REVIEW ARTICLE

Obesity, adolescence and subjectivity

Obesidade, adolescência e subjetividade

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ABSTRACT

Obesity has become an epidemic problem worldwide. In Brazil, the rise of incidence of obesity occurs particularly in adolescents. The results of measures for the control of obesity have, however, proved disappointing, suggesting the need for new ways of approaching the problem. This article presents subjective aspects involved in adolescent obesity as a contribution to this approach, in which the associated psychosocial aspects are highlighted in context.

Key words: Obesity; Adolescent; Puberty; Psychoanalysis.

RESUMO

A obesidade tem se tornado problema epidêmico em todo o mundo. No Brasil, o crescimento do excesso de peso e da obesidade ocorre, particularmente, em adolescentes. O resultado do controle da obesidade, entretanto, tem se mostrado decepcionante, indicando a necessidade de novas formas de condução de sua abordagem. Este artigo apresenta aspectos subjetivos implicados na obesidade do adolescente como contribuição à sua abordagem, em que são realçados os aspectos psicossociais em seu contexto.

***Palavras-chave:** Obesidade; Adolescente; Puberdade; Psicanálise.*

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OBESITY: A CHALLENGE TO MEDICINE

One of the most significant challenges for public health nowadays is the increase in the prevalence of obesity, which involves large portions of the world population. In the United States, there is talk of an epidemic since the incidence increased in 50% in the last two decades, with most of the population declared overweight.[1] In Latin America, epidemiological data have also shown an alarming situation because if on the one hand there is a reduction of poverty, on the other obesity emerges as a problem that tends to expand, and can be as serious in its dimension as malnutrition. This phenomenon is described as a situation of nutritional transition and reflects changes in patterns of eating habits, currently consisting of high intake of animal source foods, food high in sugar and refined flour, and low consumption of whole grains and fiber.[2]

The situation is similar in Brazil, where there was an increase in the prevalence of excess weight and obesity, revealed in a comparison between the 1974/75 census and that of 1989, which shows that obesity soared by 75 and 60%, respectively, in the proportion of obese men and women.[3]

Research in the incidence of this disease in the adolescent population reveals the same tendency observed in other population strata. Data from the Brazilian Institute

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of Geography and Statistics (IBGE) show that, in 1996, the population of adolescents was 34 million, with an estimated one quarter of them obese.[1] More recently, another publication of IBGE, the "Family Budget Research" (POF)[4] highlights the geometric growth of excess weight in the country's population, particularly in adolescents.

Studies of obesity in this age group require consideration of certain intrinsic characteristics of this period in life.

First, due to the intense physical growth and consequent increased nutritional needs, adolescents are more vulnerable to inadequate nutritional exposure.

Furthermore, several studies have indicated that a high percentage of obese adults were obese adolescents. Adolescence, along with the last trimester of fetal life and the first year of life are considered critical periods for obesity to take place.[1]

Another relevant aspect concerns the observations showing that dietary habits acquired during this period apparently persist into adulthood, which makes adolescence a propitious time to implement changes.

Obesity in children and adolescents can lead to various morbidity situations, such as dyslipidemia, hypertension, increase in insulin resistance, and sleep apnea. These conditions develop silently and interfere in health status in later life, becoming cardiac risk factors. Klish et al.[5], in a study conducted with obese children and adolescents in the U.S. showed that 80 and 20% of cases presented one and two risk factors for heart disease, respectively, and in 25% glucose metabolism was altered, with marked increase in the prevalence of type-2 diabetes. Between 26 and 37% also had polysomnography with altered results, and that 7% had true sleep apnea. These authors also reported the associations of obesity in children and adolescents with disorders of the skeletal system, such as Blount's disease and femoral head slide. Other obesity-related morbid states cited included polycystic ovary syndrome, pseudotumor cerebri, bile tract diseases, and depressive states.

As a consequence of this panorama, public health services are currently overloaded with patients with several chronic diseases, especially coronary heart disease, type-2 diabetes mellitus, hypertension and several types of neoplasm. It is probable that 200,000 people die in Latin America, every year, due to these complications.[2]

Obesity is a complex disease, determined by a combination of genetic and environmental factors. It is thus difficult to discriminate the potential of each factor in isolation.

Genetic predisposition to obesity is a significant consideration because it affects the increased deposition of fatty tissue and the high correlation between body mass index in obese children and their biological parents and siblings.[2]

On the other hand, environmental factors also act decisively, altering the individual's relationship with nutrition, regardless of genetic predisposition. Many variables are involved in obesity onset and maintenance, including early weaning and the inappropriate introduction of inadequate baby formulas, a sedentary lifestyle accompanied by intake of high-calorie foods and the use of processed food.[6]

Changes in social structures, such as the inclusion of women in the workplace, resulting in less time available for preparing meals, have also contributed to changes in dietary habits related to obesity.

Other conditions described as influential on weight issues are troubled family relationships, low economic and educational levels, and socio-cultural characteristics.[6]

All these situations interact with genetic inheritance in a complex way, and play an important role in the onset and maintenance of this disorder.[2]

Notheless, when we look at the types of approaches to controlling and treating obesity, the gap between public and individual health measures, and therapeutic failure becomes clear.

The focus given by the media and even specialized literature on the global obesity epidemic has often been characterized as reductionist for mentioning exclusively intake of high-calorie foods and sedentary lifestyle. Establishing a direct correspondence between food and body, this view disregards all the symbolic content within the act of eating, in which preparation and use of food transcend the order of mere necessity and is layered with several meanings in the various stages of life and in different cultures.

Justus[7] reflects on the complexity involved in this act when he states that "in the act of nutrition, the subject, the biological man and the social man are inextricably mixed".

In an attempt to improve outcomes in combating this disease, some studies have highlighted the need for new forms of intervention that can express the physical and mental aspects of its carrier.[8]

Parizzi[9], in a study with obese children and adolescents, showed more adherence to the treatment when it's carried out by an interdisciplinary team, concluding that qualitative studies are needed in

order to investigate the various issues involved in this disease.

OBESITY: A CHALLENGE TO DOCTORS

Professionals in health services in the care of obese patients regularly hear stories of similar content from them. These reports refer to previous failed treatments, pilgrimages to several professionals, and descriptions of miscellaneous drugs and miracle formulae used with the purpose of losing weight. It is, in fact, a repetitive speech always followed by a renewal of promises of weight loss. And yet nothing changes.

For the doctors, this "thing that resists intervention" is seen as an obstacle, producing feelings of frustration and helplessness and giving them limited alternatives: insisting on the approach used, ceasing with investigation and case monitoring, or seeking new paths that allow a change of direction.

What usually happens, for a number of reasons, is that the first two alternatives are chosen, when professionals persist with the original practice to then gradually withdraw the investment initially deposited in the treatment.

The third alternative would involve the inclusion of new instruments for monitoring cases that would enable professionals to locate other issues involved in obesity. Among the various approaches currently discussed, we would like to highlight studies with groups of obese adolescents and guidance groups for mothers, as well as psychological treatments, including psychoanalysis and cognitive behavioral therapy.

One of the aspects that seems fundamental to these various discussions and alternatives is the introduction of the obese individual to centers for producing knowledge that starts from their complaints and their case history and from what transpires in their speech and desire to be listened to by professionals in their care.

However, establishing a setting that fosters listening takes time, time to establish trust and transference, essential premises of all clinical treatment.

In current medical practice, the establishment of this transference relationship is hampered by current medical models, both in the private and public sectors; in the case of the former, because of the commercial logic that sustains it and in the case of the latter because it is characterized by waste, inefficiency, and mismanagement.

In this universe, doctors, frequently and for various reasons, remain alienated in the role of intercessor of individuals and the government or between individuals and the owners of the private health care systems, resulting in a disqualified medical act that loses its dimension of care and integrality.

Brant,[10] based on Foucault, pinpoints the late eighteenth century and early nineteenth century as "the moment when clinical Medicine alters the religious and individual concept of disease." In this new context, the symptoms are given the status of results of natural determinants of a disease, and the link between the sufferers and their afflictions is erased. "The sick person" is excluded from the scope of medicine and knowledge is disconnected from suffering:

> *This is a context in which the patient is only a reliable source of information when completely depersonalized, in which epidemiology only turns to the subject as object of attention as data on age, gender, ethnic group, physiological measurements, socioeconomic status, level of education, occupation, drug use status, dietary habits, physical activity status, and never again the subject who speaks to and is spoken by the Other.*[10]

This situation, in which the revocation of the symptom becomes the main objective to the exclusion of the carriers' background is where the interventions to control obesity are most often staged, both individually and in the discourse conveyed to combat the disease in a public health scale. Costa[11] describes this situation critically:

> *The "remedy" for such a "diversion" would be a diet consistent with the discourse that identifies causes, that is: low in calories, high in fiber, and hours in the gym working out. Nowadays, no one disagrees with the reasonableness of such a diagnosis, as well as the prescription for treatment. After all, the results are there to be verified, through numbers and statistics. Who has never succeeded with such a prescription?"*

Obesity cases that persist despite these prescriptions leave Medicine unable to face what resists its established knowledge, leading it to exclude the obese, who are identified as chronically ill, helpless cases, destined to join the ranks of referrals to other professionals or additional tests of doubtful indication.

Drawing from other areas of knowledge could assist the medical work in treating obese adolescents. Psychoanalytical theory understands adolescence as a time when, as a result of the intense bodily changes and intensified sexual drive, food intake acquires various meanings that go far beyond satisfaction of an organic necessity.

Vilhena[12] makes some considerations on this subject, and states that, particularly in adolescence,

> "*the mouth, what you eat, your body, are foregrounded as means through which adolescents show us their sexual dilemmas, difficulties, and traumas, their unique story, in short, the way they position themselves in the world.*"

In this phase subjects face the task of giving new meaning to the intense bodily changes of puberty and the need to shift the imaginary incarnation of the parents they had as children.

If in childhood the subject took the place of object of parental demand, with adolescence comes the possibility of rectifying this previous encounter.

In this sense, symptoms related to orality, such as anorexia-bulimia and obesity, which tend to erupt during adolescence, may be understood as feeble attempts to govern their bodily transformation based on image enhancement.

It is part of the doctor's job in the care of obese adolescents to create new alternatives that consider all these issues because rigid prescriptions and demands related to weight loss are unfit in these situations.

Conzensa[13] refers to the monotonous and impersonal discourse of patients with eating disorders and, based on the significantly empty repetitions relative to weight, body image and food, shows the need to bring out points of dissension of a very subjective word that can open the structure's singular field. This operation consists in not answering from the place of the expert on eating disorders but asking patients to identify where the symptoms are placed in relation to their history.

It must open a space for listening, where these individuals may, by means of their talk, express the anguish affecting them in this moment and which they deal with by eating, thus presenting to them other relationships with their obesity and relieving anxiety about this symptom. Based on this shift, new issues are brought to the task of symbolizing all of puberty's transformations, plus elements of personal history based on the structure itself. From there it is possible for a process of involvement and positioning in relation to obesity to arise, a decision on whether or not there is a desire to lose weight and the best way to do it.

In her appointment, L, a 17 year-old adolescent, exemplifies this situation. Having already undergone a few failed weight loss treatments, this young woman came to the office showing marked obesity and a depressed mood. She had left school and rarely went outdoors. Encouraged to talk, changes gradually arose: the complaint about weight shifts, giving place to dilemmas concerning the exercise of sexuality and difficulties in abandoning the position of a child, since she is the only daughter of elderly parents who control her excessively. She gradually shows significant improvement, and started to describe her own desire to go back to school, to get a boyfriend, to work. She subsequently returns to school in a move to reorganize her own life. She starts to take better care of herself, begins to wear dresses and high heels, and even says she feels pleasure in dressing up. Sometimes she complains and says she is 110 kg, but notes she's been fatter. She no longer eats as much as before. In one of her appointments at the office, she talks about a man who "cat called" her in the street: "*He called me chubby...*" and added: "*She's a beautiful chubby girl*" ...

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