active, between 90 and 149 minutes are moderately active, and those who do less than 89 minutes of physical activity per week are considered inactive. The time dedicated to vigorous activity was multiplied by two. Unhealthy weight-control practices were assessed dichotomously as "present" or "absent" for each of the four practices investigated.

Results

Sample Characteristics

Table 1 shows the eutrophic, overweight, and obese groups by gender and different behaviors related to weight-control practices. It is noteworthy that 47.7% reported not having used any of the unhealthy weight control practices asked. Among unhealthy practices, fasting (*n* = 125, 41.6%), use of weight-loss medications (*n* = 63, 21.0%), use of laxatives (*n* = 31, 10.3%), and inducing vomiting after meals (*n* = 20, 6.6%) stood out. Five participants adopted all four practices (1.7%), 10 (3.3%) adopted three, 47 (15.7%) adopted two, and 95 participants (31.7%) adopted one of the practices. The adoption of each practice was related to participants' BMI range and to other variables investigated. Table 1 shows frequencies for each variable by BMI and the chi-square test results for each group of variables.

Table 1
Comparison of group BMI frequencies through chi-square tests

Variables	Eutrophy	Overweight	Obesity	Statistics Value	*p*
Gender				$\chi^2 = 9.620$	< 0.01*
Females	75	61	80		
Males	25	39	20		
Types of Unhealthy Practices					
Laxative	8	11	12	$\chi^2 = 0.935$	0.63
Fasting	39	44	42	$\chi^2 = 0.521$	0.77
Vomiting	6	6	8	$\chi^2 = 0.429$	0.81
Medication	8	21	34	$\chi^2 = 20.374$	< 0.01*
Self-Esteem				$\chi^2 = 4.010$	0.40
Low	6	8	12		
Medium	38	29	31		
High	56	63	57		
Body Shape Concerns				$\chi^2 = 31.672$	< 0.01*
None	23	7	6		
Mild	27	18	12		
Moderate	18	32	26		
High	32	43	56		
Physical Appearance Comparison				$\chi^2 = 3.860$	0.42
Low	25	25	27		
Moderate	54	58	46		
High	21	17	27		
Physical Activity Level				$\chi^2 = 6.020$	0.42
Inactive	39	47	49		
Moderate	15	8	10		
Active	15	15	19		
Very Active	31	30	22		

Note: *Statistically Significant Difference ($p < 0.05$); *p* = Significance Index; χ^2 = Chi-Square Value.

It was found that BMI ranges are related to participants' gender, and that participants with BMIs in the overweight and obesity ranges have greater body shape concerns. On the other hand, there are no statistically significant relationships between participants' BMI range and self-esteem, comparison with others' appearance, or physical activity levels. Regarding the adoption of unhealthy weight control practices, the use of weight-loss medications has a

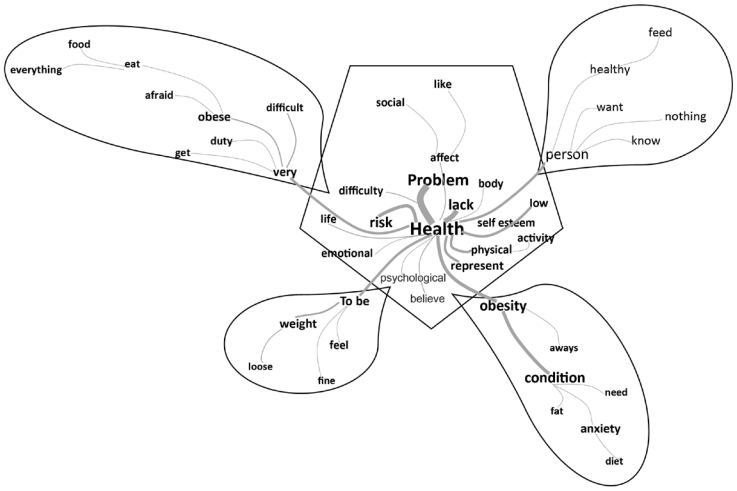
statistically significant relationship with BMI range, indicating that people with obesity make more use of this practice.

In order to assess whether body dissatisfaction was related to BMI, a single-factor variance test (ANOVA) was performed. Considering the difference between perceived silhouette and desired silhouette, a mean was calculated between groups. The scale allows a variation of 15 points between the two silhouettes, with higher values indicating greater dissatisfaction. The eutrophy BMI group had a mean of 1.44, the overweight group of 3.35, and the obesity group of 4.41. These differences in means were statistically significant [$F(2.299) = 453.087$, $p < 0.01$], indicating that body dissatisfaction is higher among people with higher BMI.

Obesity Content

Similarity Analysis was performed to understand the content shared on obesity and the organization of the elements. Words with a frequency equal to or greater than 10 were included in the analysis. Figure 1 shows the analysis results.

Figure 1
Graphical presentation of obesity content similarity analysis, considering words with a frequency equal to or greater than 10

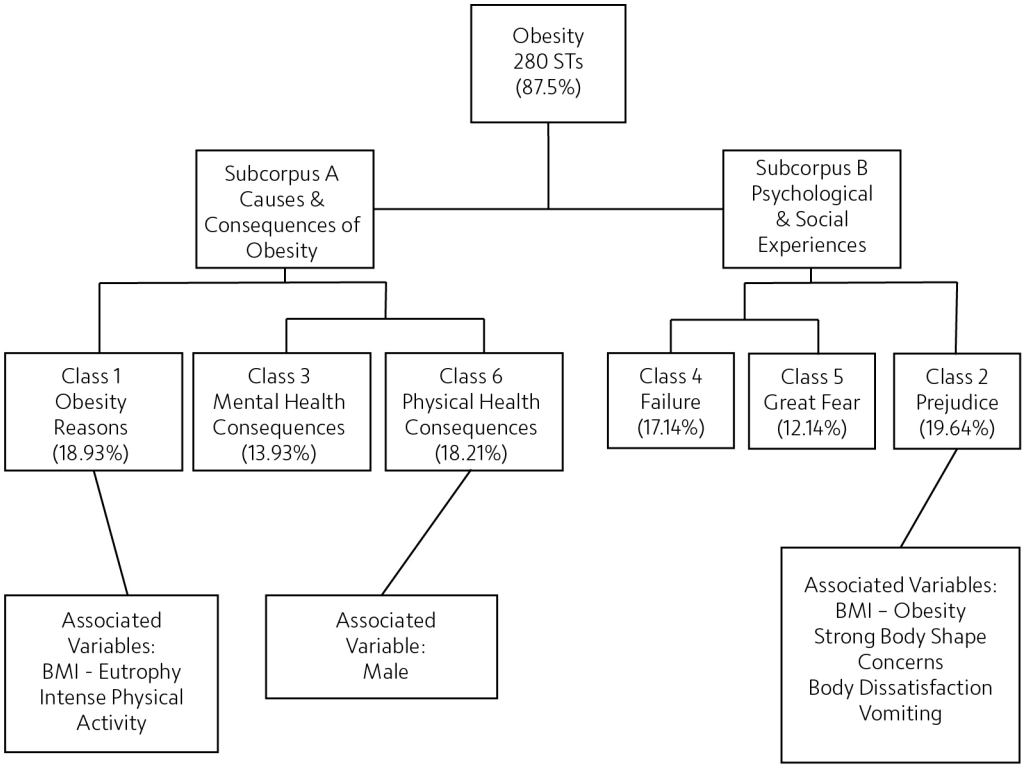


The word *health* is in a central position but strongly linked to the word problem, indicating that participants see obesity as a problem that affects health. Although the word physical is present, most words refer to emotional or mental problems. Words such as *self-esteem, psychological, emotional, and anxiety* illustrate these concerns. There is also an association between obesity and diet, a word that appears linked to the word *healthy*, suggesting a possible way to overcome obesity. On the other hand, words such as *very, difficult*, obese, and eat appear together, indicating that participants feel that it is difficult to adhere to a diet considered adequate.

A DHC was performed to understand how the content relates to the different categorization variables described in Table 1. The "Obesity" corpus had 5,585 occurrences, with 1,285 different words. DHC generated a total of 300 responses, which originated 320 Text Segments (TS), 280 of which (87.5%) were considered. Figure 2 shows a dendrogram with the division of the main corpus into two subcorpora and six classes. Responses were subdivided into two groups: A and B. The first

partition of the corpus opposes the two groups, forming subcorpora A (Classes 1, 3, and 6) and B (2, 4, and 5). For each class and subcorpus, the title, percentage of text segments, and associated variables were presented when applicable.

Figure 2
Obesity Content Dendrogram



Subcorpus A, formed by classes 1, 3, and 6, refers to the causes and consequences of obesity. Class 1 was called "Reasons for obesity" and indicated potential reasons for the onset and development of obesity. These reasons are often related to physical and emotional or psychological problems and are sometimes associated with sloppiness, carelessness, and lack of willpower, as in: "it represents lack of control over one's own life, compulsion, weakness, and discouragement" (P260, female, eutrophy BMI).

Class 3, "Mental Health Consequences" emphasizes the damage that obesity causes to mental health, discusses the health risks, and especially the impact of obesity on self-esteem: "lack of health, energy, and self-esteem is a greater problem than the physical one" (P255, male, eutrophy BMI). Class 6, "Physical Health Consequences" considers obesity as a health problem, mentioning associated conditions: "a dangerous condition that can trigger several others, such as hypertension, heart diseases, among others" (P144, female, overweight BMI).

Subcorpus B was formed by classes 2, 4, and 5 and discusses psychological and social experiences. Class 2 was called "Prejudice" and discussed feelings arising from obesity. Participants report that they feel bad about being obese and talk about the prejudice they suffer: "it is very bad for physical, emotional, and psychosocial health. It is very difficult to be obese in a world where being thin is the pattern" (P49, female, Obesity BMI).

Class 4, "Failure", deals with feelings associated with not being able to lose weight or keep a low weight. Participants talk about feelings such as defeat, embarrassment, and shame: "being obese is a defeat, it means feeling defeated, discouraged, and ignored" (P222, female, Obesity BMI). Class 5, "Great Fear", refers to obesity as something frightening, which must be eliminated. Fear of gaining weight or suffering from associated conditions is present in the STs that make up this class: "disease and death, I can't think of anything positive about getting fat" (P300, male, overweight BMI).

The two analyses performed made it possible to understand some unique aspects of this content. People with obesity BMI deal with the phenomenon from a more subjective perspective, expressing the negative feelings, difficulties, and prejudice they suffer for being obese. Participants with eutrophic BMI describe obesity, considering its causes. Negative aspects of the condition are emphasized, both from a more descriptive point of view, of those who do not experience obesity, and from a more subjective point of view, of those who are obese. Fear of obesity or its associated conditions is present in the discourse of both groups.

Through similarity analysis, it was possible to perceive that participants consider obesity as a health condition that has important consequences on mental health or psychological well-being. For participants, obesity is a condition that needs to be treated or prevented, especially through an adequate diet. However, they recognize that there are difficulties in this process. It is interesting to note that "prejudice" is present in the responses of participants with obesity BMI. However, the word does not appear in similarity analysis, demonstrating that people who do not experience prejudice may not recognize the existence of prejudice against fat people in our society.

Discussion

This study aimed to investigate the socio-representational content of obesity among people of different BMI ranges. All participants widely shared the content, and there were few differences according to gender, BMI range, or other variables investigated. For all the participants in this study, obesity is a physical and mental health problem. The content of obesity is divided into two poles, one of them described in the third person, when participants talk about "others". In this case, the content points out the causes and consequences of obesity. The other pole is in the first person. Participants talk about their experiences regarding obesity. Obese people talk about the prejudice they have suffered, and people of all weight groups talk about the feeling of failure and the fear of gaining weight.

Health is central to this debate, and this way of thinking about obesity as health-related may be based on socially disseminated conceptions that establish a health standard for social functioning (Brito & Camargo, 2011), which is characteristic of Brazilian society. Health is linked to the idea of order, and its conception is influenced by scientific and biomedical definitions that influence which behaviors are considered correct or incorrect, healthy or unhealthy (Loyola, 2013).

The way to fight obesity as a disease is prevention, which led participants to discuss diet and physical activity, but habit changes are considered difficult to adhere to. Diet plays a key role in the potential treatments for obesity (Gebara et al., 2021; Polli & Freitas, 2020), and physical activity is also considered critical to maintain or lose weight and to maintain health (D. S. Silva et al., 2018). Treatments for obesity based on diet changes and physical activity are considered expensive, difficult, and ineffective (Di Ciaula & Portincasa, 2024; Polli & Freitas, 2020). Part of the efforts to prevent and treat obesity have been to reward people's healthier choices, disregarding social aspects related to food, and to blame individuals for their "bad" choices (Quilis et al., 2024).

Thin people emphasize the causes of obesity, often associating them with sloppiness, laziness, and lack of willpower. Overweight people are blamed for their condition (Justo et al., 2018; Martins et al., 2022). Overweight is also considered a consequence of inadequate diet, lack of healthy choices, and an inactive lifestyle (Mahumud et al., 2021; Moschonis & Trakman, 2023), leading to individual responsibility.

Obesity-related experiences are also part of the knowledge shared by participants. Obesity is associated with failure. It is also associated with a strong social pressure that generates negative emotions such as sadness, insecurity, shame, anxiety, and anger (Mondragon & Txertudi, 2018), increasing the stigma of obesity and affecting psychological well-being (Polli & Scopel, 2024; Viganó et al., 2024; Williams & Annandale, 2020).

Moreover, obese people mention the prejudice they suffer. By analyzing studies that sought to understand the social representations of obesity in different contexts, it is possible to perceive that obesity is strongly associated with prejudice (Araújo, Coutinho, Araújo-Morais, et al., 2018; Gebara et al., 2022; Martins et al., 2022; Polli & Scopel, 2024; Sowinski et al., 2024), especially when people believe that such prejudice is endorsed by the opinion of a medical expert (Lee et al., 2019).

World Health Organization (1986) indicates that health encompasses physical, mental, and social aspects. In their responses about obesity, participants highlighted damage in the three aspects. From a physical point of view, obesity generates limitations and is a predisposing factor for other chronic conditions. These relationships are expressed in the class "Physical Health Consequences", which reflects the normative discourse, characteristic of the Brazilian context, in which obesity has a negative connotation because it is considered a health condition that must be fought against (Bloc et al., 2021; Gebara et al., 2022; Werder et al., 2020).

Mental health is compromised because it is related to depression, anxiety, eating disorders, and self-esteem issues. This content is present in the class "Mental Health Consequences". The class "great fear" indicates that the possibility of gaining weight and being close to having an obesity condition generates anxiety, which may compromise mental health (Mondragon & Txertudi, 2018; Polli & Freitas, 2020; Polli & Scopel, 2024). Social impairment occurs when obese people are blamed for their situation and discriminated against, suffering from social judgment. The classes "prejudice" and "failure" express this way of thinking about obesity, emphasizing the harmful consequences for the social health and interpersonal relationships of people with obesity (Araújo, Coutinho, Araújo-Morais, et al., 2018; Gebara et al., 2022; Martins et al., 2022; Polli & Scopel, 2024).

Although the literature indicates that obesity is a deviant physical characteristic of the socially established beauty model (Pinto et al., 2020; Polli et al., 2021; A. F. S. Silva et al., 2020), the participants of this study did not treat obesity in aesthetic terms. The word aesthetics was mentioned only nine times throughout the *corpus*, and the word ugly appeared only six times. The absence of an aesthetic assessment of obesity might be related to a very evident social discourse on obesity, which, based on a medical discourse, associates obesity with health issues, disguising the prejudice against obese people as a form of concern for their well-being (Araújo, Coutinho, Araújo-Morais, et al., 2018; Polli & Scopel, 2024).

It is possible that the discourse on obesity-related aesthetics, as it is counter-normative, is part of the mute zone of social representations of obesity. For Abric (2005), content about certain social objects that is not socially accepted is usually not enunciated and, therefore, is not detected, forming a mute zone of social representations. Despite the privacy and anonymity of this study, this content did not appear in participants' speech, and future studies could investigate the relationship between obesity and aesthetic standards in different social contexts.

Although women feel more exposed to aesthetic demands (Pinto et al., 2020) in the Brazilian socio-cultural context, the same does not seem to occur in relation to health. Although the sample was not balanced in terms of male and female subjects, no significant differences were found in the content of health reported by participants of different genders.

Abric (1998) draws attention to the relationship between the content of social representations and the social practices people adopt in everyday life, given that one of the functions of social representations is to guide conduct. Representations and practices are interrelated, and social representations assume the role of providing conditions for practices, which in turn are agents of transformation of representations (Rouquette, 1998). The strongly negative content of obesity is associated with the adoption of unhealthy weight control practices. More than half of the participants (52.3%) mentioned adopting at least one unhealthy practice. The attempt to maintain or achieve a thin body is related to the adoption of these practices by participants of all BMI ranges. Only the use of weight-loss medications was more common among obese participants, who also presented greater body dissatisfaction and greater concern with body shape than participants of other BMI ranges.

By analyzing the socio-representational content of obesity, it is possible to perceive how social rules about the body and its form, both regarding aesthetics and health, generate normative and counter-normative patterns that influence the practices adopted in everyday life. In social discourse, the body is described as adequate or inadequate, healthy or unhealthy, accepted or rejected. Due to this discourse, people need to guide their conduct to adapt to the accepted and socially disseminated standards. By observing the relationships between social representations and weight control practices, it is possible to notice that although the discourse on obesity emphasizes physical, mental, and social health, there is a contradiction when unhealthy weight control practices are adopted.

By attempting to achieve social health, which occurs through acceptance, inclusion in groups, and the absence of prejudice and discrimination, people may compromise their physical and mental health by adopting unhealthy weight control practices. There is a tension between physical, mental, and social health, which shows that obesity affects health globally, regardless of weight group. It seems that social health carries greater weight in the search for balance among the three forms of health. In pursuit of social acceptance, both physical and mental health can be compromised by the use of unhealthy weight control practices. When trying to reduce suffering and social exclusion, the attempt to lose weight by adopting unhealthy practices compromises physical and mental health. Therefore, psychological health is compromised in both contexts. This tension may be related to social pressure to adapt to health standards imposed by society (Fonte et al., 2019), which, in the Brazilian context, strongly associates health with thinness.

The findings of this study show that understanding the socio-representational content of obesity beyond its description, by also considering the socio-cultural context in which these beliefs are developed, and their relationship with social practices, can provide important clues about social functioning. It indicates how individuals seek to control and adapt their bodies according to the social standard present in the socially shared discourse on obesity. This discourse highlights the centrality of health and a normative, biomedical-based perspective.

The results open the space for the promotion and prevention of mental, physical, and social health through informational and educational strategies aimed at the general population, particularly patients with weight-related issues. They make it possible to understand how social

standards are created in social discourse and unfold in behavior models considered right and wrong. These models, in turn, serve as guides to action, distorting the concepts of right and wrong. Society does not question the model, it just tries to adapt to it. Having a thin body is considered right, even if health in its broad sense is compromised in order to achieve it.

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