

THESIS ABSTRACT

Psychological Aspects Of Obesity

By Sonia Found Zakaria, 1987

Obesity is a common medical problem, its prevalence is usually stated to be 35% of the male and 40% of the female population.

Understanding and studying this problem should be dealt with seriously not only because of its known medical complications and penalties - but also because of the traumatic psychological consequences of being obese in societies which today exert stronger pressures on people to be slim. Also because it is so resistant to treatment, its maintenance is difficult and relapse rate high.

Two different points of view about the pathogenesis of human obesity have emerged. One school of thought holds that obesity is not biologically determined but arises from the chronic use of food for non-nutritive purposes (Bruch, 1973).

Bruch hypothesized that obesity acted as a defense against depression. Crisps and Mc Guinness in 1975 supported this hypothesis by finding that obese were less depressed and anxious than leaner people. Further evidence by Stunkard and Rush in 1974 found that weight loss in the obese lead to depression.

Obesity is regarded psychoanalytically as a fixation at or regression to the oral stage of development.

Some insecure and guilt ridden parents try to overcome their own emotional shortcomings by an overzealous and over protecting attitude in feeding their children. These children failed to find alternative sources of satisfaction to food, as eating became a form of comforting behaviour when the individual is under stress.

Persons who were obese as children were more likely to have negative body images, and weight reduction did not bring about reduction in the intensity of this body image disparagement.

Obesity is also regarded psychoanalytically as a symbolic expression of aggression, as a substitute for sex, and as a defense against sexual anxiety.

The other school of thought, as proposed by Nisbett in 1972 states that obese individuals are biologically programmed for fat. There is evidence that human obesity runs in families. Twin and adoption studies suggest that there is a large genetic component to human obesity.

Hirsch & his co-workers (1977) proposed that some obese people have an increased number of fat cells, others have an increase in the size of fat cells. Whereas the size of the fat cells can be increased at any time in life; the number appears to be determined early at critical periods of development—perhaps through an interaction between genetic predisposition and overfeeding. Once formed, fat cells persist indefinitely, and when obese persons lose weight, it is solely by a decrease in the size of their fat cell but not their number (Powers, P.S., 1980).

Various psychometric tests have failed to find consistent psychological traits or characteristics of obese persons, but parallels between eating and addictive states were found, which may imply common psychophysiological elements or perhaps associated with the regulation of endorphins.

The treatment of obesity must begin in childhood through primary prevention. Programs should provide nutritional education and warn against critical periods for fat cell proliferation.

Also emphasize value of exercise which in addition to its physiological benefits, is associated with feelings of well being for the obese.

Behaviour therapy, especially in groups, is the most effective strategy to date in the treatment of obesity.

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