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THE PERCEIVED CONSEQUENCES AND SELF-CONCEPT OF A SUCCESSFUL WEIGHT LOSS – A QUALITATIVE STUDY

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"*Wit beyond measure is man's greatest treasure.*"

J. K. Rowling

Resumo

A obesidade e a perda de peso implicam gerir percepções face à imagem corporal e lidar com padrões sociais. A investigação mostra que o excesso de peso e a obesidade têm impacto negativo na saúde física e no estado psicológico. A imagem corporal compreende o eixo atitudinal, que inclui a componente avaliativa e de investimento, e o eixo da auto-percepção. Sendo um conjunto de generalizações cognitivas, o auto-conceito inclui percepções específicas sobre o indivíduo em contextos particulares. Sendo que a qualidade da imagem corporal afecta a auto-estima, é pertinente o estudo do auto-conceito na experiência de perda de peso. Pretende-se avaliar de forma qualitativa as consequências percebidas e o auto-conceito, e desenvolver modelos explicativos (análise de correspondência múltipla). Foram entrevistados trinta participantes que realizaram uma perda de peso bem-sucedida (perda mínima de 7% do peso inicial e manutenção mínima de 12 meses). O conteúdo das entrevistas foi transcrito e submetido a análise temática e de conteúdo. As consequências percebidas organizam-se num modelo de três factores (Crescimento pessoal/Adversidades sociais, Imagem corporal/Benefícios sociais, e Bem-estar físico/emocional), compreendendo consequências como problemas relacionais e bem-estar/felicidade. Também o auto-conceito se organizou num modelo de três factores (Investimento eficaz/Auto-estima equilibrada, Ambivalente, e Aceitação positiva/Foco), incorporando auto-conceito físico e da personalidade explícita. Incluir em igual proporção ambos os géneros e utilizar entrevistas gravadas são vantagens que destacam a contribuição da investigação. O estudo amplifica o conhecimento das consequências percebidas e do auto-conceito, no contexto de uma perda de peso bem-sucedida. A análise retrospectiva é considerada uma limitação.

Palavras-chave: perda de peso, consequências percebidas, auto-conceito.

Abstract

Managing obesity and weight loss entails dealing with body image perceptions and social standards. Research shows that overweight and obesity have negative impact on physical health and affect individuals' psychological state. The body image structure comprehends the attitudinal axis, including the evaluative and the investment components, and the self-perception axis. Designated as cognitive generalizations, the self-concept can comprehend specific perceptions about oneself according a particular context. Since the body image quality affects the self-esteem, it's relevant the self-concept study on the experience of weight loss. The present aim is to evaluate the perceived consequences and self-concept in a qualitative methodology, and develop models (multiple correspondence analysis). Thirty men and women who have made a successful weight loss (loss at least 7% of initial weight and maintained for at least 12 months) were interviewed. The content of the transcribed interviews was subjected to thematic and content analysis. Perceived consequences organize a three factor model (Personal growth/Social adversities, Bogy image/Social benefits, and Physical/Emotional well-being), including relational problems and well-being/happiness as perceived consequences. The self-concept also establishes a three factor model (Effective investment/Balanced self-esteem, Ambivalent, and Positive acceptance/Focused), incorporating physical and explicit personality self-concepts. Including the same proportion of both genders and using in-depth, audio-recorded interviews are advantages that emphasize the contribution of the present investigation. This study expands the knowledge about perceived consequences and self-concept, in the context of a successful weight loss. The retrospective analysis is considered a limitation.

Key-words: weight loss, perceived consequences, self-concept.

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Introduction

Obesity and Successful Weight Loss

Being identified as one of the most critical health issues, obesity has been estimated to affect more than 10% of the world adult population in 2008 (World Health Organization - WHO, 2014). Characterized as an atypical or disproportionate body fat accumulation that can prejudice health (WHO, 2014), obesity is a complex disease involving genetic, psychological, socioeconomic, cultural, and environmental features (Anderson & Konz, 2001). Overweight and obesity in adults are commonly classified with the Body Mass Index (BMI) which consists of an individual's weight in kilograms divided by the square of his or her height in meters (WHO, 2014). In 2008, 1.5 billion people all over the world with 20 years or older had overweight, and more than 200 million men and almost 300 million women had obesity (WHO, 2014). In the same year (WHO, 2011), it was assessed that 59.1% of the Portuguese population had overweight (61.8% males and 56.6% females; BMI from 25.0 to 29.9 kg/m^2) and 24% had obesity (21.6% males and 26.3% females; BMI $\geq$ 30.0 kg/m^2).

As a medical condition of major significance, the presence of overweight or obesity can increase the risk of multiple physical illnesses. Main examples are cardiovascular disease, coronary heart disease, hypertension, type II diabetes, sleep apnea, and musculoskeletal issues (Anderson & Konz, 2001; Sarwer, Dilks, & Spitzer, 2011; Stroebe, 2008).

However, overweight and obesity not only have impact over physical health, but also affect individuals' psychological state (Fabricatore et al., 2011; Ogden & Clementi, 2010). These physical conditions also exhibit a high association with social stigmatization, discrimination and prejudice (Stroebe, 2008).

According to Ogden and Clementi (2010), overweight or obesity have impact on personal domains such as the individual's mood, self-identity and self-perception, linking the weight to a feeling of dissociation with one's body. Previous research (Harris, Harris, & Bochner, 1982; Hebl & Mannix, 2003; Ogden & Clementi, 2010) reported that people who have overweight or obesity are frequently perceived by others as less intelligent, less capable of achieving success, lacking attractiveness, unpopular, lazy, and self-permissive.

Furthermore, the literature (Crandall & Biernat, 1990; Ogden & Clementi, 2010; Stroebe, 2008) also indicates that comments, expectations and overall attitude of others about the weight of individuals with obesity have impact on their self-perception, self-identity and

self-esteem, in addition to influence their experience as being obese. People with overweight who refer a history of stigmatization tend to report a higher dissatisfaction with their bodies, higher levels of distress, a more dysfunctional investment in their appearance, and a more negative body image (Annis, Cash, & Hrabosky, 2004; Latner & Wilson, 2011).

Weight loss has been recognized as an important approach to improve several health conditions associated with obesity (Vidal, 2002), such as preventing coronary heart disease, reducing cardiovascular risk factors, and benefiting the treatment of type II diabetes (Anderson & Konz, 2001; Vidal, 2002). The positive outcomes of a moderate weight loss of 5 to 10% of the initial weight have been well established, being associated with improvements on systolic and diastolic blood pressure, lipids and glycaemia levels, and efficient in preventing the manifestation of type II diabetes and hypertension in overweight individuals (Vidal, 2002; Wing et al., 2011). The definition of a "successful" weight loss emphasizes not only the weight decrease but also changes in health-related behaviours. Success in weight decrease has been described as an intentional weight loss (Wing & Hill, 2001) equal or beyond 7% of the initial weight (Knowler et al., 2002). The Institute of Medicine (IOM, 1995) also indicates that a 5% or greater reduction in body weight is considered successful, as well of a minimum criterion of weight maintenance of 12 months.

Research indicates that body dissatisfaction and body image improve even with a modest weight loss (Foster, Wadden, & Vogt, 1997; Sarwer et al., 2011; Sorbara & Geliebter, 2001). According to Foster and colleagues (1997), women who went through an average loss of 19 kg in a 24 weeks period demonstrated significant improvements in body image. Baldwin, Rothman and Jeffery (2009) presented a longitudinal study indicating that many weight loss-related consequences – such as perceived attractiveness, levels of self-control, positive feedback, and improvement in clothes fitting – were associated with people's satisfaction, independently of the weight lost. Additionally, Wing and Hill (2001) indicated the level of energy, mobility, mood, self-confidence and overall quality of life as improvements in consequence of weight loss achieved by members from the National Weight Control Registry.

Nonetheless, a successful weight loss isn't exclusively related to positive sequels. Gorin et al. (2007) found that weight loss related changes often fail to live up to one's expectations, even in individuals with an average loss of 19% of body weight in 2 years. Indeed, empirical evidences also indicate some perceived negative consequences – such as an unwanted increase of attention by others (Annis et al., 2004) or undesirable body changes (Sarwer et al., 2011) – by individuals who went through weight loss. Annis and colleagues

(2004) demonstrated that the increased amount of compliments received after weight loss by women on their recent physical appearance was often felt as uncomfortable and disturbing.

Furthermore, despite the frequent body image improvement, patients who undergo bariatric surgery report dissatisfaction with their body image correlated with sagging, flaccid skin in different body areas such as breasts, arms, abdomen and thighs (Sarwer et al., 2011). However, the subject of perceived – mostly, negative – consequences of a successful weight loss has received diminutive empirical attention to date (Alegría & Larsen, 2015; Sarwer et al., 2011).

Failure at the attempt of weight maintenance after a weight loss is also a frequent reality (Wing & Phelan, 2005), where weight regain is a prevalent problem (Weiss, Galuska, Khan, Gillespie, & Serdula, 2007). Studies in this area involving the consequences of weight loss successes are vital in order to identify not only the perceived positive consequences (which can reinforce the success), but also the negative repercussions that can possibly contribute to a weight regain or constitute a barrier to further weight loss, when necessary.

Weight loss encompasses several changes linked to physical, psychosocial and psychological features of the individual (Sarwer at al., 2011). Therefore, it's pertinent the study of its association with others dimensions that are included in one's self – specifically, the individual's self-concept, in order to understand the person's self-perceptions in multiple domains in a weight loss context. Consequently, it's essential a brief literature review of both psychological constructs – the self and the self-concept.

Self

The *self* can be understood as a cognitive representation of a complex structure, which assists in the organization of relevant self-knowledge (Linville, 1985). As a product of cognitive and social construction (Harter, 2008), the self comprises the totality of the individual, integrating one's body, sense of identity, and several others dimensions (Baumeister, 2004).

According to Baumeister (2010), it's possible to enunciate three basis of the self – 1) the overturn of the consciousness towards itself, identified as the awareness and knowledge a person has about oneself; 2) interpersonal relationships, since the self is emerged in reciprocal relations with others and has the function (between many others) of nourishing those relations; 3) decision-making and exercising control.

Harter (2008) designates the *Me-self* as the object of oneself knowledge and evaluation. According to the author, it's essential to consider its cognitive-developmental and social features. Consequently, transformation in the self-representations is inevitable since particular cognitive abilities and socialization experiences will play a fundamental role in the content and structural dimensions of the self.

Oyserman, Elmore and Smith (2012) defined *self* as the aggregation of a thinking agent ("I think") and an object of that contemplation ("about me"). Furthermore, the authors point out that in the content of that object resides mental concepts that particularly designate who one was, is, and will become – those mental notions are entitled *self-concept*.

Self-Concept

Through the interaction with the environment, the individual produces beliefs and self-perceptions about oneself that are influenced and reinforced by the appraisals of significant others and by the person's own behaviour (Baumeister, 2004; Schunk & Pajares, 2009; Shavelson & Bolus, 1982). Those self-perceptions are entitled as self-concept. According to Epstein (1973), the self-concept can be represented as a theory that one holds about oneself while in permanent connection with the world, pointing self-knowledge and beliefs as the self-concept's foundation. Oyserman, Elmore and Smith (2012), indicate that the self-concept designates cognitive generalizations that comprise structural aspects, attitudes and evaluative judgments. Those are used with the main purposes of a) attribute meaning to the world, b) safeguard one's sense of worth, and c) accentuate one's attention in personal goals.

Organizing one's process of information (Markus, 1977), the self-concept's structure allows not only the categorization of knowledge but also the communication between those categories (Shavelson & Bolus, 1982). When referring to its structure, is possible to affirm that the self-concept is multidimensional (Shavelson & Bolus, 1982). Several distinct evaluative judgments of personal attributes are distributed through discrete domains (Harter, 2008). This multidimensional approach allows the explanation of the different self-evaluation people do about themselves in different domains of their self-concept (Harter, 1999). These multiple domains – also designated as *schemas*, *self-schematas* (Markus, 1977), *categories*, or *aspects* (Linville, 1985) – reflect the relevant knowledge an individual has about a particular personal trait or attribute (Crisp & Turner, 2010).

Self-schemas derive from the self-related information a person process, with data acquired from repeated categorization and appraisals of the individual's behaviour by oneself and others in social experiences (Markus, 1977). The existence of self-schemas enables a person capability to a) process data related to the self in a particular schema with effortlessness, b) achieve behavioural evidence from that domain, c) anticipate personal future behaviour, and d) endure contradictory schematic-information (Markus, 1977).

The notion of a global self-concept integrating several self-schemas of particular features of an individual emphasizes the possibility that people may have a diverse collection of specific ideas about oneself (Baumeister, 2004; Markus, 1977). Furthermore, it justifies that not all self-concepts are made out of the content (Baumeister, 2004). The self-schemas that may be essential to some self-concepts may be insignificant to others. This

multidimensional approach also acknowledges that some people may not have some specific self-schema regarding a particular characteristic or area (Baumeister, 2004). For example, some people might consider themselves creative, some might think of themselves as unimaginative, and some may not recognize as being either one.

Regarding the diversity of dimensions that a global self-concept can involve, it's expected that the number of self-schemas echoes the number of roles one has in life – e.g. student, friend, parent, etc. According to Linville (1985), one conceptualizes oneself in numerous ways concerning broader experiences in particular roles, behaviours, relationships, and others. Shavelson and Bolus (1982) established two broad classes concerning the self-concept structure – 1) academic self-concept and 2) non-academic self-concept – where the non-academic self-concept is sectioned into social, emotional and physical domains. Particularly, the physical domain is further differentiated between physical ability and physical appearance.

The discrete domains can acquire specific qualities since they depend on lived experiences. In addition to the enumeration of some schemas that can compose self-concept – such as *cognitive competence*, *physical appearance*, *self-esteem*, *social acceptance*, and others – Harter (2008) designated further domains as *domain-specific self-evaluation*, enabling the customization of an individual's self-schema and one's self-concept. A person can also identify self-perceptions that describe one's personality, characterizing personal, relatively stable and nonpathological traits – designated as explicit personality self-concept (Asendorpf, Banse, & Mücke, 2002; Schnabel, Asendorpf, & Greenwald, 2008). Oyserman, Elmore, and Smith (2012) structured self-concept considering the multiple perspectives one can view oneself from. They established the a) individualistic "me" self or the collectivistic "us" self, b) distal "future" self or temporarily "now" self, and c) immersed "mind's-eye" self or the observer's "eye of others" self.

The self-verification theory (Owens, 1993) emphasizes stability as one of the most important traits of self-concept. Guaranteeing interpersonal predictability, a stable and consistent self-concept will promote well-succeeded social interactions. According to this theory, external evaluations that confirm the global idea the individual has about oneself are preferable – even if carrying a negative quality – over those who contradict the notion one as about oneself. Therefore, less dissonance between the acknowledgement of the external *feedback* and the self-concept of the individual will induce to lower inconsistency among interpersonal relationships.

Despite the feature of stability associated with this psychological construct, the structure of self-concept can also be characterized as large, dynamic and complex (Baumeister, 2004). The several dimensions that constitute a person's self-concept oscillate on one's thought at different times. Baumeister (2004) designated as *spontaneous self-concept* the specific domain of self-concept present at one's mind in a particular moment. Therefore, the spontaneous self-concept changes, even though self-esteem and others deeper facets of self-concept appear to resist variations.

The study of people's self-concept in the ambit of physical health has major importance, since different domains of one's life are affected when the person's health is threatened. Rojas, Brante, Miranda and Pérez-Luco (2011) explored the self-concept on people with morbid obesity submitted to bariatric surgery. According the authors, the participants reported increased feelings of attractiveness and satisfaction, also affirming that they felt more secure, agile, and accepted. Gender differences were also explored by Marčič and Grum (2011), where females showed a better overall self-concept, being more satisfied with themselves in the relationship domain, with partners, family, and social context. In this study, men and women indicated to be equally satisfied with individual domains, such as appearance, physical fitness, and intelligence.

When investigating the association between one's weight status and their physical self-concept, Binkley, Fry and Brown (2009) establish that both men and women who perceived they were at a normal weight reported a significantly higher physical self-concept than those who perceived themselves with overweight or obesity. As a subject studied in areas such as overweight and obesity, the physical self-concept – like many other domains that may compose one's self-concept – hasn't been explored in the field of weight loss, which values the pertinence of the current investigation.

However, despite the broad theoretical and empirical evidences comprehending the self-concept, the distinction between others psychological constructs definitions – such as *global self-esteem* and *identity* – and the definition of self-concept it's not transparent.

Global Self-Esteem. Global self-esteem can be designated as the combined attitudes – positive and/or negative – and subjective appraisals the individual as towards the self (Rosenberg, 1965; Crisp & Turner, 2010). Described as the degree of one's feeling self-respected, valued as a person and "good enough" (Rosenberg, 1965), the global self-esteem has had an important place in the literature.

The level of self-esteem can diverge depending on the context a person is integrated at a defined moment (Crisp & Turner, 2010). Additionally, it's often understood as a *sociometer* – an internal measure with the ability to characterize how strongly one is attached to others who surround him (Leary, Tambor, Terdal, & Downs, 1995). Liable on the person itself, self-esteem is not considered either an attribute or a state (Harter, 2008). Therefore, for some persons self-esteem may be contemplated as stable while others may acknowledge it as inconsistent.

Different aspects of self-esteem have been explored and studied through the literature, such as sense of power, inner and outer self-esteem, sense of worth, evaluation and affection, self-worth, sense of competence, and morality (Gecas, 1982). It's common to differentiate a) self-esteem based on a sense of competence, power, or efficacy, and b) self-esteem based on moral worth or virtue. Self-esteem is supportive when coping with disturbance, stress and adversities, and also inversely correlated with social anxiety (Baumeister, 2004), being considered a valuable resource.

Self-esteem is one of the most important aspects of self-concept (Baumeister, 2004; Gecas, 1982); it characterizes the evaluative and affective dimensions of self-concept and gives it a motivational significance. Structurally, specific information about the self is incorporated into the self-concept and – once acquiring a judgment of value – it affects an individual's self-esteem (Baumeister, 2004). In the ambit of self-esteem determination, the domain-specific self-concept features are considered the sources of self-esteem (Baumeister, 2004; Harter, 1999), understanding a specific self-esteem for each self-concept domain.

Identity. Identity includes a) the individual's interpersonal self, characterized as how others know oneself, b) potentiality, translated as the concept one has of what the individual may become, and c) global principals, values, and priorities (Baumeister, 2004). Anchoring the self to social systems (Gecas, 1983), identity carries to reality and shares with other people what only exists in the individual's mind – his/her own self-concept (Baumeister, 2004).

Identity provides meaning and focus on particular features of the individual (Oyserman, Elmore, & Smith, 2012). Two prominent traits can be pointed out – 1) continuity, understood as stability in time (being the same person over time), and 2) differentiation, allowing a person distinction to some else (Baumeister, 2004).

Comprehending evaluative components, identity provides structure and sense to some aspects or parts of the self-concept (Gecas, 1982). While self-concept encompass the notions a person has about oneself – which may include things that are not part of one's identity, such as personality attributes like being friendly or shy – identity concerns the sense of knowledge about who the person is, which also containing attributes that are outside the person's mind (Baumeister, 2004).

Therefore, identity content comprises not only personal but also social knowledge about oneself, resting on a defined self that is shared by the individual, people he/she relates to and general society – which emphasizes the social nature that is not present in self-concept (Baumeister, 2004).

Body Image

People's assumptions, feelings and actions towards their bodies is broader influenced by what Cash (2011) designates as historical factors – aspects such as the interpersonal experiences, physical traits and modifications, personality features, and cultural socialization. Consequently, those historical factors motivate the individual's elaboration of body image attitudes and appraisals.

The body image considers the subjective perceptions, beliefs, attitudes and behaviours the individual has about his/her body, being a multidimensional psychological construct (Cash, 2004, 2011). According to the author (2004, 2011) it's possible to identify two main core axis comprehended by body image – i) the attitudinal axis, that includes an evaluative and the investment components, and ii) the self-perception axis. Regarding the attitudinal frame, the a) evaluative component mentions the quality of the satisfaction a person has with one's appearance, the beliefs about one's appearance and possible self-ideal discrepancies (Cash, 2004, 2011), and the b) investment factor states the degree of cognitive, emotional, and behavioural importance that one assigns to the body's self-evaluation (Cash, 2004, 2011).

These two basic body image attitudes – evaluation and investment – are constructs with organizational capabilities in cognitive, behavioural, and emotional processes happening in contextual events (Cash, 2011). Particularly, the body image investment implicates specific self-schemas a person develops related to one's appearance. Cash, Melnyk, and Hrabosky (2004) accentuate the appearance-related self-schemas that body image investment comprehends. Because self-schemas develop according the multiple domains within the person (Markus, 1977), contextual experiences trigger one's appearance-related schema to process self-evaluative relevant information about the individual's body (Cash, 2011; Cash, Melnyk, & Hrabosky, 2004). Consequently, the study of those appearance-related self-schemas is essential when trying to understand an individual's body image experiences.

Both genders face, nowadays, unrealistic body standards that might damage one's welfare – those pretentious body image goals prompt women's ambitions for extreme thinness and men's drive for muscularity (Murnen, 2011). Negative body image investment has also been demonstrated to affect differently according to the gender (Pritchard, 2014). In this ambit, woman report more concern with the level of body fat (Charnyak & Lowe, 2010), while men tend to be more worried not only with body fat but also the muscularity level (Jung, Forbes, & Chan, 2010).

People with overweight and obesity also showed dissatisfaction with their bodies and appearances. Not only reporting dissatisfaction with one's size and weight, people with those conditions indicate dissatisfaction with distinct body traits (Sarwer at al., 2011). In fact, health improvement and the risk reduction for health-related problems are not the major motive that people point out as the motivation to weight loss. Most individuals express physical appearance improvement as motivation to weight loss (Sarwer at al., 2011).

The body image can be understood as a psychological construct that comprises one's self-concept, the self-perception of their body and appearance, and the perceived feelings towards the person's body (Alipoor, Goodarzi, Nezhad, & Zaheri, 2009), which supports the investigation of the self-concept on individuals that have experienced a weight loss process.

Study Purpose

As previously noted, there's a deficiency concerning the investigation of perceived consequences of a successful weight loss on the current literature (Alegría & Larsen, 2015; Sarwer et al., 2011). The further exploration in this background will enable the identification of negative aspects associated to a successful achievement, which might eventually contribute to a relapse. Additionally, the investigation of perceived positive consequences will allow an extended acknowledgement of what people value in this particular successful context.

The exploration of the thematic of weight loss with a qualitative approach is also lacking in the literature. In order to highlight the lack of literature of qualitative studies in the ambit of weight loss, a research was made integrating PubMed, Scielo International and EBSCO (including PsycInfo, PsycArticles, Psychology and Behavioural Sciences Collection, and Academic Search Complete as data bases). The key-words used were *weight loss* and *qualitative*, applied simultaneously and assigned as *title* at PubMed and EBSCO (to allow a broader reach, it wasn't assigned a specific field at Scielo International). No year restriction, or any other limitation, was applied.

At the present date (November, 2015) the research showed a total of 85 results – 32 at PubMed, 27 at Scielo International and 26 at EBSCO. From the obtained results, a) 43 were considered irrelevant due to different backgrounds, contexts and/or variables studied (e.g. articles related to veterinarian sciences, agriculture or engineering fields), b) 24 were repeated

between data bases, c) 5 were non-published dissertations, d) 4 were mainly related to obesity, e) 4 focused on specific intervention programs or health behaviours in weight maintenance, and f) 5 regarded qualitative studies with purpose of explore the participant's personal experiences of the weight loss.

Since capabilities such as executing global judgments of one's sense of worth and providing specific self-evaluations on multiple domains start developing around middle childhood (Harter, 1999), self-concept has been mainly investigated with children and adolescents. Additionally, the academic setting constitutes the most frequent background for self-concept exploration in compiling studies such as meta-analysis (e.g., Bear, Minke, & Manning, 2002; Huang, 2011). Investigating adult's self-concepts, specifically related to a weight loss process, may instigate a characterization of self-perceptions addressed to different domains – closely related to physical or psychological transformations, appearance perceptions or to aspects of personality – than those who emerged in literature regarding children and adolescents, which reinforces the pertinence of the present investigation.

Body image and subjects linked to weight loss are most frequently related with female population (Sarwer et al., 2011; Cash, 2011), depreciating experiences and perceptions of male individuals in this field.

Considering the highlighted above, the aim of the present study is to explore – through in depth qualitative interviews that were recorded, transcribed and analysed (Bardin, 1977; Braun & Clarke, 2006) – the positive and negative perceived consequences and the spontaneous self-concept in a sample of Portuguese male and female adults who achieved a successful weight loss.

Method

Study Design

The qualitative methodology implies the analysis of the collected information considering the individual's reference frame and personal experiences, contemplating a holistic vision in a particular context, instead of the validation of previously formulated hypothesis (Carmo & Ferreira, 1998). Thus, the data acquired through the semi-structured interview enables a more entailed comprehension regarding the investigated phenomenon – particularly, the perceived consequences and spontaneous self-concept on a successful weight loss.

The study design is classified as descriptive-transversal and exploratory, since the obtained results were collected in a precise moment and achieved without the researcher's manipulation on any variable, meeting the purpose of extending the current limited knowledge related to the explored subject (Carmo & Ferreira, 1998; Pais-Ribeiro, 2010).

Participants

A convenience sample integrated 30 individuals – 15 male and 15 female – from Continental Portugal and Islands (Appendix A), with an average age of 43.7 years (*SD* = 13.24). Participants had an average weight loss of 31.5 kg and a standard BMI of 29.7 kg/m^2 (*SD* = 6.8). The most common weight loss method (Table 1) was the change of eating habits (33%), followed by dietary changes and physical exercise (20%) and bariatric surgery (17%).

The inclusion criteria were i) 18 years or older, ii) minimum literacy and being able to answer an extensive and audio recorded interview, iii) have a weight lost equal or above 7% of the initial body weight, and iv) a minimum of 12 months of weight maintenance.

Table 1 – Frequencies and Percentage of Socio-demographic Characteristics.

Socio-demographic Characteristics	**Frequency**	**Percentage**
Marital Status		
Married/Civil Partnership	12	40
Divorced/Separated	3	10
Single	12	40
Missing	3	10
Affective-Sexual Relationship		
Yes	17	56.7
No	11	36.7
Missing	2	6.7
Professional Situation		
Active	17	56.7
Retired	4	13.3
Unemployed	3	10
Other	3	10
Missing	3	10
Educational Level		
Incomplete Primary School (4 years or less)	2	6.7
Primary School (6 years)	2	6.7
Middle School (9 years)	4	13.3
High School (12 years)	5	16.7
Bachelor (3 years in College)	3	10
Graduate (5 years in College)	9	30
Master (7 years in College)	1	3.3
Other	1	3.3
Missing	3	10
Annual Household Income		
10.000€ or less	6	20
From 10.001€ to20.000€	11	36.7
From 20.001€ to 37.500€	4	13.3
From 37.501€ to 70.000€	3	10
Superior to 70.001€	1	3.3

Missing	5	16.7
Weight Loss Methods		
Surgery	5	16.7
Change in Eating Habits	10	33.3
Physical Exercise	1	3.3
Surgery and Change in Eating Habits	1	3.3
Change in Eating Habits and Physical Exercise	6	20
Surgery, Change in Eating Habits and Physical Exercise	1	3.3
Change in Eating Habits and Other	2	6.7
Surgery and Other	1	3.3
Missing	3	10

Material

All the used materials and the collected data belong to a broader investigation about obesity and successful weight loss, that is currently being developed in the William James Center for Research (WJCR), from ISPA – Instituto Universitário de Ciências Psicológicas, Sociais e da Vida.

As a methodological process for data collection, the semi-structured interview enables the purpose of assembling detailed personal descriptions of experiences within the process of weight loss allowing, as well, to increment the deficiency of qualitative research within this field. Aiming to explore the participant's perceived consequences of the achieved successful weight loss and spontaneous self-concept – that is present at the individual's awareness at that moment – the developed semi-structured interview corresponds to a segment of a more extensive interview designed for the WJCR investigation.

The participants answered a triage-questionnaire (Appendix B), intending to collect specific information concerning the weight loss in order to verify that each individual met the inclusion criteria. An informed consent (Appendix C) was also signed by the participants, presenting the study purpose, clarifying the participation format, guaranteeing the confidentiality of the information and reinforcing the permanent possibility to quit with no prejudice; since some of the interviews were made personally, the anonymity was impossible

to ensure since the interviewer would be able to recognize the participant. At the end, it was given the chance to clarify any question as well as provided availability to contact the leading investigator to possible clarifications. A written permission for audio recording the interview (Appendix D) was also signed, ensuring the preservation of the audio recording exclusively between researchers associated to the investigation and its resource for academic purposes only. The socio-demographic and health questionnaires (Appendix E) were applied in order to collect information related to personal data (e.g. marital status, professional situation, literary qualifications) and to health habits (e.g. lower and higher weights, tobacco and alcohol consumptions).

Interview Guide

Being part of a broader investigation, the present study used as methodology a middle fragment of a complete interview guide constructed for the major investigation belonging to WJCR (original Portuguese version – Appendix F). The present segment is structurally located after the exploration of others main themes for the global study – regarding aspects such as the history of the individual's weight, the strategies of the weight loss, and others.

The guide for the applied section of the semi-structured interview address the core areas to investigate in the following order – A) negative perceived consequences, B) positive perceived consequences, and C) self-concept. The comprehension of the negative perceived consequences was established firstly in order to allow a gradual development of the thematic, since it succeeds the exploration of existing factors that contributed to an eventual uncontrolled weight gain; this way, the exploration of the negative consequences followed a thematic also probably imbued with a register of unfavourable emotions.

A. Negative perceived consequences

1. The significant weight loss and the maintenance of this new lower weight had any negative consequence? If so, which ones? Any negative consequence at a social/professional/familiar/personal/sexual or intimate level?

B. Positive perceived consequences

2. Do you think the weight loss and the maintenance of this new lower weight had any positive consequence? If so, which ones?
    2.1. Any positive consequence at a social level (in the way you plan your extra-professional activities and relate to your friends)? If so, could you tell me a bit more about it?
    2.2. And at a professional level? If so, could you describe a bit more?
    2.3. And at a familiar level (in the way you interact with your family)? Do you have children? If so, do you think your current weight as any influence in the way you interact with them?
    2.4. And at a personal level? Do you feel your weight interfers with your personal life? And at a sexual level?

C. Spontaneous self-concept

3. How do you think the people you know (those with whom you don't have a close relationship) see you currently?
4. And the people closest to you?
    4.1. How do you think your family sees you?
    4.2. How do you think your friends see you?
5. And how do you see yourself? How would you describe yourself? How do you evaluate yourself regarding your personal features?

Procedure for Data Collection

Through a convenience non-probabilistic sample process, the established contact with the participants took place between September of 2012 and June of 2013. To acquire permission for the investigation development at the hospital setting and the private practice settings (nutrition clinic and obesity treatment clinic, a formal written request was sent to the ethic council of the first (Appendix G) and of the clinical director of both latter.

In articulation with a team of healthcare professionals (from clinical/hospital settings), the researchers responsible for the investigation presented its procedures and main objectives. After the authorization's approval at the described contexts, the healthcare professionals would establish the first contact with the eventual participants, presenting the current investigation, the main subjects and its purposes. The healthcare professionals would, subsequently, reference the individuals who had demonstrated interest in taking part of the study to the leading researchers.

Part of the present sample was also gathered through social networks (Facebook, e-mail contact) and through participants referencing (snow-ball sampling).

Afterwards, each participant was contacted by one of the psychologists affiliated to the investigation in order to apply the triage-questionnaire focused on the some of the inclusion criteria (minimum loss of 7% of the initial body weight and at least 12 months of weight maintenance). This leading contact was made through e-mail, telephone or personally, by means of a previously scheduled appointment. When meeting the admission criteria, the informed consent and the permission for audio recording the interview were signed. Subsequently, the socio-demographic and health questionnaires were applied in order to characterize the sample.

The interviews were made personally or by telephone, according to the participant's availability schedule. When personally, an empty room with closed door was provided, allowing an uninterrupted individual context, whether in hospital, clinical or university clinic settings. With interviews made by telephone, the researcher who was responsible for conducting the interview guaranteed the permanent presence in an individual and soundproofed room, assuring the timing was convenient for the participant as well as achievable physical space accessibility. The interview was recorded by the same investigator that conducted the interview and it wasn't established any time limit, allowing an unrestricted

characterization of personal experiences. The analysed data are available for consultation if requested to the authors of the present investigation.

The gathered data was entirely transcribed, including not only the audible content but also inaudible and non-verbal content, such as pauses and laughs. To enable the anonymity criteria towards the remaining researchers who didn't contact with the participant, each interview was designated with a numeric and alphabetic code, concealing the participant's identification. The collected material was analysed through a pluralist approach – according to Bardin (1977) technique of content analysis, and Braun and Clarke (2006) method of thematic analysis.

Procedure for Data Analysis

The content analysis was used following the recommendations of Bardin (1977) and according to the exhaustivity and exclusivity criteria, with the purpose of acquiring an objective, systematic and quantitative description of the manifest content. Also as employed methodology, the thematic analysis enabled the identification, exploration and description of patterns (or themes) within the gathered data (Braun & Clarke, 2006).

The combined content analysis and thematic analysis enabled i) an inductive approach, since the identified themes were linked to the data itself allowing its coding and enumeration, and ii) a deductive approach, considering the theory-driven analysis present in the exploration of the content.

Since the permanent link to its epistemological a theoretical commitments is part of the qualities of an investigator who conducts data analysis through a qualitative methodology, is essential the recognition of the potential presence of analytic preconceptions throughout the study. In the present analysis, it was privileged a coding process which didn't force any data into a pre-existing coding frame or theoretical attribute, prevailing the participant's manifest content as the most significant data to identify.

The analysis was submitted to a jury of 2 researchers with an inter-rater reliability (Cohen's kappa) of 0.734 (Appendix H); this reliability indicator was calculated based on the coding of 2 from the 30 interviews, analysed separately by the two researchers after the stabilization of the developed codification grid over the analysis of the 28 interviews.

Several processes were involved in the analysis: a) establishing pre-existent categories (Appendix I), correspondently to the core areas to analyse, b) creating and defining, when justified by manifest content nature, emergent categories (sub-categories) that derived from the pre-existent categories, were mutually exclusive from each other's and contemplative of the 30 analysed interviews, c) generate personalised codes to classify each category, and d) identifying portions of speech that would integrate the emergent categories.

Mirroring the areas aiming to explore, the pre-existing categories were 1) negative perceived consequences, 2) positive perceived consequences, and 3) self-concept. The emergent categories comprehend 2 particularization levels, which reflect the need to categorize specific evolving content. For instance, pre-existing categories would be *3. Perceived consequences of the successful weight loss* and *3.2. Perceived positive consequences of the successful weight loss*, since they reflect the core subjects to explore in the present study. Following, emergent categories would be *3.2.8. Improvements in physiologic indicators* and *3.2.8.1. Reduction of blood pressure levels*, reflecting 2 levels of specification that mirrored the need to categorize the manifest content.

The characterization of the expression of all subcategories found was made through a frequency and percentage study.

Finally, it was applied a Multiple Correspondence Analysis (MCA) with the aim of representing the associations between the emergent categories resultant from the content analysis and finding inherent constructs that were major determinants in the participant's conception of the perceived consequences and spontaneous self-concept. The descriptive analysis and the MCA were realized using SPSS (v. 22).

Results

Inter-Evaluator Reliability

The calculation of the reliability represents an important component of the overall confidence in an investigation's accuracy (McHugh, 2012). The analysis of the agreement between the observers (or researchers) is used as a quality indicator of the defined categories and the raters' competence to apply the same (Warrens, 2014).

The used coefficient – Cohen's kappa – is adapted for a two raters study and a scale with two or more nominal categories, ranging from a -1 to +1 where 1 represents a perfect agreement between raters (McHugh, 2012). Values can be interpreted as a) indicating no agreement when ≤ 0, b) none to insignificant, from 0.01 to 0.20, c) fair, from 0.21 to 0.40, d) moderate, from 0.41 to 0.60, d) substantial, from 0.61 to 0.80, and e) perfect, from 0.81 to 1.00 (Cohen, 1960; McHugh, 2012).

In order to assess the reliability in the present study, the two researchers coded the same pair of transcribed interviews independently. Based on both researchers' analysis, with the develop codification grid from the previous analysis of the remaining 28 interviews, the assessment of Cohen's kappa reliability indicator was 0.734 which can be interpreted as a meaningful agreement.

Perceived Consequences

Throughout the qualitative analysis, several emergent categories derived from the participants manifest content. The first pre-determined category – Negative perceived consequences of the successful weight loss – comprehended consequences from multiple domains that the participant expressed as having a significant negative impact for oneself as a result of the achieved weight loss.

In this category, emergent consequences involved:

i. negative body image repercussions, which refers to the undesirable effects on one's physical image, such as flaccid skin, stretch marks, and excessive weight loss;
ii. dissatisfactory social impact, concerning encountered difficulties in interpersonal relations consequently to the weight loss, for example relational problems, perception of jealousy from the spouse, success depreciation, and negative reactions by others;
iii. adverse organic effects, regarding problematics that the weight loss caused on the proper body functioning, including body aches, bowel function alteration, and a decrease of physiological indicators such as haemoglobin;
iv. dietary behaviours, such as restriction of alcohol consumption and change in eating habits;
v. and psychological repercussions, including higher irritability and confrontation with failed expectations.

The absence of negative perceived consequences was also emergent and considered upon the analysis, referred to cases where the participant would specifically say that there were no negative impacts consequently to the weight loss in particular domains, such as personal, familiar, social, professional, intimate or sexual areas.

The second pre-existing category – Positive perceived consequences of the successful weight loss – also encompassed outcomes of varied natured featuring the positive impacts subsequent to the weight loss.

In the positive valence, emergent categories included references to:

i. physical image benefits, concerning an improved body image, the increase pleasure in appearance care, and the higher ease in acquiring clothing;
ii. social improvements, referring to gains reflected in interpersonal relations consequently to the weight loss, such as a higher pleasure in socialize, positive

comments and reactions, social network expansion, and deeper valuing interpersonal relationships;

iii. organic enhancements, including fatigue and pain decreases, and improvements physiological indicators such as blood pressure, cholesterol and glycaemia;

iv. progresses in physical ability, considering one's mobility enhancement;

v. health behaviours, such as restoring the practice of physical activity;

vi. marital relationship benefits and sexual enhancements, concerning quality improvement in the conjugal relation, decreased difficulty in sexual performance and sexual positive consequences due to body changes;

vii. professional benefits, concerning the increased control in professional areas and the investment in professional-related pleasurable dimensions;

viii. and psychological growths and personal changes, regarding increased self-esteem, self-confidence and emotional control, decreased embarrassments, release of useless cognitions, perception of generalized self-efficacy, cease of the perceived stigma/discrimination, feelings of tranquillity, personal realization, well-being and happiness.

Non-specified positive consequences were also present in participant's manifest content, characterizing the presence of positive perceived consequences due to the weight loss that the individual recognized but didn't mention explicitly which results were. Similarly to the negative perceived consequences, the absence of consequences for the positive valence was also coded given the analysed manifest content, for the same emergent domains.

The frequencies regarding the obtained results of both negative and positive perceived consequences of a successful weight loss are presented in Table 2.

Table 2 – Frequencies and Percentages of Perceived Consequences in a Successful Weight Loss.

Category	Subcategory	Subcategory frequency	Category frequency	Category percentage
Negative consequences	Relational problems	3	6	3.9
	Success depreciation	3		
Absence of negative consequences	Personal	7	34	21.9
	Familiar	11		
	Social	8		
	Professional	8		
Positive consequences	Well-being/Happiness	10	73	47.1
	Increased self-esteem	4		
	Increased self-confidence	3		
	Decreased embarrassments	3		
	Perceived discrimination cessation	5		
	Social network expansion	3		
	Positive comments	17		
	Easier clothing acquisition	6		
	Pleasure in appearance-care	5		
	Body image improvement	7		
	Sexual, due to body change	4		
	Mobility/Agility improvement	6		
Absence of positive consequences	Sexual/Intimate	13	42	27.1
	Familiar	13		
	Social	6		
	Professional	10		
Total	-	155	155	100

Posteriorly to the frequencies' study, a Multiple Correspondence Analysis (MCA) was made in order to generate a dimensional model representative of the perceived consequences resulted from the weight loss. As criteria for the MCA, only categories mentioned by at least 3 participants (that is, 10% of the sample) were considered. Furthermore, categories featuring non-specific consequences or absence of consequences in a given domain weren't included in the representative model, since it didn't contribute for the established purpose of exploring the existence of explicit consequences as result of a successful weight loss.

The results of the MCA for the perceived consequences are shown in Table 3.

Table 3 – Three-dimensional Model of the Perceived Consequences in a Successful Weight Loss.

Perceived consequences	**Factors**			
	Personal growth/Social adversities	**Body image/Social benefits**	**Physical/ Emotional well-being**	**Average**
Negative consequences:				
Relational problems	**.806**	.029	.075	.303
Success depreciation	**.806**	.029	.075	.303
Positive consequences:				
Well-being/Happiness	.058	.162	**.468**	.229
Increased self-esteem	.044	**.394**	.079	.173
Increased self-confidence	**.219**	.017	.194	.143
Decreased embarrassments	**.188**	.013	.048	.083
Perceived discrimination cessation	**.217**	.003	.209	.143
Social network expansion	.037	**.224**	.022	.094
Positive comments	.149	**.285**	.059	.165
Easier clothing acquisition	.074	.048	**.359**	.161
Pleasure in appearance-care	.118	**.309**	.012	.146
Body image improvement	.125	**.284**	.007	.138
Sexual due to body change	.078	**.128**	.050	.085
Mobility/Agility improvement	.042	.002	**.103**	.049
Total	2.961	1.928	1.760	2.216
Percentage of variance	21.151	13.771	12.574	15.832

Spontaneous Self-Concept

In the analysis of the spontaneous self-concept, multiple categories emerged when it was asked to the individual about how he/she thinks others – acquainted without a close relation, family and friends – see him/her and how the person sees oneself.

The first category referring to the self-concept – Physical Self-concept – comprehended emergent negative and positive valences, as well as an ambivalent/neutral field and a body investment domain. As a schema strictly regarding the physical appearance, the physical self-concept comprised how one sees oneself from a bodily perspective.

The negative physical self-concept involved:

i. the characterization of specific body areas, such as the abdomen and the face;
ii. undesirable features, encompassing flaccid skin, cellulite and bone protuberance;
iii. overall dissatisfactory appearances, as looking ill, having an overweight image or an excessively thin image;
iv. and non-specific negative physical evaluation.

The positive physical self-concept concerned overall pleasing appearances, as being elegant, beautiful, younger, healthier, fitter, and also a non-specific positive physical appraisal. The ambivalent/neutral category encompassed a neutral attitude towards one's thinness and a non-specific ambit, where a person showed ambivalence or neutrality towards its body/image.

The body investment category, encompassed in the Physical Self-concept, involved any demonstration of one's set of particular efforts that, deliberately or not, had an effect on physical shape or image.

The category related to physical capability of the spontaneous self-concept – Physical Ability Self-concept – only had an emergent positive valence, concerning one's personal assessment as having higher mobility and being physically active.

Other self-concept category was the Interpersonal Self-concept, referring one's evaluation regarding its interpersonal experiences. Having only emerged a positive valence, it involved seeing oneself as supportive, sociable, pacifist, making emotional investments and easily coexisting with others.

The Explicit Personality Self-concept concerned propositional categorizations that combine other concepts of the self and personality describing attributes. In this field, both negative and positive valence emerged throughout the analysis. The negative explicit

personality self-concept incorporated attributes such as distrust/suspicion, negligence/laziness, passivity/dependence, absence of willpower, self-destructiveness, vulnerability, neediness and features of unaccomplishedness. The positive explicit personality self-concept encompassed qualities as calm, less irritability and temperamental, persistence, energy, optimism, emotionality, considerate, self-defensive and efficient.

Lastly, the self-esteem was also integrated as an emergent category of the self-concept, comprising the Global Self-esteem domain referred to the affective and evaluative dimension of the self-concept without a specific ambit.

The frequencies concerning the acquired results of the spontaneous self-concept in a successful weight loss are presented in Table 4.

Table 4 – Frequencies and Percentages of the Self-Concept in a Successful Weight Loss.

Category	**Subcategory**	**Subcategory frequency**	**Category frequency**	**Category percentage**
Ambivalent/Neutral physical self-concept	-	15	15	20
Negative physical self-concept	Overweight Ill Excessive weight loss	7 3 3	13	17.3
Positive physical self-concept	Skinnier/Less fat Healthier	10 4	14	18.7
Appearance and body investment	-	9	9	12
Positive interpersonal self-concept	-	3	3	4
Global self-esteem	-	3	3	4
Positive explicit personality self-concept	Calm Persistent Efficient	3 3 8	14	18.7
Negative explicit personality self-concept	-	4	4	5.3
Total	-	75	75	100

Similarly to the used statistic procedure with the results of the perceived consequences, a MCA was also made with the purpose of create a representative model of the spontaneous self-concept in a successful weight loss. The condition to generate the dimensional model was identical to the one set in the model of the perceived consequences.

The results of the MCA for the spontaneous self-concept are shown in Table 5.

Table 5 – Three-dimensional Model of the Spontaneous Self-Concept in a Successful Weight Loss.

Spontaneous self-concept	**Factors**			
	Effective investment/ Balanced self-esteem	**Ambivalent**	**Positive acceptance/ Focused**	**Average**
Ambivalent/Neutral physical	.126	**.172**	.007	.101
Negative physical				
Overweight	.192	.018	**.318**	.176
Ill	.270	**.357**	.030	.219
Excessive weight loss	.229	**.420**	.025	.225
Positive physical				
Skinnier/Less fat	.091	**.198**	.005	.098
Healthier	.000	**.124**	.105	.076
Appearance and body investment	**.152**	.087	.018	.086
Positive interpersonal	.151	**.498**	.031	.227
Global self-esteem	**.414**	.008	.029	.150
Positive explicit personality				
Calm	.087	.051	**.486**	.208
Persistent	.082	.000	**.417**	.166
Efficient	**.237**	.043	.001	.094
Negative explicit personality	**.295**	.212	.126	.211
Total	2.324	2.187	1.598	2.037
Percentage of variance	17.879	16.826	12.291	15.665

Discussion

The purpose of the present investigation is to explore the perceived consequences and the spontaneous self-concept of male and female Portuguese adults who accomplished a successful weight loss, through the content and thematic qualitative analysis of previously recorded and transcribed interviews.

Perceived Consequences

Derived from the frequencies' analysis, the negative consequences more commonly perceived between the participants were relational problems and success depreciation.

A study on the experiences of obstacles and facilitators to weight loss in a dietary intervention reports barriers of social nature, including the perception of friendships or family as a possible obstacle to weight loss (Hammarström, Wiklund, Lindahl, Larsson, & Ahlgren, 2014). Since a meaningful part of socialization were activities such as having coffee or meals together, maintaining healthy diet habits translated into feelings of isolation, afraid of emphasizing new eating behaviours and difficult control management (Hammarström et al., 2014). Consequently, encounters with friends, co-workers and family turned into social relational problems perceived as a barrier to the weight loss (Hammarström et al., 2014).

Within romantic relationships, a study by Kinzl et al. (2001) about sexuality and sexual disorders as consequences of weight loss after gastric banding indicates that 20% of the participants stated an improvement in partnership after surgery, against 70% that affirmed no differences in the quality of relation with the partner, and 10% of cases where the weight loss had negative repercussions on the partnership. The 10% of cases who mentioned negative repercussions referred increased marital discord and jealousy as sources of negative effects in partnership, which can also be a possible interpretation for the relational problems as an emerged negative consequence of the successful weight loss in the present investigation.

Concerning psychosocial functioning, body image and personality after bariatric surgery, van Hout, Fortuin, Pelle and van Heck (2008) pointed higher hostility, dominance and egoism as participants' personality alterations postoperatively. These personality variations may cause impact on existing relations and the self-perception of relational problems, perceived by the individual as a consequence of his/her weight loss.

In a study related to psychosocial effects of weight loss also after gastric banding (Kinzl, Traweger, Trefalt, & Biebl, 2003), the reaction of friends and family to the individuals weight loss was negative in 20% of cases. The perception of negative reactions by close relatives and meaningful people on one's weight loss may be felt, to the individual, as success depreciation (mentioned in the present study by 10% of the participants).

Furthermore, a possible relation may exist between the perception of success depreciation by others and the occurrence of relational problems, since both were mentioned by 10% of the participants in the present investigation.

Regarding the positive valence of the perceived consequences, the more frequently referred outcomes (reported by at least 3 participants) were i) well-being/happiness, ii) increased self-esteem, iii) increased self-confidence, iv) decreased embarrassments, v) perceived discrimination cessation, vi) social network expansion, vii) positive comments, viii) easier clothing acquisition, ix) pleasure in appearance-care, x) body image improvement, xi) sexual, due to body change, and xii) mobility/agility improvement.

Health-related quality of life (HRQOL) regards self-perceptions on psychological, physical and social functioning, and overall well-being (Lasikiewicz, Myrissa, Hoyland, & Lawton, 2014; Testa & Simonson, 1996; Warkentin, Das, Majumdar, Johnson, & Padwal, 2013). Including one's perception of signs of health, disease symptoms, coping strategies and – of greater relevance in obesity cases – perceptions of stigma or discrimination, HRQOL improvements have been recognized in studies with weight loss backgrounds (Lasikiewicz et al., 2014; Rueda-Clausen, Ogunleye, & Sharma, 2015; Swencionis et al., 2013; Wing & Hill, 2001). The present investigation findings concerning the positive perceived consequences are consistent with these outcomes regarding HRQOL improvements, since the participants manifested beneficial consequences at psychological, physical and social levels and, moreover, i) general well-being.

The increased ii) self-esteem and iii) self-confidence explored in the manifest content are also supported by previous studies (Blaine, Rodman, & Newman, 2007; Epiphaniou & Ogden, 2010; van Hout et al., 2008; Rueda-Clausen et al., 2015; Wing & Hill, 2001) as a common effect of the weight loss.

Posteriorly to the weight loss, the literature points out an improvement in social interactions (Castro, Carvalho, Ferreira, & Ferreira, 2010; Epiphaniou & Ogden, 2010; Hayden, Dixon, Dixon, Playfair, & O'Brien, 2010; van Hout et al., 2008), often related to the increased self-esteem and self-confidence, that was also explored by the participants in the

present study in emergent categories such as v) perceived discrimination cessation and vi) social network expansion.

Linked by the increases in self-esteem and/or self-confidence and the developments in one's social skills and interactions with others, the individual experiences self-acceptance and a sense of normality within social encounters (Epiphaniou & Ogden, 2010) that supports the findings of the iv) decreased embarrassments as a positive perceived consequence of the weight loss in the current investigation. Still in the social sphere and contrary to the 20% of negative reactions previously pointed out in a study regarding psychosocial effects of weight loss (Kinzl, et al., 2003), the analysed perceived consequence of vii) positive comments is confirmed by the outcome of entirely positive reactions by others in 75% of the cases.

The perceived consequence of x) improvements in body image is consistently demonstrated in the literature (Annesi & Porter, 2015; Foster et al., 1997; Lasikiewicz et al., 2014; Sarwer et al., 2011; Sorbara & Gelieber, 2001), particularly as a parameter concurrent with weight loss as a result of a specific intervention and closely related with the amount of lost weight (Lasikiewicz et al., 2014). In a formerly mentioned study, Kinzl and colleagues (2003) also reported that 90% of the participants felt happier with one's appearance after weight loss. Appearance evaluation, body dissatisfaction and body esteem are several forms assessed after weight loss with positive outcomes (Lasikiewicz et al., 2014), validating the frequent improvement in the individual' greater body satisfaction obtained in the present investigation.

Regarding weight loss effects after bariatric surgery (Castro et al., 2010), women stated a greater pleasure in having personal body care, supporting the finding of the positive consequence about ix) pleasure in appearance-care.

Moreover, a plausible interpretation regarding the ix) pleasure in appearance-care is the possible association of the perceived positive consequences of x) body image improvements and viii) easier clothing acquisition. With the weight loss enabling a more effortless acquirement of suitable clothes (Baldwin et al., 2009) – possibly due to the greater availability of standardize sizes and shortage accessibility of bigger sizes – the pursuit of a fitting wardrobe would be a more natural and uncomplicated task, with the probability of being more pleasurable as well. Furthermore, the x) body image improvements, increased ii) self-esteem and iii) self-confidence, might also be sources of a personal boost for one's appearance-care to be transformed into a more pleasurable daily routine.

The perceived xi) sexual positive consequences, due to body change are also related in literature. Kinzl and colleagues (2001) address that 63% of the participants state a more

enjoyable sex life after weight loss in contrast to 15% that found no differences in sexual satisfaction pre or postoperatively, and 12% that reported less pleasurable sexual relations after weight loss. In a qualitative study about body image and function after bariatric surgery (Castro et al., 2010) evidences of enhancements in marital relation and women' sexual function was associated to body transformations that allowed more physical agility and uninhibited feelings, consequently leading to a more satisfying sex life.

Finally, the positive perceived consequence of xii) improvements in mobility/agility display a weight loss outcome at a physical level (Sarwer et al., 2011). Concerning women's weight change and HRQOL in a prospective study, Fine and colleagues (1999) report an association between weight loss and improved physical function. In the previous designated study regarding body image and functioning (Castro et al., 2010), it's also stated the gain of movement freedom and functions enrichments as weight loss positive effects.

For the pre-existing category of Perceived Consequences, the MCA allowed the generation of a three-dimensional model in order to reflect the present findings.

The first factor – "Personal growth/Social adversities" – includes both negative consequences relational problems and success depreciation, as well as an increased self-confidence, decreased embarrassments and the perceived discrimination cessation.

As previously proposed, the relational problems and success depreciation (perceived negative consequences) may establish some kind of relation between them. A person's perception that others – co-workers, friends, family, and/or spouse – don't value an achieved success might lead to relational problems, especially if the success was felt as an important accomplishment worthy of acknowledgment.

The three positive consequences comprehended by the "Personal growth/Social adversities" factor are increased self-confidence, decreased embarrassments and perceived discrimination cessation. On a qualitative study about perceived discrimination and stigmatization, Hayden and colleagues (2010) report significant results regarding self-confidence, self-beliefs and self-esteem in two groups – one with women with obesity and other with women who had lost weight after bariatric surgery. Those findings describe how the major source of change in the perception of discrimination is the actual behavior of the individual. When with excessive weight, women affirm that a normative behavior with others would be being shy, withdrawn and inhibited; thus, a self-made protective barrier created an impact on how others interacted with them, exacerbating the feelings of being discriminated (Epiphaniou & Ogden, 2010; Hayden et al., 2010). When exploring the transformation after the weight loss, women referred that their perceptions of a decreased discrimination was

mostly because of how they themselves had changed in terms of being more self-confident and having a less socially inhibited behavior (Hayden et al., 2010).

The outcomes stated by Hayden et al. (2010) justify the presence of the positive consequences comprehended by the "Personal growth/Social adversities" factor – increased self-confidence, decreased embarrassments and perceived discrimination cessation. Though including perceived negative consequences of social nature – relational problems and success depreciation – the factor in analysis emphasizes how personal development can co-exist with social difficulties and even improve one's welfare in social environments.

The second factor – "Body image/Social benefits" – incorporates as positive consequences ii) increased self-esteem, vi) social network expansion, vii) positive comments, ix) pleasure in appearance-care, x) body image improvement, and xi) sexual, due to body changes.

Concerning one's satisfaction with body appearance, van Hout et al. (2007) reports improvements in body image, perceived attractiveness, enhancements in psychosocial functioning and lower levels in social anxiety as weight loss outcomes after gastric banding. Also supporting social and appearance-related consequences, Kinzl and colleagues (2003) outcomes include happiness with physical appearance stated by 90% of the participants and positive comments by other in 75% of the cases.

Furthermore, in the exploration of psychological benefits from weight loss succeeding behavioral and/or dietary interventions (Lasikiewicz et al., 2014) body image and/or body esteem improvements and self-esteem are commonly manifested positive effects. An increased self-esteem (Kinzl et al., 2001) and the satisfaction with personal body care after weight loss (Castro et al., 2010) are also linked with an increased sexual function, supporting the findings regarding the sexual consequences due to body changes.

Feelings of social integration and sexual improvements are identified outcomes in a qualitative exploration of weight loss experiences (Nascimento, Bezerra, &Angelim, 2013), emphasizing social and sexual related consequences encompass by the second factor.

Outcomes highlighting the association between the individuals' satisfaction with appearance, social improvements and sexual-related benefits support the current findings of the "Body image/Social benefits" factor.

In the third factor – "Physical/Emotional well-being" – a relation is shown between i) well-being/happiness, viii) easier clothing acquisition and xii) mobility/agility improvements.

The indicated enhancement in mobility as positive outcome of weight loss (Fine et al., 1999; Wing & Hill, 2001) and its association with the satisfaction of regaining movement

freedom (Castro et al., 2010) sustain the association between an exclusively physical improvement and a general well-being present in the "Physical/Emotional well-being".

The easiness in purchasing clothes may be linked not only to an appearance-related context but also to the individual's satisfaction with body acceptance by having a wider choice when concerning personal appearance-care, sustaining a contributing element for one's well-being.

Spontaneous Self-Concept

According to the frequencies analysis, the most commonly referred categories of the self-concept were i) Physical Self-concept, ii) Interpersonal Self-concept (only the positive valence), iii) Explicit Personality Self-concept, and iv) Global Self-esteem.

The i) Physical Self-concept comprehends emergent categories from positive and negative valences, as well as the ambivalent/neutral ambit and the appearance and body investment domain. This emergent content concerning one's body image and physical self-concept is sustained by Cash et al. (2004, 2011) theory, since it comprehends both the individual's self-perceptions and attitudes (through evaluation and investment) about the one's concept ("How do you see yourself? How would you describe yourself? How do you evaluate yourself regarding your personal features?").

The positive physical self-concept encompassed as most mentioned sub-categories a skinnier/less fat appearance and a healthier physical image. Several studies regard health-related positive self-evaluations after weight loss (Alegría & Larsen, 2015; Annesi & Porter, 2015; Gilmartin, Long, & Soldin, 2013). A skinnier perceived self is linked with satisfaction since it mirrors a feeling of self-realization (Nascimento et al., 2013).

The negative physical self-concepts included sub-categories illustrating dissatisfactory appearances such as looking ill, having an overweight image and an excessively thin image. Undesirable body changes such as flaccid or sagging skin are a possible outcome of weight loss (Sarwer et al., 2011). A dramatic body transformation if often lived as a massive distortion in body image leading to body dissatisfaction (Alegría & Larsen, 2015) and a consequent state of physical depersonalization and feelings of unreality towards one's body (Gilmartin et al., 2013; Nascimento et al., 2013). A self-perceived image of having excessive

overweight in women who had a weight loss surgery it's also associated with a sense identity-incongruence (Alegría & Larsen, 2015).

The ii) Interpersonal Self-concept was mostly manifested as a positive spontaneous self-perception, which is supported by the literature that affirms improvements in one's self-concept regarding the sense of inclusion, self-acceptance and social attachment (Castro et al., 2010; Epiphaniou & Ogden, 2010: Gilmartin et al., 2013).

The iii) Explicit Personality Self-concept combined as more frequently positive categorizations attributes such as calm, persistent and efficient (Goldberg, 1990; Schmukle, Back, & Egloff, 2008). The manifested negative attributes (such as distrust/suspicion, negligence/laziness, etc.) were grouped in the frequency analysis, creating a global negative explicit personality self-concept. Sullivan, Cloninger, Przybeck and Klein (2007) in a study about personality characteristics in obesity and relation with weight loss, report that individuals with overweight demonstrated lower persistence and self-directedness when compared to lean subjects. When exploring broader identity after weight loss, Epiphaniou and Ogden (2010) demonstrate one's perspective of greater efficacy for not only weight-related but others areas in life.

The iv) Global Self-esteem, recognized as one of the most important facets of self-concept (Baumeister, 2004; Gecas, 1982), was also one of the most commonly perceived contents. Regarding weight loss background, self-esteem is one of the most explored features of the individual (Lasikiewicz et al., 2014; Rueda-Clausen et al., 2015; van Hout et al., 2008), supporting its highlight as one of the most frequently emerged category.

For the pre-existing category of Spontaneous Self-concept, the respective MCA enabled the creation of a three-dimensional theoretical model.

In the first factor – "Effective investment/Balanced Self-esteem" – revealed a connection between one's investment (category "appearance and body investment" from Physical Self-concept), global self-esteem, the perception of being efficient (positive category of Explicit Personality Self-concept) and the negative valence regarding personality traits.

In qualitative and exploratory study, one's investment (body-contouring surgery) is associated not only with better physical health but also as psychological benefits such as a higher self-esteem (Gilmartin et al., 2013). This supports the present relation demonstrated between appearance and body investment and global self-esteem. In the same investigation, the perception of having accomplished efficiency in body investment is as well linked with further investments, as engaging in a higher education, a new career path or more activities with family.

Designating combined attitudes – of positive and/or negative valance – and evaluations concerning the self (Rosenberg, 1965; Crisp & Turner, 2010), the global self-esteem may be acknowledged as stable or inconsistent (Harter, 2008). Particularly regarding self-concept, specific self-esteem is attributed to domains-specific self-concept features (Baumeister, 2004; Harter, 1999). Though the finding of a positive global self-esteem may look contrary to the presence of negative explicit personality self-concept, it must be reinforced that global self-esteem translates much more than a specific self-esteem attributed to the negative personality as a specific domain; the global self-esteem in the factor "Effective investment/Balanced Self-esteem" encompass the global self-concept of the individual, including the perception of efficacy and the acknowledged investment.

The second factor – "Ambivalent" – not only incorporated the ambivalent/neutral body image category, but also others opposing emergent categories related to the Physical Self-concept – i) negative perception of excessive weight loss and positive perception of being skinnier/less fat, and ii) negative perception of looking ill and positive perception of being healthier. Additionally, the Interpersonal positive Self-concept also prevailed in the second factor.

Both qualitative studies from Nascimento et al. (2013) and Epiphaniou and Ogden (2010) portrait a shift in one's self following weight loss; appearance distortion related to the fast and massive body transformation leads to a sense of strangeness (Gilmartin et al., 2013; Nascimento et al., 2013) that may be related with the ambivalent perception of one's physical self and, consequently, with the manifested content present in the current investigation. In the process of psychological and emotional adaptation to the weight loss and its experience, the individual affirms significant improvements in social inclusion and interaction (Epiphaniou & Ogden, 2010; Nascimento et al., 2013) which supports the finding of a positive interpersonal self-concept in the present factor.

The third and last factor – "Positive acceptance/Focused" – demonstrated an association between the perceived appearance of overweight (negative Physical Self-concept) and personality attributes of calm and persistence (both positive Explicit Personality Self-Concept).

Contrary to the findings of Sullivan and colleagues (2007) – which affirmed that people with overweight showed lower persistence compared to lean participants – the present factor associated a perceived overweighed image with a positive feature of persistence. Nevertheless, it's essential to highlight that these participants weren't in weight loss process or weight loss maintenance. The participants of the present investigation not only have a

record of a successfully achieved weight loss (equal or above of 7% of the initial body weight) but also have a minimum of 12 months of weight maintenance. This positive experience with weight loss might contribute to upper levels of perseverance in a weight-related path that may not yet be completed, since one's may desire to lose more weight.

The already accomplished weight loss enabled, however, the change from a life more centred around restriction, social interaction avoidance, perceived stigma, and restrict attention in one's body shape to a more liberated self with the sense of social inclusion, balanced diet routines and self-acceptance (Epiphaniou & Ogden, 2010). With the possible long-term aspiration and goal of going further in the weight loss process, the positive feature of calm can be sustained by the acknowledgement of the accomplished success and the positive outcomes from it, which might provide tranquillity to face the path one's still wants to course.

Limitations and Future Directions

The present study demonstrates the association of positive and negative perceived consequences of a successful weight loss among each other's, as well as multiple manifested spontaneous self-concepts of varied natures.

As with any study, limitations exist in the present investigation. First of all, the findings are not generalizable to the population given the limited sample size and its convenience nature, and the disparity in the weight loss methods. However, the main purpose was not to generate the obtained findings but to analyse in-depth one-on-one interviews conducted with the 30 participants of both genders in order to explore the perceived consequences and self-concept in the context of a successful weight loss. Nonetheless, care must be taken when drawing interferences from the present study since its support on retrospective reflections (given the 12 months of maintenance).

Despite its limited size, the resource to a sample comprehending both male and female gender individuals constitutes a strength in the present study since the analysed categories should represent significant contents for both genders. Moreover, a sample of 30 participants is rather larger than those presented in other qualitative studies (e.g. Alegría et al., 2015; Castro et al., 2010; Epiphaniou, 2010; Gilmartin et al., 2013; Hammarström et al., 2014; Nascimento et al., 2013)

Though variables of personal and context nature cannot be entirely controlled, conducting some telephone interviews has limitations since the presence of an interviewer is beneficial considering non-verbal responses and the possible to do a better adaptation to one's responses throughout the interview. However, since weight history may be a sensitive issue, the telephone interviews can also be a comfortable method considering one's embarrassment in talking about it. Another limitation is the fact that interviewers were conducted by university students, what may have led to a narrow depth in significant content exploration.

Nevertheless present limitations, these findings provide additional qualitative knowledge on limited literature regarding personal perceived consequences and self-concept in a weight loss background. The obtained outcomes might be pertinent to take into account on weight loss-related interventions, since negative consequences may be translated in barriers to one's weight maintenance, needed to be approach throughout the treatment development.

It’s essential to explore the obtained associations in future studies, with a possible longitudinal distinction in order to allow a comparison of one’s perspective along the weight loss course, and a favourable larger size sample. Since the participants adopted approach to the weight loss differs (e.g. surgery, nutritional counselling) it might be advantageous to explore the individuals perceived consequences and self-concept according to each strategy.

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Appendixes

Appendix A: Outputs

Martial State

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	casada/união de facto	12	40,0	44,4	44,4
	divorciada/separada	3	10,0	11,1	55,6
	solteira	12	40,0	44,4	100,0
	Total	27	90,0	100,0	
Missing	System	3	10,0		
Total		30	100,0		

Afective-Sexual Relationship

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Não	11	36,7	39,3	39,3
	Sim	17	56,7	60,7	100,0
	Total	28	93,3	100,0	
Missing	System	2	6,7		
Total		30	100,0		

Professional Situation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	active	17	56,7	63,0	63,0
	retiered	4	13,3	14,8	77,8
	unemployed	3	10,0	11,1	88,9
	other	3	10,0	11,1	100,0
	Total	27	90,0	100,0	
Missing	System	3	10,0		
Total		30	100,0		

Educational_Level					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4 years or less (primary school)	2	6,7	7,4	7,4
	6 years (primary school)	2	6,7	7,4	14,8
	9 years (middle school)	4	13,3	14,8	29,6
	12 years (high school)	5	16,7	18,5	48,1
	Bachelor (3 years in college)	3	10,0	11,1	59,3
	Graduate (5 years in college)	9	30,0	33,3	92,6
	Master (7 years in college)	1	3,3	3,7	96,3
	Other	1	3,3	3,7	100,0
	Total	27	90,0	100,0	
Missing	System	3	10,0		
Total		30	100,0		

Annual Household Income					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	10.000 euros or less	6	20,0	24,0	24,0
	from 10.001 to 20.000 euros	11	36,7	44,0	68,0
	from 20.001 to 37.500 euros	4	13,3	16,0	84,0
	from 37.501 to 70.000 euros	3	10,0	12,0	96,0
	superior to 70.001 euros	1	3,3	4,0	100,0
	Total	25	83,3	100,0	
Missing	System	5	16,7		
Total		30	100,0		

Weight Loss Methods					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	cirurgia	5	16,7	18,5	18,5
	mudança de comportamentos alimentares	10	33,3	37,0	55,6
	exercício físico	1	3,3	3,7	59,3
	cirurg e mudança de comp alimentar	1	3,3	3,7	63,0
	comp aliment e exerc fisico	6	20,0	22,2	85,2
	cirurgia, mud comp alim, ex fisico	1	3,3	3,7	88,9
	comp alim e outro	2	6,7	7,4	96,3
	cirurg e outro	1	3,3	3,7	100,0
	Total	27	90,0	100,0	
Missing	System	3	10,0		
Total		30	100,0		

Appendix B: Triage-Questionnaire

1 - Quanto pesava antes de começar a perder peso?_____ kg.

2 - Quanto peso perdeu desde o momento que começou a perder peso até hoje?_____ kg

3 - Pedimos-lhe agora ajuda para perceber em que momento (há quanto tempo) atingiu uma perda de 7% do seu peso corporal.

a) Para calcular a quantos quilos correspondem os 7% no seu caso pessoal basta multiplicar o seu peso inicial (antes de começar a perder peso) por 7 e depois dividir o resultado por 100. Exemplo:
   Peso inicial = 90Kg
   Então 90 x 7 / 100 = 6,3kg (7% do peso corporal)

Por favor calcule agora 7% do seu peso e insira esse número (que corresponde a quilos) no espaço em branco, na fórmula que se segue:

Peso inicial (quilos que tinha antes de começar a perder peso) x 7 / 100 = _____ kg

b) Agora localize-se por favor no tempo: há quanto tempo aproximadamente (em que mês, e de que ano) atingiu essa perda de 7% do seu peso corporal?
   Mês _____; Ano _____.

c) E durante quanto tempo (meses ou anos) manteve esta perda de peso, ou seja, não aumentou o seu peso acima dos 7% perdidos (por ex., se o peso inicial é 90 kg e se os 7% do peso corporal equivalem a 6,3kg, durante quanto tempo conseguiu manter esta perda de 6,3kg (ou seja, 90kg - 6,3kg = 83,7kg) sem voltar a aumentar de peso acima dos 83,7kg)? _____

4 - Quanto pesa actualmente?_____ kg. E qual a sua altura?_____ m.

Appendix C: Informed Consent

A presente investigação, efectuada na especialidade de **Psicologia da Saúde**, da responsabilidade da Prof. Doutora Filipa Pimenta (ISPA – Instituto Universitário), e com a orientação da Prof. Doutora Isabel Leal (ISPA – Instituto Universitário) e co-orientação da Prof. Doutora Jane Wardle (University College London), é financiada pela Fundação para a Ciência e Tecnologia (referência SFRH/BPD/77799/2011).

Esta investigação estuda os factores associados à manutenção de um peso excessivo e explora igualmente processos associados à perda de peso bem-sucedida.

Neste momento, convido-o(a) a participar nesta fase da investigação através do preenchimento das questões que encontrará nas páginas seguintes e da participação numa entrevista sobre a experiência e história pessoais com o seu peso.

Esta investigação tem igualmente o objectivo, numa segunda fase, de ajudar os participantes com excesso de peso a diminuírem o seu peso, de uma forma apoiada, através de uma intervenção psicológica. Algumas pessoas poderão ser convidadas a participar nesta segunda fase, convite esse que poderão rejeitar, se assim o desejarem, sem que isso tenha quaisquer consequências. Se quiser participar na segunda fase, deverá preencher também a última folha.

A sua participação é de elevada importância para que possamos conhecer de uma forma mais objectiva e abrangente **como é que as mulheres e os homens portugueses vivem a obesidade e o excesso de peso, e conseguem, nos casos de sucesso, diminuir o peso corporal excessivo**.

Sublinha-se que a participação é voluntária e que todos os dados são totalmente **confidenciais**. Assegura-se ainda que a sua participação (ou recusa em participar) em nada interfere com o seu acompanhamento multidisciplinar, no caso de estar ser contactado em contexto hospitalar/clínico. Esclarece-se ainda que poderá ter acesso aos resultados do estudo contactando a investigadora responsável por e-mail.
Muito obrigada pela sua participação.

A investigadora responsável,
Filipa Pimenta, PhD
Unidade de Investigação em Psicologia e Saúde
ISPA - Instituto Universitário
Rua Jardim do tabaco, 34
1149-041 Lisboa
Tel.: 218 811 700
e-mail: filipa_pimenta@ispa.pt

Se aceita participar, por favor rubrique esta página e a seguinte e, de seguida, retire para si a primeira página (são ambas iguais e a primeira página é para si).

Data: ____/____/____

_____

(Rúbrica do participante)

Appendix D: Written Permission for Audio Recording

Autorização para a gravação da Entrevista

Declaro que dei autorização para os investigadores fazerem a gravação áudio desta entrevista, sabendo que todos os meus dados são confidenciais e que nenhuma identificação pessoal será associada aos conteúdos trabalhados ou revelada.

_____

(Rubrica)

Appendix E: Socio-Demographic and Health Questionnaires

QUESTIONÁRIO SÓCIO-DEMOGRÁFICO

a) Idade: ___

b) Raça: Caucasiana (branca)___ Negra___ Asiática___ Outra___

c) Estado civil: Casado(a)___ Divorciado(a)___ Separado(a)___ Solteiro(a)___ União de Facto___ Viúvo(a)___

d) Tem actualmente uma relação afectiva e/ou sexual: Sim___ Não___

e) N.º de filhos que tem: _____

f) Situação profissional: Activo(a)___ Reformado(a)___ Desempregado(a)___ Outra_____

   i. Que profissão exerce/exerceu? _____

g) Habilitações literárias: 4 anos de escolaridade ou menos___ 6 anos de escolaridade___ 9 anos___ 12 anos___ Bacharelato (3 anos/faculdade)___ Licenciatura (4 ou 5 anos/faculdade)___ Outro_____

h) Rendimento total anual bruto do agregado familiar: Até 10.000€___ De 10.001 a 20.000€___ De 20.0001 a 37.500€___ De 37.501 a 70.000€___ Superior a 70.000€___

QUESTIONÁRIO DE SAÚDE

A – Menopausa (só para mulheres):

1. Tem ciclos mentruais regulares, com a menstruação a acontecer todos os meses? Sim___ Não___

2. Nos **últimos 12 meses** teve alterações no seu ciclo menstrual (a duração dos ciclos alterou-se significativamente ou passou 2 ou mais meses sem ter o período)? Sim___ Não___

3. Já esteve **12 meses** (ou mais tempo) sem ter menstruação? Sim___ Não___

4. Que idade tinha quando tevea sua última menstruação? _____ anos

B – Saúde geral e Peso

5. Teve recentemente alguma(s) doença(s)? Sim___ Não___

   i. Se sim, qual(quais)? _____

6. Teve recentemente algum problema psicológico? Sim___ Não___

7. Qual o seu peso actual? _____ kg

8. E a sua altura? _____ m

9. Qual foi o **peso mais alto** que teve em toda a vida adulta (excluindo gravidez)? _____ kg

i. Quando (em que ano) teve este peso (mais alto)? _____

ii. Durante quanto tempo manteve este peso (mais alto)? _____ meses.

10. Qual o **peso mais baixo** que teve em toda a vida adulta? _____ kg

i. Quando (em que ano) teve este peso (mais baixo)? _____

ii. Durante quanto tempo manteve este peso (mais baixo)? _____ meses.

11. Desde quando começou a ter peso a mais? Desde criança___ Desde a adolescência___ Desde o início da idade adulta___ Desde a menopausa___

Outro (explique, por favor)_____

12. Quantas tentativas fez para emagrecer na sua vida:

i. que tenham resultado numa perda de peso: _____

ii. que não tenham resultado numa perda de peso: _____

C – Consumo de tabaco, álcool e café

13. É fumadora? Sim, sou fumadora___ Não, sou ex-fumadora___ Não, nunca fumei___

i. (Caso seja fumadora) Fuma todos os dias? Sim___ Não___

ii. (Caso seja fumadora) Quantos cigarros fuma: **por dia**____ ou **por mês**____?

14. Consome bebidas alcoólicas? Sim___ Não___

i. Se sim, com que regularidade: diariamente___ todos os fins-de-semna___ raramente___

ii. Se sim, em que quantidades: até ficar embriagado(a)___ moderadamente___ menos de um copo por cada ocasião___

15. Costuma tomar café? Sim___ Não___

i. Se sim, quantos cafés costuma tomar? Mais de 5 cafés por dia___ Entre 4 e 3 cafés por dia___ Entre 2 e 1 café por dia___ Só tomo café ocasionalmente___

D – Exercício físico e peso:

16. Pratica algum tipo de exercício físico (ir ao ginásio, caminhadas, etc.)? Sim___ Não___

ii. Se sim, quantas vezes por semana? _____

iii. Se sim, durante quanto tempo (horas ou minutos) exercita? _____

Appendix F: Interview Guide (Original Portuguese Version)

A. Consequências negativas percebidas

1.1. A perda de peso significativa e a manutenção deste novo peso mais baixo tiveram alguma consequência negativa? Se sim, quais? Teve alguma consequência negativa a nível social/profissional/familiar/pessoal/sexual ou íntimo?

B. Consequências positivas percebidas

2. Acha que a diminuição de peso e a manutenção deste novo peso mais baixo tiveram alguma consequência positiva? Se sim, quais?

2.1. Teve alguma consequência positiva a nível social (na forma como planeia as suas actividades extra-laborais e se relaciona com os seus amigos)? Se sim, podia falar-me um pouco mais sobre isso?

2.2. E a nível profissional? Se sim, podia desenvolver-me um pouco mais a ideia?

2.3. E a nível familiar (na forma como interage com a família)? Tem filhos? Se sim, acha que o seu peso actual tem influência na forma como interage e se relaciona com eles?

2.4. E a nível pessoal? Sente que o seu peso interfere com a sua vida íntima? E a nível sexual?

C. Auto-conceito

3. Como acha que as pessoas suas conhecidas (com quem não tem uma relação de proximidade) o/a vêem actualmente?

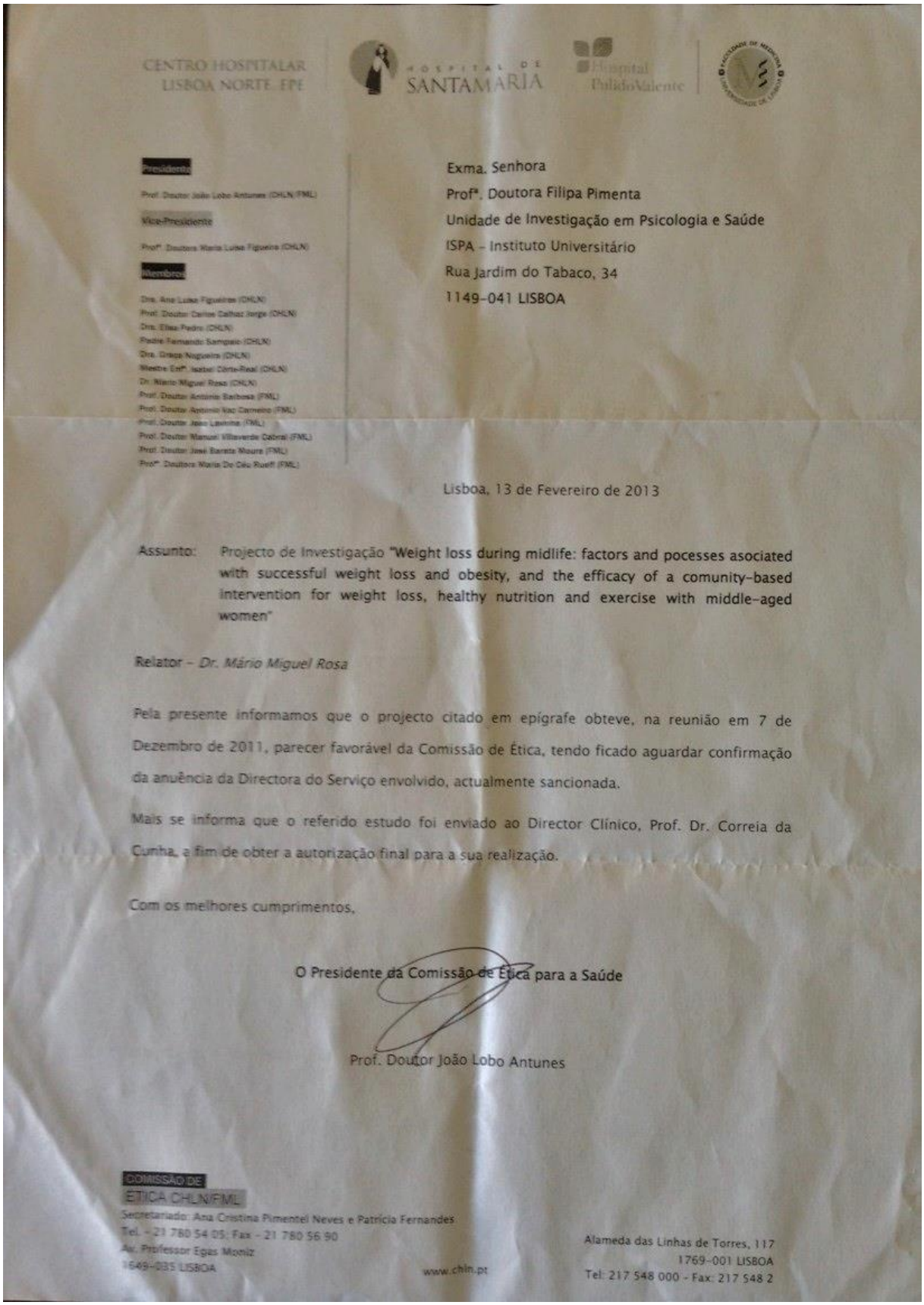
4. E as pessoas mais próximas de si?

4.1. Como o/a vê a sua família?

4.2. Como o/a vêem os seus amigos?

5. E como se vê a si próprio/a? Como se descreveria? Como se avalia em relação a si próprio/a, àquilo que o/a caracteriza?

Appendix G: Ethic Council Authorization



CENTRO HOSPITALAR LISBOA NORTE, EPE

HOSPITAL DE SANTA MARIA

Hospital Pulido Valente

FACULDADE DE MEDICINA UNIVERSIDADE DE LISBOA

Presidente

Prof. Doutor João Lobo Antunes (CHLN, FML)

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Mestre Enfª. Isabel Côrte-Real (CHLN)
Dr. Mário Miguel Rosa (CHLN)
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Prof. Doutor António Vaz Carneiro (FML)
Prof. Doutor João Lavinha (FML)
Prof. Doutor Manuel Villaverde Cabral (FML)
Prof. Doutor José Barata Moura (FML)
Profª. Doutora Maria Do Céu Ruaff (FML)

Exma. Senhora
Profª. Doutora Filipa Pimenta
Unidade de Investigação em Psicologia e Saúde
ISPA - Instituto Universitário
Rua Jardim do Tabaco, 34
1149-041 LISBOA

Lisboa, 13 de Fevereiro de 2013

Assunto: Projecto de Investigação "Weight loss during midlife: factors and pocesses asociated with successful weight loss and obesity, and the efficacy of a comunity-based intervention for weight loss, healthy nutrition and exercise with middle-aged women"

Relator – *Dr. Mário Miguel Rosa*

Pela presente informamos que o projecto citado em epígrafe obteve, na reunião em 7 de Dezembro de 2011, parecer favorável da Comissão de Ética, tendo ficado aguardar confirmação da anuência da Directora do Serviço envolvido, actualmente sancionada.

Mais se informa que o referido estudo foi enviado ao Director Clínico, Prof. Dr. Correia da Cunha, a fim de obter a autorização final para a sua realização.

Com os melhores cumprimentos,

O Presidente da Comissão de Ética para a Saúde

Prof. Doutor João Lobo Antunes

COMISSÃO DE ÉTICA CHLN/FML
Secretariado: Ana Cristina Pimentel Neves e Patrícia Fernandes
Tel. - 21 780 54 05; Fax - 21 780 56 90
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Alameda das Linhas de Torres, 117
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Tel: 217 548 000 - Fax: 217 548 2

Appendix H: Inter-Evaluator Reliability Output (Cohen's Kappa)

	Value	Asymp. Std. Error	Approx. T	Approx. Sig.
Measure of Agreement Kappa	.734	.086	13.732	.000
N of Valid Cases	137			

Appendix I: Codification Grill

3. Consequências percebidas da perda de peso bem-sucedida **(3-PPBSConseq)**: Consequências percebidas da perda de peso bem-sucedida.

   3.1. **Consequências negativas percebidas da PPBS**

      3.1.1. Avaliação negativa da PPBS, associando-a a uma doença **(3.1.1.-PPBSConseq_Neg_Doença):** avaliação negativa da identificação da perda de peso por parte de outros como um sinal de doença

      3.1.2. Avaliação negativa da PPBS, associando-a a magreza excessiva **(3.1.2.-PPBSConseq_Neg_MagrExc):** avaliação negativa da PPBS por parte de outros conhecidos, reconhecendo-a como magreza excessiva

      3.1.3. Humor deprimido após uma PPBS cirúrgica **(3.1.3.-PPBSConseq_Neg_DeprimCirurg):** relato de alteração de humor, vontade de se isolar, após a PPBS decorrente da cirurgia

      3.1.4. Diminuição do tamanho dos seios após a PPBS **(3.1.4.-PPBSConseq_Neg_DiminSeios):** verbalização de uma diminuição dos seios percebida como uma consequência negativa da PPBS

      3.1.5. Afetação do rosto **(3.1.5.-PPBSConseq_Neg_AfectRosto):** relato de uma afetação do rosto percebida como negativa, após a PPBS

      3.1.6. Ausência de consequências negativas a nível profissional **(3.1.6 – PPBSConseq_Neg_AusênciaProf)**: referência de que não existem quaisquer consequências negativas da PPBS no âmbito profissional

      3.1.7. Problemas relacionais **(3.1.7.-PPBSConseq_Neg_ProbRelacional)**: agravamento de problemas pré-existentes ou surgimentos de problemas com uma pessoa significativa

      3.1.8. Sentir dores corporais **(3.1.8.-PPBSConseq_Neg_Dor)**: sentir dores corporais que antes não existiam e/ou que se agudizaram com a PPBS

      3.1.9. Flacidez da pele **(3.1.9.-PPBSConseq_Neg_Flacidez)**: sentir que a pele (sem especificar zona corporal) ficou mais flácida após a PPBS

      3.1.10. Ciúmes **(3.1.10.-PPBSConseq_Neg_Ciumes)**: percepção de ciúmes por parte do parceiro subsequentes ao emagrecimento ou/e investimento na aparência

3.1.11. Redução dos índices de hemoglobina **(3.1.11.-PPBSConseq_Neg_Hemoglobina)**

3.1.12. Alteração da função intestinal **(3.1.12.-PPBSConseq_Neg_FunIntestinal)**: relatos de alteração do funcionamento intestinal consequente à PPBS

3.1.13. Desvalorização do sucesso **(3.1.13.-PPBSConseq_Neg_Desvalorizaçao)**: percepção de desvalorização por parte de outro em relação ao sucesso pessoal de PPBS

3.1.14. Restrição do consumo de álcool **(3.1.14.-PPBSConseq_Neg_Alcool)**: diminuição ou restrição total do consumo de álcool

3.1.15. Mudanças de hábitos alimentares **(3.1.15.-PPBSConseq_Neg_MudAlimentar)**: percepção de mudanças e/ou restrições alimentares, e controlo necessário para as mesmas

3.1.16. Desuso do vestuário **(3.1.16.-PPBSConseq_Neg_Vestuario)**: percepção de que a roupa que era habitualmente usada deixa de servir após a PPBS

3.1.17. Reacções de outros **(3.1.17.-PPBSConseq_Neg_Reacçoes)**: percepção de reacções por parte dos outros de estranheza e/ou perplexidade face a mudanças comportamentais adquiridas durante a PPBS

3.1.18. Estrias **(3.1.18.-PPBSConseq_Neg_Estrias)**: relato de que a pele (sem especificar zona corporal) ficou com estrias após a PPBS

3.1.19. Medo da confirmação da auto-imagem corporal negativa **(3.1.19.-PPBSConseq_Neg_MedoConfAINeg)**: Medo que o outro avalie o seu corpo no contexto íntimo da mesma forma negativa que ela o avalia, inibindo a sua exposição física como consequência

3.1.20. Ausência de consequências negativas a nível social **(3.1.20 – PPBSConseq_Neg_AusênciaSoc)**: referência de que não existem quaisquer consequências negativas da PPBS no âmbito social

3.1.21. Ausência de consequências negativas a nível familiar **(3.1.21 – PPBSConseq_Neg_AusênciaFam)**: referência de que não existem quaisquer consequências negativas da PPBS no âmbito familiar

3.1.22. Ausência de consequências negativas a nível íntimo e/ou sexual **(3.1.22.-PPBSConseq_Neg_AusênciaInt)**: Relato de ausência de consequências negativas percebidas de carácter íntimo e/ou sexual

3.1.23. Ausência de consequências negativas a nível pessoal **(3.1.23.-PPBSConseq_Neg_AusênciaPessoal)**: Relato de ausência de consequências negativas percebidas a nível pessoal

3.1.24. Ausência de consequências negativas sem especificação **(3.1.24.-PPBSConseq_Neg_AusênciaS/Esp)**: Relato de ausência de consequências negativas percebidas sem caracterização/especificação do âmbito ou nível dessas consequências

3.1.25. Confrontação com expectativa fracassada **(3.1.25.-PPBSConseq_Neg_ExpecFracassada)**: Confrontação com a não concretização de uma expectativa de melhoria de um sintoma de dor decorrente da PPBS

3.1.26. Maior irritabilidade **(3.1.26.-PPBSConseq_Neg_Irritabilidade)**: manifestação de maior irritabilidade consequente à PPBS

3.2. **Consequências positivas percebidas da PPBS (3.2.-PPBSConseq_Pos)**

3.2.1 Aumento de autoestima **(3.2.1.-PPBSConseq_Pos_Autoest):** aumento da autoestima (i.e. avaliação positiva da sua pessoa) consequente à perda de peso bem-sucedida

3.2.2 Bem-estar/Felicidade **(3.2.2.-PPBSConseq_Pos_Bem-estar):** manifestação de felicidade, contentamento, bem-estar ou satisfação com a perda de peso bem-sucedida

3.2.3 Melhoria da qualidade do sono **(3.2.3.-PPBSConseq_Pos_Sono):** melhoria da qualidade ou rotina do sono após a perda de peso bem-sucedida

3.2.4 Diminuição ou ausência de cansaço físico **(3.2.4.-PPBSConseq_Pos_DiminCansaço):** verbalização de diminuição ou ausência de cansaço físico, após a PPBS, e em comparação com o cansaço físico experienciado antes da PPBS

3.2.5 Diminuição ou ausência de dor física **(3.2.5.-PPBSConseq_Pos_DiminDor):** diminuição ou ausência de dor física, decorrente da PPBS, e em comparação com a dor física experienciada antes da PPBS

3.2.6 Diminuição da irritabilidade e impaciência **(3.2.6.-PPBSConseq_Pos_DiminIrrit):** diminuição da irritabilidade e da impaciência, após a PPBS, e em comparação com o que experienciava antes da PPBS

3.2.7 Melhorias ao nível da mobilidade/agilidade **(3.2.7.-PPBSConseq_Pos_Mobilidade):** referência a uma melhoria da mobilidade/agilidade associada à PPBS

3.2.8 Melhorias nos indicadores fisiológicos **(3.2.8.-PPBSConseq_Pos_Saude):** identificação de melhorias de saúde ao nível dos indicadores fisiológicos

3.2.8.1 Redução dos níveis de tensão arterial **(3.2.8.4.-PPBSConseq_Pos_Saude_TensArterial)**

3.2.8.2 Redução dos níveis de glicémia **(3.2.8.2.-PPBSConseq_Pos_Saude_Glicemia)**

3.2.8.3 Redução dos níveis de colesterol **(3.2.8.3.-PPBSConseq_Pos_Saude_Colesterol)**

3.2.8.4 Redução da diabetes **(3.2.8.4.-PPBSConseq_Pos_Saude_Diabetes):** Redução da gravidade da diabetes ou remissão

3.2.8.5 Redução da sudação **(3.2.8.5.-PPBSConseq_Pos_Saude_Suor)**

3.2.9 Vontade/Expectativa de viver durante mais tempo **(3.2.9.-PPBSConseq_Pos_VontViver):** manifestação de uma vontade/ou de uma expectativa de viver durante mais tempo associada aos ganhos decorrentes da PPBS

3.2.10 Maior facilidade na aquisição e/ou reutilização de vestuário **(3.2.10.-PPBSConseq_Pos_AdquirirVestuário):** percepção de uma maior facilidade na aquisição e/ou reutilização de vestuário associada à diminuição dos números do vestuário ou perda de peso, e consequente alegria/felicidade

3.2.11 Prazer em cuidar da aparência **(3.2.11.-PPBSConseq_Pos_PrazerAparênc):** manifestação da existência de prazer em vestir-se ou arranjar-se após a PPBS

3.2.12 Operações plásticas **(3.2.12.-PPBSConseq_Pos_OpPlástic):** ter direito, de forma gratuita, após a PPBS, conseguida de forma cirúrgica, a operações plásticas

3.2.13 Maior controlo emocional **(3.2.13.-PPBSConseq_Pos_ControlEmoc)**: desenvolvimento de um maior controlo das emoções e reacções subsequentes após a PPBS

3.2.14 Prazer em "sair" **(3.2.14-PPBSConseq_Pos_PrazerSair):** verbalização da existência de prazer em sair de casa após a PPBS

3.2.15 Prazer em dançar ou fazer outras atividades que envolvam movimento **(3.2.15.-PPBSConseq_Pos_PrazerDançar):** verbalização da existência de prazer em dançar após a PPBS

3.2.16 Aumento do prazer e da disponibilidade para brincar/rir **(3.2.16.-PPBSConseq_Pos_PrazerBrincarRir):** verbalização da existência de prazer em brincar/rir após a PPBS

3.2.17 Prazer em conviver **(3.2.17.-PPBSConseq_Pos_PrazerConviver):** verbalização da existência de prazer nas interacções sociais após a PPBS

3.2.18 Melhorias na qualidade da relação de casal **(3.2.18.-PPBSConseq_Pos_QualCasal):** verbalização de melhorias na qualidade da comunicação, intimidade, disponibilidade na relação com o parceiro decorrente da PPBS

3.2.19 Diminuição dos constrangimentos **(3.2.19.-PPBSConseq_Pos_DiminConstrang):** diminuição dos constrangimentos relativos ao corpo viabilizada pela PPBS

3.2.20 Melhorias ao nível respiratório **(3.2.20.-PPBSConseq_Pos_MelhorRespir):** diminuição ou eliminação das dificuldades respiratórias associadas ao excesso de peso ou obesidade, após a PPBS

3.2.21 Aumento da auto-confiança **(3.2.21.-PPBSConseq_Pos_Autoconf):** aumento da auto-confiança consequente à perda de peso bem-sucedida

3.2.22 Comentários ou reacções positivas e alegria associada **(3.2.22.-PPBSConseq_Pos_ComentPos):** existência de comentários ou reacções positivas (verbais e não verbais), por parte de outros acerca da PPBS e/ou alegria/felicidade decorrente dos comentários/reacções

3.2.23 Aumento do controlo profissional **(3.2.23 - PPBSConseq_Pos_ControlProf)**: aumento do controlo, após a perda de peso, para gerir áreas relacionadas com a esfera profissional

3.2.24 Retomar a prática de actividade física **(3.2.24.-PPBSConseq_Pos_ActFísica):** retomar a prática regular de exercício físico

3.2.25 Melhorias ao nível das competências de gestão do tempo **(3.2.25.-PPBSConseq_Pos_GesTempo)**

3.2.26 Aumento da autoeficácia relacionada com o peso/corpo **(3.2.26.-PPBSConseq_Pos_AutoEfic):** percepção de que se é capaz, de forma auto-suficiente, de mudar hábitos e fazer adaptações relacionados com o peso/corpo e felicidade por o conseguir

3.2.27 Melhoria da imagem corporal **(3.2.27 - PPBSConseq_Pos_ImagCorpPos)**: percepção positiva de parte ou do corpo total ou da imagem corporal

3.2.28 Expansão da rede social **(3.2.28.-PPBSConseq_Pos_RedeSocial)**: aumento ou expansão da rede social consequente à PPBS e respectiva emoção positiva

3.2.29 Capacidade de análise **(3.2.29.-PPBSConseq_Pos_CapacAnálise)**: Desenvolvimento da capacidade de auto-análise, incluindo análise de crenças/pensamentos decorrente da PPBS

3.2.30 Investimento em dimensões profissionais prazerosas **(3.2.30.-PPBSConseq_Pos_InvestProfPrazer)**: Relato de investimento em dimensões particulares da profissão que provocam prazer ou das quais se gosta muito

3.2.31 Investimento em dimensões prazerosas sem especificação **(3.2.31.-PPBSConseq_Pos_InvestPrazerS/Esp)**: Relato de investimento em dimensões não específicas que provocam prazer ou das quais se gosta muito, não relacionadas com o corpo, peso e trabalho

3.2.32 Valorização de relações interpessoais **(3.2.32.-PPBSConseq_Pos_ValorRelInterpessoais)**: Valorização de relações pré-existentes e que não eram "tão" valorizadas antes do processo de PPBS

3.2.33 Consequências percebidas positivas, sem especificação **(3.2.33.-PPBSConseq_Pos_S/Esp)**: Relato da existência consequências positivas, sem especificação

3.2.34 Generalização de auto-eficácia **(3.2.34.-PPBSConseq_Pos_AutoefGlobal):** Generalização da percepção de auto-eficácia para a gestão de dimensões outras (ex. relações) que não ligadas ao corpo/diminuição do peso e que surge após a PPBS

3.2.35 Libertação de cognições inúteis **(3.2.35.-PPBSConseq_Pos_LibertCogniNeg):** libertar-se ou largar cognições/memórias/objectos simbólicos, negativos ou inúteis

3.2.36 Ausência de consequências positivas a nível social **(3.2.36.-PPBSConseq_Pos_AusênciaSoc)**: Relato de ausência de consequências positivas percebidas de carácter social

3.2.37 Sentir-se em forma **(3.2.37.-PPBSConseq_Pos_Forma)**: experiência de se sentir em forma após a PPBS

3.2.38 Melhorias ao nível da saúde em geral, sem especificação **(3.2.38.-PPBSConseq_Pos_SaudeSemEsp):** identificação de ganhos ao nível da saúde, sem especificação

3.2.39 Cessação da discriminação/estigmatização percebida **(3.2.39.-PPBSConseq_Pos_CessDiscriminaçao)**: término da percepção da discriminação/estigmatização por parte de outros em relação ao peso elevado

3.2.40 Sentir-se realizado **(3.2.40.-PPBSConseq_Pos_Realizado)**: relato de se sentir realizado consequentemente à perda de peso

3.2.41 Sentimento de tranquilidade **(3.2.41.-PPBSConseq_Pos_Tranquilidade)**: descrever sentimentos de tranquilidade consequentemente à perda de peso

3.2.42 Consequências percebidas positivas de carácter sexual, sem especificação **(3.2.42.-PPBSConseq_Pos_Sexual_S/Esp)**: Relato da existência de consequências positivas de carácter sexual, sem especificação

3.2.43 Ausência de consequências positivas a nível profissional **(3.2.43.-PPBSConseq_Pos_AusênciaProf)**: Relato de ausência de consequências positivas percebidas de carácter profissional

3.2.44 Ausência de consequências positivas a nível íntimo e/ou sexual **(3.2.44.-PPBSConseq_Pos_AusênciaInt)**: Relato de ausência de consequências positivas percebidas de carácter íntimo e/ou sexual

3.2.45 Ausência de consequências positivas a nível familiar **(3.2.45.-PPBSConseq_Pos_AusênciaFam)**: Relato de ausência de consequências positivas percebidas de carácter familiar

3.2.46 Consequência positiva sexual decorrente de uma mudança corporal **(3.2.46.-PPBSConseq_Pos_SexMudCorp)**: relato de consequências positivas percebidas a nível sexual decorrente de mudanças de parte e/ou totalidade do corpo após a PPBS

3.2.47 Ausência de consequências positivas a nível pessoal **(3.2.47.-PPBSConseq_Pos_AusênciaPessoal)**: Relato de ausência de consequências positivas percebidas de carácter pessoal

3.2.48 Ausência de consequências positivas sem especificação **(3.2.48.-PPBSConseq_Pos_AusênciaS/Esp)**: Relato de ausência de consequências positivas percebidas sem caracterização/especificação do âmbito ou nível dessas consequências

3.2.49 Diminuição de mal-estar corporal **(3.2.49.-PPBSConseq_Pos_DiminMalEstarCorp)**: Relato de diminuição de algum mal-estar corporal após a PPBS

3.2.50 Diminuição da dificuldade no desempenho sexual **(3.2.50.-PPBSConseq_Pos_DiminDifSexual)**: relato da diminuição da dificuldade ou de problemas no desempenho sexual após a PPBS

3.3 **Consequências percebidas neutras, associadas à PPBS (3.3.-PPBSConseq_Neutr):** consequências (internas ou eventos) que sejam verbalizadas pela pessoas, mas às quais não é atribuída explicitamente qualquer valência positiva ou negativa, seja em termos cognitivos ou emocionais.

3.3.1 Dificuldade manifestada por parte dos outros seus conhecidos em reconhecer a pessoa após a PPBS **(3.3.1.-PPBSConseq_Neutr_DificReconhec):** dificuldade manifestada por parte dos outros seus conhecidos em reconhecer a pessoa após a PPBS

4. Auto-conceito **(4-PPBSAutoConc):** autoconceito espontâneo (Baumeister, 2004) e autoconceito observador dos "olhos dos outros" (Oyserman, Elmore, & Smith, 2012) aferido após a PPBS; conhecimento e avaliação do self. Estruturado considerando a teoria do autoconceito de Richerd Shavelson (autoconceito não-académico: físico, social e emocional), Susan Harter (vários domínios específicos do autoconceito incluindo físico, auto-estima, social, relações próximas familiares/amigos/íntimas, etc.) e Thomas Cash (imagem corporal, dividida em auto percepção e atitudes – avaliação e investimento).

4.1. **Aparência Física Auto Percebida / Imagem Corporal (4.1.-PPBSAutoConc_ImagCorpAuto):** o modo como a pessoa se vê a si própria de um ponto de vista corporal/aparência, abrangendo as atitudes (ambivalente/neutra, positiva ou negativa) e o investimento, referente a parte ou à totalidade da aparência/corpo auto percebido.

4.1.1. Avaliação Ambivalente/Neutra do Corpo Auto percebido **(4.1.1-PPBSAutoConc_ImagCorpAuto_AmbivNeutra):** a pessoa é inconsistente na sua avaliação do corpo/aparência, ora descrevendo-o negativamente ora positivamente (ambivalente), ou sente que a percepção que tem do corpo/aparência (ou de parte deste) não impacta de algum modo, acabando por ter uma atitude e uma percepção neutras face ao corpo/aparência

4.1.1.1 Sem especificação **(4.1.1.1-PPBSAutoConc_ImagCorpAuto_AmbivNeutra_S/Esp)**: Ambivalência ou neutralidade em relação ao corpo ou aparência

4.1.1.2 Magreza **(4.1.1.2-PPBSAutoConc_ImagCorpAuto_AmbivNeutra_Magro)**: ambivalência em relação ao grau de magreza

4.1.2. Avaliação Negativa da Aparência / Corpo Auto Percebido **(4.1.2-PPBSAutoConc_ImagCorpAuto_Neg):** o próprio não se sente satisfeito com a aparência/corpo (ou parte do corpo/aparência) ou descreve do ponto de vista físico negativamente.

4.1.2.1 Sem especificação **(4.1.2.1.-PPBSAutoConc_ImagCorpAuto_Neg_S/Esp)**: avaliação negativa do corpo sem especificar

4.1.2.2 Abdomen/estômago/barriga **(4.1.2.2.-PPBSAutoConc_ImagCorpAuto_Neg_Barriga)**

4.1.2.3 Rosto **(4.1.2.3.-PPBSAutoConc_ImagCorpAuto_Neg_Rosto):** avaliação negativa do rosto na sua totalidade ou parcialmente

4.1.2.4 Envelhecimento **(4.1.2.4.-PPBSAutoConc_ImagCorpAuto_Neg_Envelh)**: avaliação negativa do corpo, no geral, parcialmente ou sem especificação, associada ao processo de envelhecimento

4.1.2.5 Excesso de peso **(4.1.2.5.-PPBSAutoConc_ImagCorpAuto_Neg_ExcPeso)**: avaliação negativa do corpo (todo ou parte) decorrente da percepção de excesso de peso e/ou respectiva emoção negativa

4.1.2.6 Flacidez **(4.1.2.6.-PPBSAutoConc_ImagCorp_Neg_Flacidez)**: avaliação negativa do corpo decorrente da percepção de flacidez (peles descaídas)

4.1.2.7 Celulite **(4.1.2.7.-PPBSAutoConc_ImagCorp_Neg_Celulite)**: avaliação negativa do corpo não especificando área decorrente da percepção de celulite

4.1.2.8 Doente **(4.1.2.8.-PPBSAutoConc_ImagCorp_Neg_Doente)**: avaliação do emagrecimento corporal como sinal de doença

4.1.2.9 Saliência dos ossos **(4.1.2.9.-PPBSAutoConc_ImagCorp_Neg_SalienOssos)**: avaliação negativa da visualização dos ossos salientes após a PPBS

4.1.2.10 Complexos **(4.1.2.10.-PPBSAutoConc_ImagCorp_Neg_Complexos)**: A expressão de complexos relacionados com o corpo decorrente da PPBS

4.1.2.11 Conformar **(4.1.2.11.-PPBSAutoConc_ImagCorp_Neg_Conformar)**: expressão de um conformismo, resignação a uma aceitação de um corpo emagrecido e percebido como negativo

4.1.2.12 Emagrecimento excessivo **(4.1.2.12.-PPBSAutoConc_ImagCorp_Neg_EmagreExc)**: avaliação do corpo como excessivamente magro

4.1.3. Avaliação Positiva da Aparência / Corpo Auto Percebido **(4.1.3-PPBSAutoConc_ImagCorpAuto_Pos)**: a pessoa exprime satisfação ou emoções positivas face à sua aparência/corpo ou parte do seu corpo/aparência.

4.1.3.1 Avaliação Positiva do Corpo sem especificação **(4.1.3.1.-PPBSAutoConc_ImagCorpAuto_Pos_S/Esp)**

4.1.3.2 Jeitosa **(4.1.3.2.-PPBSAutoConc_ImagCorpAuto_Pos_Jeitosa)**: percepção de proporções equilibradas ou harmoniosas, considerar-se jeitosa

4.1.3.3 Bonita/Elegante **(4.1.3.3.-PPBSAutoConc_ImagCorpAuto_Pos_Bonita)**

4.1.3.4 Magro(a) ou menos gordo(a) **(4.1.3.4.-PPBSAutoConc_ImagCorpAuto_Pos_Magr)**

4.1.3.5 Mais saudável **(4.1.3.5.-PPBSAutoConc_ImagCorpAuto_Pos_Saudavel)**: percepção de saúde ou de melhoria do estado de saúde/da saúde

4.1.3.6 Músculos mais definidos **(4.1.3.6.-PPBSAutoConc_ImagCorpAuto_Pos_Musculos)**

4.1.3.7 Mais jovem **(4.1.3.7.-PPBSAutoConc_ImagCorpAuto_Pos_Jovem)**

4.1.3.8 Mais em forma **(4.1.3.8.-PPBSAutoConc_ImagCorpAuto_Pos_Forma)**

4.1.3.9 Aparência actual **(4.1.3.9.-PPBSAutoConc_ImagCorpAuto_Pos_ApActual)** aparência ou estilo actual e moderno

4.1.4. Investimento na Aparência / Corpo Auto Percebido **(4.1.4-PPBSAutoConc_ImagCorpAuto_InvestCorpAuto):** importância e conjunto de esforços que, propositadamente ou não, têm um impacto na forma e/ou aparência física

4.1.5. Percepção da aparência / do corpo **(4.1.5.-PPBSAutoConc_ImagCorpAuto_PercepCorp)**: processo de percepção da aparência ou do corpo (totalidade ou parte)

4.1.5.1. Dificuldade **(4.1.5.1.-PPBSAutoConc_ImagCorpAuto_Dificuldade)**: dificuldade em percepcionar o peso perdido

4.1.5.2. Evitamento **(4.1.5.2.-PPBSAutoConc_ImagCorpAuto_Evitamento)**: evitamento da percepção da imagem corporal

4.2. **Capacidade Física (4.2.-PPBSAutoConc_CapFis): funcionalidade e capacidade física.**

4.2.1. Avaliação Positiva da Capacidade Física **(4.2.1.-PPBSAutoConc_CapFis_Pos)**: a pessoa exprime satisfação e/ou melhorias na sua capacidade física.

4.2.1.1. Mobilidade **(4.2.1.1.-PPBSAutoConc_CapFis_Pos_Mobilidade)**: facilidade na mobilidade

4.2.1.2. Fisicamente activo **(4.2.1.2.-PPBSAutoCon_CapFis_Pos_FisActivo)**: identificar-se como activo ou praticante de desporto/exercício físico

4.3. **Social (4.3.-PPBSAutoConc_Social): domínios interpessoais (relações íntimas/com família/com amigos, entre outros)**

4.3.1. Experiências sociais/interpessoais positivais **(4.3.1.-PPBSAutoConc_Social_Pos)**: características e experiências sociais e interpessoais positivas.

4.3.1.1. Conviver **(4.3.1.1.-PPBSAutoConc_Social_Pos_Conviver)**

4.3.1.2. Solidariedade **(4.3.1.2.-PPBSAutoConc_Social_Pos_Solidariedd)**

4.3.1.3. Investimento afectivo **(4.3.1.3.-PPBSAutoConc_Social_Pos_InvAfec)**

4.3.1.4. Ser sociável **(4.3.1.4.-PPBSAutoConc_Social_Pos_Sociavel)**: ver-se como sociável, flexível, adaptável no contexto social

4.3.1.5. Conciliador **(4.3.1.5.-PPBSAutoConc_Social_Pos_Conciliador)**: ver-se como conciliador, apaziguador, no contexto interpessoal

4.4. **Auto-estima global (4.4.-PPBSAutoConc_AutoEstGlob)**: referência a auto-estima global sem especificar domínio, isto é, dimensão afectiva e avaliativa do auto-conceito

4.5. Auto-conceito da personalidade explícita **(4.5.- PPBSAutoConc_PersExplic)**:

4.5.1. Auto-conceito de personalidade explícita positiva **(4.5.1.- PPBSAutoConc_PersExplic_Pos)**

4.5.1.1. Calma **(4.5.1.1.-PPBSAutoConc_PersExplic_Pos_Calma)**: sentir-se mais calmo

4.5.1.2. Menor irritabilidade **(4.5.1.2.-PPBSAutoConc_PersExplic_Pos_Irrit)**: sentir-se menos irritado

4.5.1.3. Menos temperamental **(4.5.1.3.- PPBSAutoConc_PersExplic_Pos_Temperament)**: ter reacções menos intempestíveis, agir menos repentinamente e sem reflectir, de acordo com aquilo que sente ou deseja no momento; explosivo

4.5.1.4. Persistência **(4.5.1.4.-PPBSAutoConc_PersExplic_Pos_Persistencia)**: ver-se como persistente, organizado e meticuloso

4.5.1.5. Espirituosidade/Boa-disposição **(4.5.1.5.- PPBSAutoConc_PersExplic_Pos_Espirituoso)**: ver-se como bem-disposto, vivaz e entusiasta

4.5.1.6. Energia **(4.5.1.6.-PPBSAutoConc_PersExplic_Pos_Energia)**: ver-se como energético, com vitalidade

4.5.1.7. Espontaneidade **(4.5.1.7.- PPBSAutoConc_PersExplic_Pos_Espontaneidd)**: ver-se como espontâneo, despreocupado e impulsivo

4.5.1.8. Optimismo **(4.5.1.8.-PPBSAutoConc_PersExplic_Pos_Optimismo)**: ver-se como optimista, jovial, alegre

4.5.1.9. Segurança **(4.5.1.9.-PPBSAutoConc_PersExplic_Pos_Segurança)**: sentir-se seguro

4.5.1.10. Reservado/a **(4.5.1.10.-PPBSAutoConc_PersExplic_Pos_Reserv)**: ver-se como reservado; expor-se diferenciadamente em função do grau de intimidade

4.5.1.11. Emoção **(4.5.1.11.-PPBSAutoConc_PersExplic_Pos_Emoçao)**: ver-se como emotivo

4.5.1.12. Atencioso **(4.5.1.12.-PPBSAutoConc_PersExplic_Pos_ConsDif)**: ver-se como alguém que considera a opinião dos outros de forma diferenciada, estando atento de forma adaptativa a opiniões significativas

4.5.1.13. Consideração **(4.5.1.13.-PPBSAutoConc_PersExplic_Pos_Consideraçao)**: ver-se como alguém que demonstra respeito pelos outros, atento

4.5.1.14. Auto-defesa **(4.5.1.14.-PPBSAutoConc_PersExplic_Pos_AutoDefesa)**: ver-se como directa e defensiva de si mesmo

4.5.1.15. Eficaz **(4.5.1.15.-PPBSAutoConc_PersExplic_Pos_Eficaz)**: ver-se como eficaz/competente por ter atingido uma meta relacionada com o peso ou outra

4.5.2. Auto-conceito de personalidade explícita negativa **(4.5.2.-PPBSAutoConc_PersExplic_Neg)**

4.5.2.1. Desconfiança/Suspeição **(4.5.2.1.-PPBSAutoConc_PersExplic_Neg_Desconfiança)**: ver-se como não aceite, discriminado e desconfiado em relação a outros

4.5.2.2. Negligência/Preguiça **(4.5.2.2.-PPBSAutoConc_PersExplic_Neg_Negligência)**: ver-se como negligente e preguiçosa

4.5.2.3. Passividade/Dependência **(4.5.2.3.-PPBSAutoConc_PersExplic_Neg_Passividade)**: ver-se como passiva e/ou dependente de algo exterior

4.5.2.4. Ausência de força de vontade **(4.5.2.4.-PPBSAutoConc_PersExplic_Neg_AusForçaVont)**: ausência de força de vontade ou fraqueza de espírito

4.5.2.5. Auto-destruição **(4.5.2.5.-PPBSAutoConc_PersExplic_Neg_AutoDestrui)**: traços de auto-agressão ou auto-destruição

4.5.2.6. Vulnerabilidade **(4.5.2.6.-PPBSAutoConc_PersExplic_Neg_Vulnerabilidd)**: ausência de assertividade e/ou capacidade de se proteger

4.5.2.7. Carência **(4.5.2.7.-PPBSAutoConc_PersExplic_Neg_Carencia)**: sentir fragilidade e necessidade de ser cuidado

4.5.2.8. Irrealização **(4.5.2.8.-PPBSAutoConc_PersExplic_Neg_Irrealização)**: sentir-se irrealizado e incapaz de concretizar uma meta desejada