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Therapeutic approach to obesity: between concepts and prejudices

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Abstract

Obesity is historically full of meanings, product of historical values and beliefs derived from social and cultural contexts that shaped the concept we have today. With the process of medicalization, obesity is regarded as a disease that needs to be fought and, therefore, certain judgments and criticisms of the patient with obesity are widespread, establishing judgments that impact on various aspects of overweight individuals. Immersed in this cultural context, health teams have a similar behavior pattern to the general population. Seen as an individual choice, obesity is associated with laziness, lack of personal willpower, among other attributes that contribute to their rejection - historical forces and dynamics that make up the representation of obesity. Understanding the mechanisms and expressions of the obesity stigma should be part of the training of health professionals, who should prevent the recurrence of stigma, which, due to social pressures, must be imposed on the exercise of professional routine. This essay aims to explore the relationships between concepts and prejudices associated with obesity, contributing with a reflection on the therapeutic approach to obesity.

Key words: Obesity. Social Stigma. Prejudice.

Introduction

Therapeutic approaches to obesity have been limited to the biological model from which derive strategies that are insufficient to deal with the implicit complexity of determining this disease, living and coping with it.

How people explain the disease, its causes and consequences in different contexts, cultures and social groups, including the biological phenomenon and its relationship with social aspects, helps understand the experience of living under a certain condition, in this case, "being obese". This rationale is founded on Medical Anthropology, branch of study in which social and natural sciences dialogue to understand a given phenomenon.[1] It can be said that it is a branch of knowledge in which social and natural sciences dialogue to understand a given phenomenon.

The values, customs and beliefs relating to a certain disease are part of a culture and a broader context and cannot be studied separately, i.e. one cannot understand how an individual perceives a disease, pain or even death without understanding the culture in which the individual is immersed. It is also necessary to understand how health, disease and the process of getting ill are socially organized, for example, how people are rated as ill, or how they present their disease to others and the attributes assigned to it.[1]

Among the most common diseases in the world today, obesity occupies an outstanding position. More than 312 million people in the world are obese and more than one billion are overweight.[2] In a systematic review performed by Marie and peers[3] in 2014, who examined 1,769 papers around the world, conclusion is that between 1980 and 2013, the proportion of overweight in adults rose from 18.9% to 36.9% among men and 29.8% to 38% among women, up from 857 million people to 2.1 billion in 2013. In some countries, prevalence of obesity is higher than 50%. However, although obesity and overweight rates have soared in recent years worldwide, discrimination of obese people has not diminished, but rather increased. According to the National Survey of Midlife Development, in the United States, overweight-related discrimination in ten years increased by 66%, up from 7% in 1995/96 to 12% in 2004/2006.[4]

Medicalization, as defined by Conrad[5], a process in which problems traditionally regarded as non-medical, come to be medical issues, and consequently, treated as a disorder and disease, is part of how culture deals with the ill and the disease and, more specifically, contribute to determine what disease is and who are ill. Medicalization of obesity, by labeling it as a "disease", replaces traditional moral causes for medical reasons. It creates a justification to "fight" against obesity and the obligation to help and treat without the blame that moralizing visions put on it, creating a pretext for everyone to "attack" obese patients and assume it as an attempt to fight the disease. [6]

Due to its global importance and the complexity of causes and treatments, obesity deserves to be viewed and discussed beyond its biological aspect. Exploring the relationships between obesity-related concepts and prejudices is the aim of this essay, thus contributing new insights on the therapeutic approach to obesity.

Some historical considerations on obesity

Obesity is laden with symbols and values built over years of history, meanings that were created with the word origin, which etymologically comes from Latin "obedere", formed by the roots "ob" (over, which encompass) and "-edere" (to eat). Therefore, "one who overeats", relating to the individual with unacceptable attitudes and considered "abnormal" by that group.[7]

Mantzoros[8] describes some milestones in the history of obesity over the years. The first description of obesity dates back to the Paleolithic Age (about 25,000 years ago), with a series of artifacts found throughout Europe. These artifacts vary in shape and size, but have in common figures with big breasts, the most important being the "Venus of Willendorf", showing not only the existence of obesity but also and perhaps a projected and idealized symbol of fertility and health. During the Neolithic period (8,000 to 5,500 years BC), various other artifacts were found with exaggerated large breasts and big hips and bellies, representing the "Mother Goddess".

In the Egyptian culture (2,500 BC), findings show that obesity was nothing else than a commodity of the rich, despite some obese mummies had an outstanding position among fortunate people. In Ancient China, obesity was already treated by inserting needles into the body, as in today's acupuncture, in an attempt to reduce appetite and cause loss of weight and body size. Tibetans, following such Chinese traditional belief, believed that the cause of obesity was overweight and the only way to treat it was to reduce foods intake, and already described in their manuscripts the fact that "excess food [...] causes diseases and shortens life expectancy".

During the Classical Ages (500 BC to 100 AC), the Greco-Roman medicine dedicated to understand and characterize obesity. Hippocrates devised various strict measures to treat obesity, showing that diet and "changes in lifestyle" are recurrent guidelines in the history of obesity:

> *Obese people and those willing to lose weight should perform heavy work before eating. Meals should be eaten after exercise, still feeling the pain of fatigue and without any other refreshment before the meal, except diluted, slightly chilled wine [...]. In addition, they should eat only once a day, not bath, sleep on a hard bed and walk naked as much as possible.*[9]

Galen, a great Greek physician of the same time, took a step towards the obesity rating movement when he characterized it as "mild" and "excessive".[8]

In the Scientific Age, around 1614, moving forward in the attempt to rate obese people and influenced by Galileu's principles on measurement, Santorino devised a scale that enabled physicians to rate obesity, with body measures and longitudinal evolutions of weight loss or gain.[8] This movement reinforced the idea of rating and labeling the obese according to their weight in a numerical scale.

Adolphe Quetelet, concerned about defining the characteristics of "normal people" and fit them into a normal distribution, published in 1835 a book where he compiled his studies, revising the changes in height and weight according to age and the ratio between height and weight to predict obesity indexes, thus creating the Quetelet index. In 1972, Ancel Keys named this index as body mass index (BMI). [10]

In the 1985 Conference on obesity impacts on health, the National Health Institute agreed to refer to obesity as a disease. The International Statistical Classification of Diseases and Related Health Problems provides international codes for each disease, as well as signs, symptoms and causes, and has two entries for obesity (278.00 and 278.01, "unspecified obesity" and "morbid obesity", respectively)[11]. In 1998, the World Health Organization declared that obesity is the main non-communicable disease of the twenty-first century.[12]

Lawrence, 2004,[13] when reviewing documents and news from 1985 on, stated that since 1992, media coverage of obesity increased exponentially, mostly associated with terms such as junk food, fast food and environment, reflecting a greater concern on the subject. Obesity is no longer just seen as a risk factor for other diseases and comes to be understood as a chronic disease through the positive energy balance between energy intake and expenditure. More recently, hormonal and inflammatory aspects in the fat tissue were added to this concept, a shift from the epistemic condition and core of the problem to a focus on body fat.[14]

Implicit and explicit concepts on obesity

Based on studies on the sanitary consequences derived from overweight, in recent decades literature also focused on the social impacts of obesity, showing that its effects go beyond the mere physiological issue.

In Puhl's reviews in 2001[15] and 2009,[16] the impact of prejudice on the various aspects of the daily life of obese patients became clear. Salaries, job promotions and hires are lower among overweight

subjects. They are seen as less disciplined and less efficient when compared to non-obese people. An eight-year, cross-sectional study with young adults showed that obese women earn US$ 6,000 less than non-obese women.[17]

When negative attitudes and biases regarding overweight exist among health professionals, they can affect the clinical judgement and hinder the access of these patients to healthcare systems.[16] Example is the lower likelihood of overweight women to undergo pelvic exams such as Pap smear or mammograms, when compared to eutrophic women, indicating that obesity is an obstacle to the access of preventive care services.[18] The amount of requests for clinical tests and consultation time were also lower for obese patients. For example, doctors spent nine minutes less time with the obese than with other patients.[19] Studies also mentioned differences in dealing with the obese patient among medical specialties and categories of healthcare professionals.[20,21]

When evaluating attitudes of 620 American physicians towards obese patients,[22] it was found that 50% or more of the respondents viewed them as awkward, ugly and noncompliant. About 30% to 45% of the physicians viewed this kind of patient as sloppy, lazy and weak-willed; and 9% to 3% indicated obese individuals as unpleasant and dishonest, respectively.

Study conducted with 250 physicians, among them general clinical practitioners, pediatricians and psychiatrists, concluded than more than 40% had a negative attitude towards obese patients; only 56% believed to be skilled to treat obesity and 46% mentioned that the treatment was successful.[23] In a review on beliefs and practices about obesity among healthcare professionals,[24] it was concluded that treating obesity is a difficult task for most of the physicians studied. Between 74% and 96.4% of them stated that treating obesity is not an easy task, mainly when setting long-term goals, which lead them to a feeling of impotency and frustration.

The problems mentioned show difficulties in coping with obesity, which go beyond the institutional walls. According to Kirk,[25] such tensions culminate in maintaining a medical system that are unable to treat overweight effectively.

Gracia-Arnaiz,[26] when comparing the vision of healthcare providers and young patients with obesity in an ethnographic study in Catalonia, Spain, concluded that the perspective diverges and converges in some points. Young patients are considered victims of a permissive, copious society and, at the same time, guilty for not following medical recommendations. And in a twofold process of medicalization and moralization, the patient should quit their "bad" eating habits and develop a series of "normal" habits", following nutritional, scientifically established guidelines, and learning to eat in a "civilized manner".

Study with 389 professionals in the Annual Meeting of North American Association for the Study of Obesity, held in Quebec, Canada, showed that even among the "specialized" groups interested in obesity, there has been a considerable level of prejudice, similar to that of the population in general. The study found that obese patient is viewed as lazier, more stupid and of less value. Younger and leaner women were the most judgmental.[27]

Undoubtedly, the stigma suffered by obese patients has a negative impact on their emotional health and affects their well-being, increasing low self-esteem, which likely contributes to maintain and gain weight.[28,29]

Reflection on the therapeutic approach to obesity

Individuals who practice modern scientific medicine form a group with their own values, rules, hierarchies, and theories about this disease. During the academic studies in the health area, a particular view on this disease is gradually built, which will last throughout their career.[1] Amongst such values and ideals is the basis of scientific rationality, that is, thinking based and measured objectively: "clinical facts" very often become the reasons for actual investigations. As a result, a growing process of numerical definitions used to classify health and disease conditions takes place – that is, physical and biochemical parameters (weight, height, blood substances count, hormonal levels) –, which produce a numerical rating scale for what is considered normal or healthy. Consequently, disease and abnormality become the deviation from such scale, either up or down.[1]

More than a system of ideas, practices and scientific models, professional practice consists of a system symbolically constructed, expressing values, beliefs and moral issues of a given society within a historical context. In recent decades, in industrial societies, this moral aspect of medicine has gained momentum with the decline of religious values, because misfortune was once caused by a moral failure and disease is today caused by an unhealthy lifestyle. Former deadly sins of gluttony and sloth have been replaced by the new concepts of "improper eating habits" and "physical inactivity".

With these new values and moral judgements linked to the disease, the pathologies that are attributed to personal choices convey a responsibility that falls upon the patient himself and can lead to their stigma. Under a social perspective, the stigma attached to certain diseases produces additional suffering to patients. They feel themselves responsible and guilty before society, incorporating moral judgements about the circumstances that might have caused the disorder. They suffer discriminations in various aspects of life, such as the examples cited above.

Obesity, for Bartolomé,[7] represents a visible sign of "norms infringement", i.e. an obese person is seen as an individual that contradicts the ideal model of modern society, which is the obsessive cult of body, beauty and thinness. It is manifested by the fear of getting fat and not having a socially accepted body. Lean bodies represent a prototype that gathers the features considered perfect. Concerns and inconveniences are consequences for those who are not within such socially established limits.

"Lipophoby"[6] or "fatphobie"[30] is a recent phenomenon in the Western societies, characterized by a systematic rejection of fat and fear of becoming obese. Such beauty standards have been changed according to social, historical, cultural and geographical contexts, in a constant struggle between the accepted, desired and beautiful, *versus* the rejected, criticized and ugly. In the early days of humankind, obesity was a synonym for fertility and health, as well as in Middle Age, to be later turned down by Jewish-Christian ideologies of moderation and restraint. Thus, since Renaissance, in the Western industrial societies the obese figure has increasingly lost its value.

Valuing slim bodies is also linked to the third-world awareness and criticism of capitalism – the same way that the capitalist accumulates money and resources, the obese accumulates energy in the form of body fat. In the traditional collective imaginary of "anti-capitalism" of the 1960s, the boss was represented as a pot-bellied man with a cigar and money getting out from the top hat. The obese silhouette, according to cartoonists, comes to denounce the capitalism system and food inequalities between colonies and post-colonies of the southern hemisphere *versus* the northern hemisphere. Fatness passes to be morally wrong under this perspective, meaning selfishness on the part of those who do not accept the logic of redistribution, while thinness becomes a signal of moral integrity.[6]

Gracia-Arnaiz[31] comments that today eating habits contributed to promote the discourse of "civilizing the appetite". As scientific findings began to show the connection between diet, disease and health, some ideals of self-control, restraint and moderation formerly used regarding food were resumed, transforming the eating issue into "moral factories", modeling body ideals and food and behavioral practices. The ideal and desired body becomes not just an image and an aesthetic symbol but a question of power.[32] In the context of a lipophobic society, body size is a parameter used to classify people not just regarding their biological and health aspects but of personality and moral too.[31]

While a slim body is viewed as morally, medically and aesthetically desirable, synonym of moderation, self-control and effort, an obese body means laziness, gluttony and disease.[16] An obese individual may represent a personal, social and medical failure, and weight loss is viewed much more as an attempt to evade from social and emotional pressures than an actual concern with health.[31]

"Being on a diet" is the result of numerous existing pressures, becoming a permanent and desirable condition that involves moralization and medicalization processes and, paradoxically, changes the food obsession model for another biomedical nutritional model, which dictates what should or should not be eaten.[33]

Despite numerous studies showing the most diverse causes of obesity, such as genetic, hormonal and metabolic factors, personal causes for excessive body fat are still overestimated.[34] Obese people are still labeled as big eaters, who do not have self-control and eat more than they should, reflecting a moralistic interpretation, and full of prejudice. And, as already seen, health providers, because they are immersed in this power game, end up acting the same way that the population in general does.[26]

Considering the relationship between symbolic beliefs and rejection of the obese, Crandall[35] proposes that anti-fat attitudes result from a world vision influenced by ideologies derived from a puritan work ethics, free will, belief in a fair world and the notion that people have what they deserve. He points out that these forces together and in different proportions are justifications for the "stigmatizer" to attribute controllable causes to others, tending to blame the obese for their own weight. He also concludes that racism and anti-fat attitudes have a similar ideological root, i.e. they are based on conservative, authoritarian values and ideologies and reject differences. Anti-fat attitudes do not have a social suppression as strong and well structured as racism, but are common and explicit in everyday life, probably because they are a new standard in our society.

Although social scientists have addressed prejudice against obesity for decades, it still is at a maturity stage that falls short from needs. This prejudice is comparable to the racism of 50 years ago: manifest, explicit, and widespread in everyday life. [35]

The fatty body as a mirror of personal traits is so strong that even after losing weight the stigma can remain. Vartanian,[36] compared obesity surgery with diet and exercise to lose weight, and the students, after being informed of the patient's history, rated this patient as more lazy, sloppy and less competent, sociable, attractive and healthy. When knowing that an individual used to be obese and lost weight through surgery, the students considered the patient as the one who "has taken the easy way out", the effortless one.

Another perspective is that obesity can be seen as the outcome of the individual's inability to meet a balanced energy expenditure. In such individualistic vision, the patient is viewed as someone who cannot make right decisions on what to eat and what spends energy, and is unable to manage his own body and make rational decisions.[15,16,24] Thus, social attributions relating to the causes

of obesity reinforce stigma manifestations, for thinking that the obese individual is the one to be accountable for his own condition because of lack of willpower and self-discipline, which implies personal responsibility as the centerpiece in the stigmatization process of the obese individual.

With the rise of obesity, public expenditures to treat it increased at the same rate. Some groups complain about public healthcare costs with diseases caused by lack of self-care, i.e. obese patients are labeled as "those who don't take care of their health" or "don't want to take care and spend public money for that", and therefore are punished even more for such moral dilemma of individual guilt.

Media plays a key role in disseminating values, ideals and, consequently, prejudices. Puhl[16] examined the relationship of the media with obesity and found that obese characters in the entertainment media usually perform with a stereotyped eating behavior or comic or ridiculous traits, with speeches followed by laughs in the audience, most of them described as unattractive, stupid and unhappy. In the news media, this can also be seen by the way emphasis is put on the personal responsibility for obesity, focusing on causes and solutions at an individual level, such as overeating and how to change their own diet. This reflects the public understanding of obesity, masking other dimensions of this disease and reinforcing individual guilt and biases. On the other hand, there are sites and forums focused on discussion, support and guidance that can help reverse such pejorative approach, as shown by the study of Wen-ying.[37]

Final considerations

The way we perceive obesity is filtered through its historical trajectory and mechanisms of "normalization" of the body and behavior. These numerous forces build the image of obesity and the obese patient in a dynamic and fluid manner.

Obesity is recognized as multifactorial world epidemics, but not enough to influence its treatment. Often, recognition of the factors that go beyond the health area, such as the environmental influence, maintain the aspects herein discussed in a nebulous and complex field.

Understanding the mechanisms and expressions of obesity stigmas should be part of the training of health professionals. Being careful with preventing the recurrence of this stigma, given the social pressure forces, must be a daily exercise of healthcare providers.

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