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Subjective body-related experiences, and perception of the interventions and empathy of the healthcare team in adolescents with overweight

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ABSTRACT

Introduction. Overweight adolescents are confronted daily with stereotypes that condition their body image, self-esteem, and mood.

Objectives. To describe, in adolescents with overweight, the subjective experiences related to the body in daily life and their perceptions regarding the interventions and empathy of the health team.

Population and methods. Descriptive study with qualitative approach. Semi-structured interviews were conducted with adolescents aged 11 to 18 years with selfreported mass index (BMI) ≥ 26 and referring to medical or nutritional follow-up for overweight, attended at the Adolescence Service of a hospital in the Autonomous City of Buenos Aires, between October 1, 2021, and May 31, 2022.

Results. Twenty adolescents were evaluated, with a median age of 13.5 years, most of them from female sex (16/20). All reported body dissatisfaction from an early age (median age: 10 years old). They mention difficulty dressing due to the lack of different sizes; they even limit sports practice. They suffered weight-related body humiliation at school, in the family, or public (15/20). They perceived weight control in a dual way: weight loss was the primary stimulus for treatment, but its centrality in the consultations generated discomfort. The leading causes of therapeutic abandonment were the impossibility of temporarily sustaining the recommendations and the lack of weight loss. The treating team was willing to listen to the patients but needed to understand their daily experiences, physical, material, esthetic, social conditioning, beliefs, and perceptions.

Conclusion. The adolescents included in this study perceived specific interventions of the healthcare team as beneficial, with empathic deficiencies.

Keywords: *adolescent; overweight; emotions; weight reduction program; empathy.*

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INTRODUCTION

Weight-related problems, both eating disorders (EDs) and those characterized by overweight, are on the rise and affect health to varying degrees and in different spheres: biological, psychological, and social.[1]

Adolescence is a period of change during which psychosocial development occurs, which tends, among other issues, to the acceptance of body image.[2] This process occurs in a social, political, and cultural context that imposes beauty stereotypes that influence adolescents' perception of themselves, reinforcing a certain idealization of thinness, which favors the emergence of EDs.[3] Adolescents with overweight face a negative social stigma daily. Having overweight not only refers to a person's body, but it also implies being considered ugly, undesirable, unhealthy, "flabby," or "shapeless," and, often, these social labels also translate into acts of discrimination.[4] Their bodies are seen as the flip side of the beauty models to which they are constantly compared, which often undermines their body image, one of the most important predictors of self-esteem.[5]

In contrast, social movements have emerged in the West that not only question fat-phobic behaviors but also advocate for the recognition of body diversity and, in this sense, question the actions, regulations, and standards of healthcare teams regarding the treatment of people with overweight. Among them, the Health at Every Size movement promotes better health behaviors for people of all sizes without weight as a mediator.[6]

In overweight adolescents care, interventions simplify the equation by focusing on healthy eating and age-appropriate physical activity recommendations, leaving out the subjective experiences related to weight in daily life and the psychological, emotional, and social factors that influence body shape.[7]

It seems pertinent to include in the interventions aspects that allow us to know their vision and desires regarding their bodies, as well as their ambivalences, emotions, motivations, frustrations, daily life experiences, and what they perceive during the health team's interventions. However, only some studies evaluate these aspects in our population.

This study aimed to describe the subjective experiences related to the body in daily life, the perceptions regarding the interventions, and empathy of the health team in overweight adolescents between 11 and 18 years of age who are under follow-up in the Adolescence Service of a pediatric hospital in the Autonomous City of Buenos Aires (CABA).

POPULATION AND METHODS

Descriptive study, qualitative approach with semi-structured interviews conducted by the principal researcher with subjects between 11 and 18 years old with body mass index (BMI) greater than 26 according to self-reported weight and height and referred to medical or nutritional follow-up for overweight, who were in the waiting room of the Adolescence Service of a pediatric hospital in CABA from October 1, 2021, and May 31, 2022. Non-probabilistic, purposive, consecutive, and voluntary sampling was performed. Patients unable to understand questions due to intellectual, visual, or hearing impairment were excluded.

As an instrument, a guide of open-ended questions was prepared based on the existing literature, with thematic axes by the study's objectives. Two thematic axes were added later during the interviews: unhealthy weight control behaviors (UWCB) and the imaginary of body diversity (*Supplementary material 1*).[8-11] The interviews were recorded in audio format and unrecorded in their entirety. The total number of interviews was determined through the theoretical saturation of the discourse.[12,13] The content analysis of the discourse[14] was carried out by structuring the information obtained in items corresponding to the answers to each question and, subsequently, in categories and subcategories organized according to the thematic axes referred to above. A distinction was made between representative questions, which provided items representative of each category, and other guiding questions, which complemented the information obtained (*Supplementary Material 2*). For the characterization of the sample, the degree of overweight of each participant was classified according to the World Health Organization.[15]

In the demographic description, median of the ages (with minimum and maximum) were calculated.

Approval was obtained from the institutional Ethics Committee (registration number 5287 dated 3/8/2021). The consent of an adult or the adolescent was requested, depending on age.

RESULTS

Characteristics of the population. Subjective experiences. Unhealthy weight control behaviors. Imaginary of bodily diversity

Twenty overweight adolescents were

interviewed, reaching the theoretical saturation of the discourse. The population was predominantly female (16) with a median age of 13.5 years (min. 11, max. 17), schooled, of low socioeconomic level according to the family affluence scale (FAS), and, in the majority, overweight and obese grade 1. The median age of the first consultation for overweight was 10 years (min. 7, max. 14), motivated by family members or health professionals. All reported body dissatisfaction from an early age (median age 10 years; min. 6, max. 15) secondary to comments from family members, mainly the mother or peers. They reported difficulty dressing, playing sports, and other aesthetic difficulties that conditioned their activities. A total of 15 cases reported discrimination or rejection, mainly at school or in public. More than half of the overweight adolescents evaluated on CCPPS admitted having performed them at some time (11) or thought about performing them (2). Some PSAs (5) related overweight to poor health, low self-esteem, and sedentary lifestyles. They also claimed to observe, compare, and criticize various bodies, including their own (*Tables 1-4*).

Perception of healthcare team interventions

The healthcare team's interventions were perceived as beneficial in favor of weight loss and general well-being. The lack of contemplation of experiences, individual perspectives, and situations in the socio-familial context was negatively highlighted. All the participants mentioned similar recommendations: food group restrictions and increased physical activity. Weight control was perceived dually: its decrease was the primary stimulus for treatment, but its centrality in the consultations generated discomfort and reluctance. The leading causes of therapeutic abandonment were the impossibility of temporarily sustaining the recommendations and the lack of weight loss.

Perception of healthteam empathy

The health team was perceived to listen, care, and deal with their problems, but a certain lack of understanding of their experiences and perspectives was mentioned (*Tables 5* and *6*).

DISCUSSION

Body-related experiences are related to the self-perception of body image or the mental

Table 1. Population characteristics (n = 20)

Category	Subcategory	Total
Median age (min.-max.) [years]		13,5 (11-17)
Gender	Female (cis)	16
	Male (cis)	3
	Male (trans)	1
Schooling	Primary school	2
	High school	18
Place of origin	CABA	3
	PBA	17
Nationality	Argentinian	18
	Bolivian	1
	Venezuelan	1
Socioeconomic level according to FAS scale	Low	14
	Middle	6
BMI	25-29	9
	30-34	6
	35-39	2
	≥40	3
UWCB (skipping meals, not finishing a meal, self-induced vomiting) (n = 15)		11
Median age (min-max) at the first visit for overweight [years]		10 (7-14)
Median age (min-max) at the first perception of body dissatisfaction [years]		10 (6-15)
Discrimination or rejection at school or in the street		15

BMI: body mass index, CABA: City if Buenos Aires (by its Spanish acronym), FAS: Family Affluence Scale, PBA: province of Buenos Aires, UWCB: unhealthy weight control behaviors.

Table 2. Category: first consultation motivation. Imaginary bodily diversity

Category	Subcategory		Synthesis of analysis	Representative item*
Motivation of the 1st consultation for PD**	Concern • Personal • Family • Professional		The majority reported that the motivation for consultations at an early age were mainly by their mothers, some were referred by the health team and only one by personal motivation.	*Because I wanted to.* *I consulted because my mother was worried about my weight.* *At a health check-up, I was told I was overweight.*
Imaginary of bodily diversity (n: 5)	**Bodies with overweight***	**Identification**	They identified with people with overweight.	*When I see a fatter person, I feel the same or worse than them.*
		Negative bias: • Activity • Personality • Health	Expressed negative beliefs about people with overweight related to lack of willpower, sedentary lifestyle, self-esteem, and health conditions.	*Fat people don't do anything.* *Fat people don't do much for themselves, and they tend to have low self-esteem.* *When I see a fat person, I think they are in poor health, and I find it disturbing.*
	Slim bodies	**Comparison**	They compare themselves with thin bodies from lack or insufficiency.	*When I see a skinnier person, I think I'm not good enough to be that skinny.*
		Positive bias: • Personality • Health • Opportunities	They assumed that skinny people had better attachments, opportunities, and lifestyle. .	*I think that, because they are skinny, people can have more friends.* *Skinny people are healthier, I think they eat better.* *Society gives thin people more access.*

**Each sentence corresponds to an interview and is an item of analysis.*

representation each person has of his or her body in a social and family context. In other words, it is influenced by the relationship with the environment, personal experiences, and objective, subjective, verbal, and non-verbal information received from others, which is crossed by various imaginaries and social stereotypes.[16] Comments or criticisms that reinforce thinness models as a synonym of beauty («fat talk»), such as «how skinny you are, «I can›t make it to summer,» and «that cookie is fattening» may contribute to a certain perception of body discomfort.[17] Accordingly, the population studied emphasized the impact of the external gaze from an early age and acknowledged suffering body humiliation mainly at school or in the peer group. This phenomenon refers to all those actions or comments that judge other people by the body they have, which generates shame, anger, and sadness.[18]

Coincidentally, the 2019 national discrimination map of the National Institute against Discrimination, Xenophobia and Racism (INADI, by its Spanish acronym),[19] shows that overweight is the second cause of discrimination in schools.

As a result, it is not surprising that the overweight adolescents were embarrassed to show parts of their bodies. They went so far as to restrict their activities, including sports, by adding to their physical functioning an aesthetic limitation that intensified their sedentary lifestyle. This constraint was also related to the difficulty in dressing, mainly due to the lack of sizes, despite a size law in Argentina.[20] Related to this, a survey conducted among adolescent women in Entre Ríos found a high prevalence of "discomfort" as a feeling and of the project of making hypocaloric diets after going shopping and not finding the correct size for them.[21] This

Table 3. Category: subjective experiences related to the body

Subcategory			Synthesis of analysis	Representative item*
Record of discomfort with her body	**Self-perceived**	**By comparison**	They reported registering discomfort and/or insecurity related to their bodies from a very early age, either by comparison or by comments related to their body size or by feeling negatively observed.	*When I went to kindergarten, I saw that the other girls were skinnier than me.*
		For health or aesthetics		*Since I was 6 years old, I started to notice if I had a belly or if I ate a lot. I feel uncomfortable because I am fat.*
		Insecurity		*I don't feel comfortable with my body, it makes me feel quite insecure.*
	External look	**Peer group**		*At school, I was bullied at lunchtime because of my weight. They told me that since I was already fat, I didn't need to eat. In elementary school, I felt that everyone was looking at me in the playground, especially the older kids. One boy made fun of my body and that's when he started to tease me (my body).*
		Family		*Since I was 6/7 years old, my mom put pressure on me because of my weight.* *My mom told me I was fat, that I had to lose weight because of what people might say.* *I don't mind my body, but many people tell me that I must lose weight, even my mom, who insists that I should exercise.*

**Each sentence corresponds to an interview and is an item of analysis.*

implies that access to a variety of sizes could reduce some dissatisfaction with body image and the appearance of unhealthy weight control behaviors, both of which are risk factors for the development of eating disorders.

To conclude this section, it should be noted that the entire population evaluated reported body dissatisfaction linked to overweight. According to the literature, body dissatisfaction is associated with the presence of anxious and depressive symptoms.[22]

Although this symptomatology was not evaluated in this study, the high frequency of body dissatisfaction merits considering these aspects in future studies.

In this study, interventions are understood as everything that occurs in the consultation for overweight: anamnesis, physical examination, recommendations, appointments for subsequent follow-up, and interconsultations. Regarding the dietary recommendations received, the overweight adolescents evaluated mentioned suggestions to restrict certain types of food. This led, on the one hand, to the perception of follow-up consultations as a moment of control over compliance with the recommendations and, on the other hand, the impossibility of sustaining them over time. In this sense, it is interesting to consider that, according to large-scale studies, food restrictions and prohibitions are associated

Table 4. Category: subjective experiences related to the body

Subcategory		Synthesis of analysis	Representative item*
Social or aesthetic conditioning in relation to their body	**Use of clothing: social events daily use bathing suit**	Reported that the inability to dress as they wished affected their daily and social activities, sometimes resulting in their isolation.	*I didn't want to go to 15th birthdays so I wouldn't have to wear dresses or muscle shirts that show my arms. The clothes I like don't come in my size; I must buy clothes for older people.*
	Sports practice	They would relegate the practice of sports until they lost weight or had a slim body for personal comfort or for fear of the external gaze.	*I like to dance, but I don't want others to see me until I lose weight. I would like to play field hockey, but I want to be thinner.*
Discriminatory experiences in relation to their body (n = 15)	**Spaces:** • sports • school • family • public space	They reported situations of discrimination or fear of being discriminated against at school, in public spaces or in the family.	*In physical education they reject me because of my body, so I make up that something hurts so I don't play. My brothers made fun of me while I was dancing, and I stopped dancing.*
Limitation of activities because of their body	**Because of discomfort or fear of being: discriminated against in the activity** • recreational • sport • school	They reported conditioning their behavior by restricting academic, recreational or sports activities.	*To practice the sport I want to, I should lose weight; otherwise, they will make fun of me.* *I* would like my body to be different so I can do things that I would look bad doing now.
	Because of physical difficulty	They mention physical discomfort associated with overweight that limits recreational or sporting exercise.	*Physical activity that I used to do now I can't because I started with chest pains.*

** Each sentence corresponds to an interview and is an item of analysis.*

with long-term weight gain.[23,24] In turn, it should be noted that both early dieting and unhealthy weight control behaviors, which are frequently underdiagnosed, may favor the development of eating disorders. The population evaluated presented both risk conditions.

Adverse experiences were reported regarding the centrality of weight in the consultations, mainly due to the failure to lose weight, to the point of being another reason for abandoning treatment. However, when inquiring about imaginary therapeutic scenarios that achieved positive changes in health, although they did not correspond to changes in weight, they were considered synonymous with failure. That is to say that, in the imaginary of the population studied, weight was not only the determining variable in the treatment, but thinness was an analog of health, good habits, high self-esteem and greater social possibilities. These beliefs are probably influenced by the negative social stigma they face daily and by a discursive environment that overvalues thinness.

In this work, empathy of the healthcare team is understood as "an attribute that is first and foremost cognitive (rather than emotional) understanding (comprehension, rather than feeling) of the patient's experiences, concerns and perspectives, combined with the ability to communicate this understanding."[10] In this sense, the majority of the population evaluated perceived that the healthcare team listened and took care of their problems but mentioned a certain lack of understanding of the daily experiences and perspectives of the overweight adolescents, which implies a lack of empathy for the part of the treating team.

According to the course of this work and based on the existing literature, it is interesting to rethink the interventions of the treating team and to add

Table 5. Category: perception of the healthcare team's interventions

Subcategory		Synthesis of analysis	Representative item*
Positive	**Associated with weight loss**	Conformity associated with weight loss and correspondence with greater *comfort in consultations and/or with* their social environment.	*The recommendations helped me feel better because I lost 3 kilos.* *When I managed to lose weight, I felt comfortable in the office.*
	In relation to healthy habits	Approval for healthy lifestyle changes .	*They helped me because I feel healthier and more active.*
	Motivation for change	Conformity with the positive motivation received to adopt healthy habits compatible with the likes or desires or based on their benefit.	*They told me that I could do the exercise that I like. That made me want to continue in treatment.*
Negative	**Discomfort with the physical examination**	Negative experience of discomfort related to weight control or physical examination.	*I don't like it; I feel uncomfortable when they measure my weight.*
	Similarity in consultations and loss of motivation	Reiteration of intervention modalities despite not achieving the desired objectives, leading to treatment abandonment.	*I tend to get discouraged and quit. I know that if I do what they tell me, I could go down, but they always tell me the same thing and it doesn't work for me.*
	Fault for noncompliance or for lack of relegation weight	Guilt related to the real or subjective difficulty of not being able to comply with the team's recommendations and/or due to the lack of evidence of weight loss that leads to abandonment of treatment.	*I felt guilty when they weighed me and I saw that I hadn't lose weight.*
	Focusing the intervention on weight or in the body	Disagreement with weight or body pointing mainly to highlight the lack of targets.	*Every time I come in; the doctor tells me I'm chubbier. She always talks about my body.*
	Dietary and physical activity recommendations	Difficulties in complying with or sustaining dietary changes. Perception of indications as restrictive. Barriers to physical activity related to discomfort with the body due to real or subjective discrimination, or for lack of attire according to size.	*I have a hard time eating less, or not eating certain foods.* *I couldn't do sports as I was told because, where I live, if you're fat, you can't do sport*s.

** Each sentence corresponds to an interview and is an item of analysis.*
Intervention: includes anamnesis, physical examination, recommendations, appointments for subsequentfollow-up, interconsultations.

tools to improve the quality of the interventions. Among them, we could encourage changes in eating behaviors and stimulate physical activity with long-lasting strategies, not focused on weight, with motivations based on empathy. It is recommended to seek the incorporation of intuitive eating, which allows a connection to be established between what you eat and how you feel in the short and medium term, relating food to mood, concentration, energy levels, satiety, comfort in eating, hunger, pleasure, and satisfaction; highlighting the importance of commensality, or sharing the table or eating space with the family or social group of belonging, and encourage, in general, to talk less about body size.[25,26] It is suggested to inquire in the consultations about body dissatisfaction and aesthetic issues related to the acquisition of clothing and activities of daily living, including recommended physical activity, and to inquire about anxious or depressive symptomatology and experiences of humiliation or discrimination.

It is necessary to promote acceptance and self-esteem since it has been documented that people with strengthened self-esteem are more likely to adopt positive health behaviors.[27] In

Table 6. Category: perception regarding the empathy of the health team

Subcategories		Synthesis of analysis	Representative items*
Positive	**Associated with a listening space**	They recognize in the treating team a suitable listening space.	*At the hospital, I always felt comfortable to be able to talk.*
Refusal	**Lack of consideration for experiences related to the body or UWCB**	Lack of space to be able to express real intentions change or unveil UWCB.	*I never said what I did or how I felt about my body, so no one knew that skipped meals or vomited.*
	Lack of consideration for their feelings or beliefs	Absence of space for expressing feelings or beliefs related to the overweight and the interventions provided.	*In addition to the weight, I would have I would like to be asked how I feel.* *I would have liked to be able to say that it didn't help me that pressure on me and that I did not feel comfortable.* *The gynecologist insists that I must lose weight and she doesn't think if I would have any problem with that.*

UWCB: unhealthy weight control behaviors.
**Each sentence corresponds to an interview and is an item of analysis.*
Empathy: a primarily cognitive attribute that involves understanding the patient's experiences, concerns and perspectives, combined with the ability to communicate this understanding.

this regard, transdisciplinary devices that can accommodate and generate actions that favor an improvement in the self-perception of body image could be beneficial, perhaps mimicking tactics used for minority groups, such as transgender people, on whom medical, aesthetic or social strategies are sought to improve the relationship with their own body.[28] It would be interesting to create spaces not only for clinicians or nutritionists but also for different areas or disciplines, such as estheticians, dermatologists, psychologists, occupational therapists, scenic artists, social science professionals, and other specialists,[29] that enable the exchange with peers and allow them to reflect on their bodies, on the various dominant models of beauty and social mandates, and to work on situations of mistreatment, discrimination, humiliation, and associated unhealthy weight control behaviors.

It could be helpful as a contribution to the work done by social movements that advocate body diversity paradigms based on the negative consequences of discrimination against people with overweight.[30] All this can only be achieved through the continuous and constant improvement of the empathic relationship of the health team that allows the necessary adaptation for each overweight adolescents.

Finally, it seems necessary to think about this problem from the perspective of the joint work of health and education teams through various strategies, such as the appropriate application of comprehensive sexual education (CSE) to sweep away prejudices and stereotypes rooted in the very heart of society, strengthen tolerance and integration, and prevent different forms of discrimination and mistreatment.[31]

Weaknesses of the study

In first place, it was necessary to adapt some questions, breaking them down or generating examples, to improve the quality of the responses since monosyllabic discourse emerged at the beginning. Second, when explaining the framework at the beginning of the interviews, a bias may have been generated in the initial responses regarding body dissatisfaction and its relationship with weight. Third, the number of males in the sample was low, consistent with their lower representation in health services. Fourth, very high BMIs needed to be sufficiently represented in the sample, probably mimicking the population characteristics of the service where the study was conducted. Lastly, the interviews

and the data collection were carried out by a single person, with a possible related bias.

Strengths

Interviews and debriefings were conducted by only one person, which favored less variability in the style of interviews and first categorizations.

CONCLUSION

Body dissatisfaction was common in the population evaluated, and half suffered body humiliation. Weight control was perceived in a dual manner: weight loss was the primary stimulus for treatment, but its centrality in the consultations generated discomfort. The leading cause of therapeutic abandonment was the impossibility of temporarily sustaining the treatment: recommendations and the lack of weight loss. There were empathic deficiencies in the approach to daily experiences, physical, material, esthetic, social conditioning, beliefs, and perceptions. ■

Supplementary material available at: https://www.sap.org.ar/docs/publicaciones/archivosarg/2024/10360_AO_Retamar_Anexo.pdf

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