


On anorexia and bulimia: conceptions and etiological suppositions from the perspective of Health professionals


Alexandre Costa-Val^(a)

<alecostaval@yahoo.com.br> 


Vívian Andrade Araújo Coelho^(b)

<vivianaacoelho@gmail.com> 

Marília Novais da Mata Machado^(c)

<marilianmm@gmail.com> 

Rosana Teresa Onocko Campos^(d)

<rosanaoc@mpc.com.br> 

Celina Maria Modena^(e)

<celina@minas.fiocruz.br> 

^(a) Departamento de Medicina de Família, Saúde Mental e Saúde Coletiva, Escola de Medicina, Universidade Federal de Ouro Preto. Campus Morro do Cruzeiro, s/no. Bauxita. Ouro Preto, MG, Brasil. 34400-000.

^(b) Curso de Medicina, Universidade Federal de São João Del Rei. Divinópolis, MG, Brasil.

^(c) Departamento de Psicologia, Faculdade de Ciências Humanas, Universidade Federal de Minas Gerais. Belo Horizonte, MG, Brasil.

^(d) Departamento de Saúde Coletiva, Faculdade de Ciências Médicas, Universidade Estadual de Campinas. Campinas, SP, Brasil.

^(e) Programa de Pós-Graduação em Saúde Coletiva, Ciências Humanas e Sociais em Saúde, Centro de Pesquisas René Rachou. Fundação Oswaldo Cruz. Belo Horizonte, MG, Brasil.

Anorexia and bulimia are serious syndromes that require careful management. Clinical practice and literature show, however, that their approach is often inadequate. In this study, we were interested in knowing the discourse of health professionals about the characterization and etiology of these disorders. Semi-structured interviews were conducted with 13 workers from the public health network of a city in Minas Gerais/Brazil. From the points of convergence, divergence and silence of the speech, we locate discursive axes such as distortion of the body image; stigma; the slim body aesthetic pattern conveyed by the media. We came to the discursive formation of all of them through a critical dialogue with medical psychoanalytic and sociological literature. The results point to the insufficiency of biomedical knowledge in this context, indicating the need for dialogues with other theories to reach more effective strategies of approach.

Keywords: Mental health. Anorexia. Bulimia. Health personnel.

Introduction

According to the Diagnostic and Statistical Manual of Mental Disorders V (DSM V)¹, anorexia nervosa and bulimia nervosa are syndromes described among eating disorders which are characterized by persistent changes in eating behavior associated with disturbances in the way weight or body shape are experienced. They are severe conditions that cause physical, psychological and social harm, affecting negatively patients, families and health services^{2,3}.

Even though, from the epidemiological point of view, complete syndromes are rare in the general population, their prevalence rates among adolescents and young female adults are outstanding^{1,2,4,6}. Anorexia nervosa is the third most common chronic disease in adolescence, and among all psychiatric conditions, it is the one with the highest mortality rates. In addition, it is known that subjects with these symptoms lead a quality of life worse than that led by those diagnosed with schizophrenia^{2,7-9}.

The psychic and organic manifestations of these health conditions are delicate and require careful attention from health professionals². However, clinical practice and literature^{3,6,10-12}, show that this approach is often inadequate. In general, subjects resist seeking help, and when they do, they neither feel welcomed nor adhere to treatments. On the other hand, professionals point out that they do not feel to be tooled up to sustain a bond and develop negative countertransference relationships, associated with the assumption that it is rather hard to approach these subjects. This data is especially relevant when it refers to Primary Health Care professionals who, although often being the first ones in the health network to establish contact with these subjects, are scarcely familiar with the matter¹³.

In this context, the lack of hegemonic biomedical knowledge becomes evident, indicating the requirement of interaction with other theoretical references. Therefore, the field of Collective Health, committed to the performance of Mental Health, constitutes a privileged ground for the investigation of these conditions, as well as for the debate on existing interpretations and approaches.

In order to detail and deepen the complexity involved in the subjective aspects of these manifestations and their management, previous qualitative research focused on symptoms, patient and family experiences and therapeutic relationship. However, few have approached health professionals' discursive constructions on the topic^{3,10-12,14}.

In this study, we were interested in knowing how workers in a health care network understand these conditions, concerning their characterization and etiology, circumscribing the central ideas of their speeches. This information is relevant because it is directly related to the way professionals say they recognize, welcome and treat subjects with this symptomatology. Starting from a critical dialogue between the medical-psychiatric, psychoanalytic and sociological literature, we hope that this study will contribute not only to broadening the debate on strategies to assist this population, but also to problematize the extent of contemporary psychiatric knowledge in the field of Mental Health.

Methodological approach

This is a qualitative study in which semi-structured interviews were conducted from June to December 2014, involving health professionals from a city in the metropolitan region of Belo Horizonte, in the state of Minas Gerais, Brazil. At that time, there were twenty teams of Family Health Strategy (FHS), three Basic Supporting Units; a Psychosocial Care Center (PCC); an Alcohol and Drugs PCC; a Child and Adolescent Reference Center and a Mental Health Clinic in this health network. The integration between the Primary Health Care and Mental Health teams occurred through periodic meetings to discuss cases and the constant participation of a Mental Health professional from the FHS team who received and provided matrix technical support for the cases within the area.

The selection of the interviewees was intentional: while attending the periodic meetings, we contacted the professionals who had already attended to anorexic and/ or bulimic patients; we explained our investigation study to them and, under their consent, we scheduled interviews at their workplaces. As many as thirteen professionals, eight from different Mental Health sectors (four psychiatrists, one occupational therapist, three psychologists) and five others from Primary Health Care services (two physicians, two nurses and a nursing technician) were interviewed.

We developed key questions such as: “What do you understand as anorexia and bulimia?”, “What are their causes?”. The intention was to circumscribe the field without restricting it too much, allowing the interviewees to be free to go further in case they wanted to. We recorded and transcribed the interviews which lasted, on average, 45 minutes.

The analysis was based on Foucault’s definition that discourse is the “material reality of the thing pronounced or written”¹⁵ (p.8). In order to examine the professionals’ discourse, we drew inspiration from the same author’s archeological analysis, defined as what “individualizes and describes discursive formations”¹⁶ (p. 130). We asked: - How was this discourse built up? Where was it yielded? Is it possible to determine a set of statements and practices that could back it up? Which rules may determine it? Repeating Foucault¹⁶, we aim to seek: “The set of anonymous, historical rules, always determined in time and space, which defined, at a certain given time and for a certain given social, economic, geographical or linguistic area, the conditions required to exercise the enunciative function” (p. 136).

In order to organize the material, we aimed at points of convergence around the conceptions and causes of anorexia and bulimia, in addition to considering divergences and silences. Thus, we spotted some highlighted themes. We structured the analysis so as to support a critical dialogue between the theoretical frameworks from the Health field - which are possibly the main responsible elements for the constitution and regulation of the discourse-object that we analyzed - from Psychoanalysis and Social Sciences. We divided the results into two large groups, highlighting, in quotation, the themes we found.

The study was approved by the Ethics and Institutional Research Committee (CAAE-23492213.1.0000). A code was assigned to each participant which makes it impossible to identify them and preserves the confidential nature of the information (Chart 1).

Chart 1. Research participants

Mental Health Team Members				
Identification	Occupational Categories	Training time (years)	Working time in the city (years)	Post-Graduation
Psig1	Psychiatrist	8	4	Medical Residency in Psychiatry; Specialization in Clinical Psychology
Psig2	Psychiatrist	10	3	Medical Residency in Psychiatry
Psig3	Psychiatrist	11	3	Medical Residency in Psychiatry; Medical Residency in Child and Adolescent Psychiatry
Psig4	Psychiatrist	10	2	Medical Residency in Psychiatry; Medical Residency in Child and Adolescent Psychiatry; Master's and Doctorate's Degree in Neurosciences
T0	Occupational Therapist	12	8	Not applicable
Psic1	Psychologist	30	16	Specialization in Community Medicine, Social Psychiatry, Psychology and Mental Health
Psic2	Psychologist	8	7	Specialization in Psychoanalysis Theory
Psic3	Psychologist	10	7	Specialization in Hospital Psychology
Family Health Team Members				
Identification	Occupational Categories	Time to training (years)	Working time in the city (years)	Post-Graduation
Med1	Physician	10	2	Medical Residency in Family and Community Medicine
Med2	Physician	27	3	Specialization in Rheumatology, Homeopathy and Medical Appraisal
Enf1	Nurse	8	7	Medical Residency in Family and Community Medicine, Urgency and Emergency Management
Enf2	Nurse	4	3	Specialization in Family and Community Medicine
Tec	Nursing Technician	15	25*	Not applicable

Source: Authors' private designed by the authors.

*Note: the professional had already worked for the public health care system before graduating from the technical nursing school.

Results and discussion

After all, what is anorexia and bulimia?

In general, the majority of interviewees presented definitions similar to those from the DSM¹, prioritizing an objective description of the observed phenomena that allow their categorization as pre-established psychiatric disorders. The focus was on “eating behaviors”, either in restriction practices - in anorexia - or in compulsive food intake followed by vomiting - in bulimia. The “distortion of the body” image was also an emphasized element, as follows:

They are psychiatric disorders that interfere in the person's food intake, in the person's behavior towards the available nutritional source. And, the way the person sees herself/himself. For instance, Maria is an extremely thin patient who

still finds herself fat. [...] Therefore, it is a form of change based on the perception the person has. (Enf1)

It should be noted that the discursive inclusion of anorexic and bulimic manifestations in the psychiatric field is often understood as merely formalizing an essence that was previously underdiagnosed or otherwise named. However, the standard procedures governing Psychiatry today seem to contribute to the reproduction of these health conditions in the way they currently present themselves. The power of these designations that are disseminated discursively through medical, psychological, legal procedures, etc. can be detected when we observe, for example, that the first descriptions of anorexia did not take into account the discomfort concerning the image¹⁷.

In an attempt to build up some explanation for this image phenomenon, some professionals tried “to bring these patterns close to others which were better known”:

I always saw anorexia as something closer to a psychotic picture, departing much from the distortion of the body image, from the experiences of the self, from the corporeality itself. [...] But at the same time, a psychotic scenario different from the schizophrenic one, as the medication, at least in the ones I have seen, does not render much response. (Psiq1)

This parallel between anorexia and something closer to a psychotic condition is not uncommon in the literature^{11,18,19}. Hepworth¹¹, in his work on the social construction of anorexia, emphasizes that the identification of the causes of clinical conditions is fundamental so that Medicine can establish proper treatments. However, due to the notorious difficulty to identify the etiology of psychiatric conditions, treatments in this field are usually established *a posteriori*, based on the conclusions drawn from the observation of the effects of medications or other interventions. However, in the approach towards eating symptoms, professionals face a deadlock: unlike the delusional ideations of psychoses that may decrease with the use of antipsychotics, distortion of body image withstands this intervention².

Another attempt to draw closer to more established conditions is found in the idea of “comorbidities”, that is, in the possibility that subjects present two or more psychiatric disorders simultaneously^{1,2,20}:

We focus a lot on the identification of other associated psychiatric disorders, which is a very large prevalence. [...] We aim to stick to solid criteria when identifying these other conditions, because there are studies that show that if a patient has anorexia and depression, if you treat depression, it improves the prognosis. And, the same goes for anxiety etc. [...] We propose to carry out a treatment whenever a comorbid condition is identified, a drug treatment. (Psiq3)

Comorbidities are not only attempts to construct an explanation based on other more established conditions in the psychiatric field. As the approximation of these symptoms usually occurs in conditions that present more consistent responses to the standardized treatments - usually based on medications or psychotherapies

that lend themselves to the statistical quantification of their effects - it is possible to offer an evidence-based treatment²¹. Nevertheless, this fragmentation of the subject into diagnostic categories is linked to the fragmentation of the self, of the own necessities and feelings, making it harder to use the word and proceed the elaboration of a requirement for help²². Furthermore, as we had mentioned before, anorexic and bulimic symptoms do not respond properly to the protocolled approaches², consisting into a huge challenge for professionals, mainly when they are attached to the biomedical logic.

The “fear of gaining weight” was emphasized in the interviews, mainly for the diagnosis of anorexia. However, clinical practice shows that these subjects do not always reveal this discomfort. This contributed to the fact that, in the fifth edition of the DSM, the criterion was extended to include not only the evident fear of gaining weight, but also the presence of persistent habits that interfere with weight gain^{1,23}. Another important element was the “body weight”, mainly to determine the difference between anorexia and bulimia:

[...] essentially what distinguishes anorexia from bulimia is the current weight [...] You may have a bulimic patient with purgative symptoms and she/he will be with normal weight or, eventually, even overweight. In anorexia cases, you may have anorexic patients with purgative symptoms or only with restrictive symptoms, but according to the DSM, what will characterize the diagnosis of anorexia is the weight below that criterion [...]. (Psiq3)

[...] anorexia is more related to weight loss. Because the body is always fat, it's always too big ... it's too much. [...] Bulimia, I think it's linked to this thing of eating a lot and producing a certain intention of emptying, isn't it? (Psic1)

In fact, one of the DSM¹ criteria to diagnose anorexia is the fact that a minimum body weight is not sustained. The manual indicates that the determination of the low weight should be relativized according to the patient's history of corporal and weight development. In practice, however, the relativization of what would be an adequate weight for a given subject is, most often, overshadowed by the rigid definitions of the statistically determined ideal weight parameters²⁴. In addition, the differential diagnosis is usually complicated: anorexic and bulimic conditions often in alternated order or one following the other, which means that we find periods of anorexic symptoms in bulimia, moments of binge eating and purging in anorexia, and, usually, coming out of the anorexic condition by the bulimic path²⁵.

Given the insufficiency of the manuals criteria to make this distinction, some interviewees cited guiding characteristics towards clinical practice. In this sense, the “radical refusal” present in subjects with anorexic symptoms was highlighted. In fact, as previously demonstrated in other studies^{2,6,10,14}, both the pathological status of these practices and the treatment are persistently rejected.

In the psychoanalytic perspective, the refusal can be understood as a way of preserving a subject's singular space; in the last analysis, it is related to desire. Jacques Lacan²⁶, the psychoanalyst, makes this point explicit in stating that the demand is a kind of false request. After all, when whatever the subject asks the Other for is

attended to promptly, the absence ceases to exist and, without the absence, definitely there is no room to go on desiring. This thesis evidences the inadequacy of the term “anorexia” - which etymologically derives from Greek *an*, absence, and *orexis*, appetite or desire - because the denial of full satisfaction of the demand may, indeed, be a way of evidencing a lack in the Other, thus preserving the subject’s desire²⁶. This elaboration is in line with that of Lasègue¹⁹, one of the first physicians to describe anorexia, already warning that what is at stake is not the lack of appetite, but a way to maintain some control over the Other: “I think anorexia is more severe. It is a radical refusal. I think that in bulimia there is still some flexibility when you eat the food and something is unbearable and it is thrown back” (Psic2).

It is worth noting that this refusal is not restricted to food, also involving the symbolic, social and relational Other:

I find it difficult to handle the two kinds of problems, you know? I think about the anorexic subjects ... their refusal is remarkable! It strikes me hard! And then, the refusal of food, yes, but I think it is the refusal of the other, the refusal of the relationship, the refusal of that construction, you know? Whereas, in a bulimic person, I do not see such an explicit refusal, but I see something more troubled. It makes a relation, but a relation, thus, of sometimes disqualifying, of breaking a rule, do you know? (Psic1)

This indication that subjects with bulimic symptoms keep a relationship with the other in a more problematic manner seems to contribute to the sedimentation of an imaginary pattern in relation to these health conditions, found not only among health professionals, but also among patients and throughout the society, in general. Studies corroborate this fact by showing differences between the personalities of those who develop anorexic symptoms and those who develop bulimic symptoms^{1,2}. Beyond these findings, we are interested in highlighting the discourse concerning these manifestations. Traditionally, anorexia is understood as an excess of control and, bulimia, as the absence of control. It is not uncommon in the daily routine of the clinic practice, for example, to define bulimic subjects as “frustrated anorexic subjects”. Characteristics associated with bulimia such as impulsivity and deliberate risk behaviors (including sexual acts and substance abuse) have a negative social value^{1,2}. This datum contributes to the fact that “professionals’ stigma towards bulimia be greater than that towards anorexia”²⁷.

Although few, some interviewees have shown a certain critical distance concerning the criteria of psychiatric manuals, emphasizing that in these health conditions there is something that is beyond the food symptoms and the weight itself:

I find it very limited that we take up this issue of psychiatric disorder and reduce to a disorder that is purely a set of symptoms to carry out the diagnosis. [...] subjective and psychotherapeutic issues have a very extensive and rather varied component. [...] They have clearer signs such as important weight changes, but I think, fundamentally, it is a change in the relation with food and the relationship with the act of eating [...]. (Psic2)



I understand that it is a psychopathology, which is not specifically related to eating disorder. It's much bigger than that. (Ps2)

In fact, it is observed that the reduction of these conditions to the phenomena highlighted by the current psychiatric manuals corroborates a logic of treatment strongly focused on the adjustment of food, weight and satisfaction with the image. This type of approach, however, is limited, since it disregards the subjective and singular aspects of the subject⁶.

What are the causes of anorexia and bulimia?

The etiological debate about psychiatric conditions was at the core of Classical Psychiatry in the 19th century. At that time, there was a concern over the detailed description of conditions and the development of explanatory theories²⁸. This debate, however, has lost momentum since the creation of DSM III in 1980, which adopted a supposed atheoretical perspective to describe and classify mental disorders. As psychiatric knowledge was unaware of the etiology and the psychic illness process, a classification was created based on phenomena easily observed in the clinic practice, which could be described in an objective way. However, the scientific assumption contained in the intended atheoretical position of the manual actually implied the adoption of a physicalistic view of mental illness. In such a way, one can understand this atheoreticism as the acceptance of a specific theory about mental suffering, keeping distance from a psychological reading and driving Psychiatry into the realm of Medicine²⁹.

The manual would fulfill not only psychiatrists' interests, who needed to establish a more precise delimitation of the boundaries between normal and pathological, and consequently establish Psychiatry's field of action, but also the interests of the pharmaceutical industry, which needed to separate people who should or should not take medication. In 1994, the American Psychiatric Association (APA) published the DSM IV. Although this manual has a conceptual connection with DSM III, it intends to go beyond the act of simplifying the communication between researchers and clinicians within this field of knowledge, as much as to stand as the educational support for the teaching of psychopathology²¹.

Current Psychiatry results from the attempt to bring psychiatric knowledge closer to the Evidence Based Medicine model, a medical movement that advocates the use of existing scientific evidence, and currently available, with good internal and external validity, for the application of its results in clinical practice. The emphasis is on studies of clinical epidemiology, excluding what is not measurable, that is, subjects and their subjectivities. This proposal intends to circumscribe data, through controlled clinical studies, that guarantee standardized treatments based on scientific evidence³⁰. In this context, instead of discussing possible causes of psychic suffering, it is assumed that pre-established conditions exist despite the observer. Correlated signs and symptoms are sought in order to diagnose and treat them. In such a way, any subjective aspects are eliminated, either from the professional or the patient^{21,22}. In this sense, resuming the etiological discussion can have a rupturing effect over this logic.

The majority of the interviewed professionals emphasized that “the social valorization of the slim body fomented by the media” contributes significantly to the genesis of these health conditions:

Certainly [it is related to the slim body ideal]. Let’s say it is around 50-70%, more or less. Certainly, I think it is connected. Because, nowadays, a great deal of patients come to me asking for anorexigenics, sibutramine or others which are no longer being used... (Med1)

This interviewee pointed out that the pushing force of slimness in contemporary society is also linked to the “demand for medicines to lose weight” at the Primary Healthcare Units. According to data from the International Narcotics Control Board, Brazil is one of the largest consumers of these substances worldwide. In 2010, in order to stop this accelerated growth, the Brazilian government enforced strict rules concerning the commercialization and consumption of medicines for weight loss. The amount became limited to the prescription and the maximum doses of each substance decreased³¹, which, as the interviewee pointed out, helps to deny this type of prescription.

Much has been said on “women’s greater vulnerability to the aesthetic standards dictated by culture”. The social place of the object of desire exposed to the other’s eyes and the expectation towards perfection were some of the highlighted reasons:

These media formulations regarding women, what they have to be and how they have to be, which is a beautiful body, which is not. I think it has to do with girls’ ideal to become fashion models. Even if we think of toys, Barbies, dolls, the woman is always exposed to these ideals, to what is expected from a beautiful woman [...]. The woman is always in this place, seeking for an ideal, looking for something to offer to men. She is much demanded in that way, the way of perfection. [...] Men are not demanded in that way. (TO)

Bourdieu³² corroborates this idea, pointing out that male domination imposes on women the place of a symbolic object, incessantly exposed to the objectification operated by the look and speech from others (not only men). This compels them to push the “body-for-the-other” experience to the limit, determined by male expectations and naturalized by society. As a result, the woman remains in a constant state of insecurity concerning her image and a state of symbolic dependence onto others. However, we should not forget that anorexic and bulimic symptoms may also be present in men, indicating that the experience with the image goes beyond the issues related to genders³³.

Other professionals, although they commented on the influence of the slim body ideal in the development of eating symptoms, did question the overvaluation of this element for not explaining the etiology in a separated way:

Well, I think this will vary from individual to individual. But, what I postulate would be that this individual would have personal predisposing issues which lead the person to believe that the materialization of that aesthetic will fulfill

certain prior internal necessities of their own [...] Sometimes there is an overvaluation of the media role. [...] but I think there is an overvaluation because it is the most easily identifiable cause. If you get the psychic and the social, they have the same weight. (Psiq4)

The tension between culture, society and subject, which has always been at the center of the etiological debates about psychiatric conditions, is even more evident when it comes to anorexia and bulimia²⁰. In the current medical literature, the predominant idea is that these manifestations have a multifactorial etiology, that is, they are determined by several factors that interact in a complex way in a given subject^{1,2}. The emphasis, however, lies more on the factors associated with these tables from statistical studies than on the causal nexus itself, distancing itself from the richness of the etiological debate of Classical Psychiatry. Arnaiz³⁴ highlights that the recognition of the role of cultural factors in the genesis of eating symptoms is currently only rhetorical. The anthropologist comments that, although the “bio-psychosocial” character of these manifestations is mentioned, the research ends up focusing on the biological one, as one of the interviewees criticized:

You have all the discussions of biological causes, right? Of the biological tendencies, of the types of personality in which it is most common. Now, I do not know. [...] I do not usually see biology as very determinant. So you may have tendencies, you have a certain vulnerability to some kind of illness, but I think where it really comes from is in the person’s history. (Psiq1)

Indeed, in the medical literature^{1,2}, sociocultural factors are addressed in a simplified way, reduced to the ideal of socially valued slimness and family dynamics. The complex relationship between social, economic and political factors is often overlooked in these analyzes. There is a tendency to approach these health conditions in an individual way, disregarding articulations of the clinical experience with the complex interaction between the processes linked to the social and gender inequalities and the commercial strategies of the food and pharmaceutical industries³⁴.

This strategy is in solidarity with the maintenance of the logic of bio-politics, which, as Foucault³⁵ has already announced, is characterized by tacit games of power supported by dominant discourses that, ultimately, aim at the management of bodies and population. Dunker³⁶ complements, stating that current bio-politics tend to translate as pathologies the uneasiness caused by the disruption of social support systems. One of the interviewees resumed this discussion by relating these manifestations to the “fragility of relationships in contemporary society”:

I think [the slim body ideal spread by the media] contributes, but not isolated. It contributes in this context where the significant is actually overlooked. [...] We put so much emphasis on what is evident, which is much on the surface, that the possibility of people getting ill increases in that way. In a context where relationships are already complicated, they are already lacking affection. I think that even with all this emphasis on appearance, if we could build different relationships, there would not be so many people getting ill like that. (Psiq1)

It is worth noting that clinical practice shows that subjects do not adopt these behaviors to be similar to the patterns propagated by the media. In fact, what is observed is that they are, definitely, not similar to the models and are outside the logic of sharing socially constructed values. From the point of view of psychoanalysis, what is at stake is an autoerotic psychic satisfaction that does not pass through the other and, therefore, breaks up with the social bond⁶.

In fact, psychoanalytic studies have discussed the question of the image in contemporary times. Based on experimental data from comparative psychology, Lacan³⁷ distinguished the moment of the constitution of the Self based on the image of the body itself seen in the mirror. Experience shows that the child, still immature in relation to the motor and physiological domain, senses the body as fragmented; when confronted with a mirror, the image of the whole body makes the person rejoice, which does not occur before the person seeks in the adult's eyes the confirmation of that reflection; from that point, the person alienates her/himself from this complete image, which marks the first moment of the constitution of the Self. In other words, the other's look and all the other meanings coming from it, are fundamental for the subject to go into the collective code of language, symbolic universe par excellence that provides a support for the subjectivation of the representation of the unified image and its connection to socially elaborated situations. Ultimately, this process describes the formation of the Ideal of the Self, that is, a symbolic identification that will regulate the relation of the subject with his/her body, his/her image and the social Other³⁷.

The deformation of body image, often present in today's anorexia and bulimia, seems to be related precisely to this symbolic matrix: the Ideal of the Self. Currently, we observe a weakening of the power of the symbolic instance - a thesis taken up by some authors as liquefaction of the links, the fall of grand narratives, the decline of ideals, the dismantling of social support, among others^{6,36,38,39}. Without the support of a symbolic reference, without the point of view that Freud found in the Ideal of the Self, the image falters. This image stops working as a veil for something of the psyche that ends up in the mirror as an excess of flesh, an excess not symbolized. This surplus - known in psychoanalysis as enjoyment - distresses subjects with anorexic and bulimic symptoms, who find in fasting and purging a form of defense³⁸.

The problematic in the constitution of the image in contemporary time gains resonance in the speech of several professionals who understand that the development of anorexia and bulimia is related to traumas due to attacks to the image. These attacks, usually called "bullying", seem to reinforce the discomfort of an image characterized by the fragility of its symbolic support.

In general, I believe that there is some trauma, some anguish, some suffering that this has brought to the person that triggers this change of posture, of attitude. Because until then, if there is nothing to bother, to unleash it, the person will continue living her life, fat, overweight, obese, slim, anyway. (Enf1)

In our interviews, we found strategies similar to those pointed out by Hepworth¹³ in his study with professionals. The researcher points out that the repetition of terms such as "unfamiliarity", "complexity", "may be", "multifactorial" work as keys to justify the lack of an aetiological discussion of a problem whose essence is

puzzling. Moreover, this supposed common and indeterminate etiology, according to Dunker³⁶, is fundamental for the dissemination of these symptoms in the form of rigid appointments established by the biomedical discourse. This type of imprisonment in a certain discursive logic seems to contribute to some social responses, such as the norms that try to regulate the weight of fashion models, control the prescriptions of anorexigenic medicines, as well as the occurrence of bullying, among others⁶. In this context, the regulation of bodies and lives sustained by current bio-politics becomes more evident.

Final considerations

This research allowed us to realize and describe a discourse about anorexia and bulimia: the discourse from professionals who are active today, in the second decade of the 21st century, in the public health service of a city in the state of Minas Gerais, in Brazil. We meant to know how the discourse is built up, that is, the determinations, not only local ones but also historical and social that regulate it. Given the complexity of the subject and the methodological choice of the study, the possibilities of understanding the target issue have not been exhausted. But, we believe, we have stirred discussions and questions for new investigations on this scarcely approached topic.

As we have seen, despite the variety of conceptions and etiological assumptions among professionals, their discourse reflects ideas derived from the dominant medical-psychiatric knowledge in the contemporary world, in particular the DSM. So, it was not by chance that most of the speeches that stood out were those from psychiatrists. We consider it important, however, that further studies be carried out in order to take into account the specificities of each professional category and field of activity.

Regarding the conceptions, those within the target discourse used to carry out the diagnosis, elements such as the presence of self-induced alterations in eating behaviors, image distortion and body weight variation have been brought into light. The belief that these practices constitute well-established psychiatric conditions and the attempt to inscribe them in this field is clear.

When we confront our analysis with a vast literature on the subject, we come across indications that health professionals in everyday practice do not seek to understand these manifestations, but to frame them in a homogeneous group, treat them, medicate them and sedate them. This observation corroborates the preponderance of current bio-political logic in health practices: building a tight and homogeneous discourse on suffering, leaving no room for the manifestation of singularities. However, this overly normative appointment of a symptom is reductive in relation to the domain of experiences that it compresses and generalizes.

Regarding the etiology, the idea that the imperative of the slim body aesthetic pattern is at the basis of anorexic and bulimic practices prevails. From this premise, other elements are being developed: the predominance of these pictures in females, the incessant search for diets and weight-loss medicines, the generic naming of bullying suffered by those who do not fit the ideals. Such assumptions, once again, disregard the subjects and their singular aspects, constituting itself as a maneuver quite characteristic of the current bio-politics that aims, in the last instance, at trying a discursive integration of the uneasiness to the diagnosable and treatable suffering.

This social recognition, however, fundamentally excludes contemporary uneasiness due to the decline of ideals and over-standardization. We do not intend to exhaust, with such arguments, the aetiological diversity of these pictures or to propose a universalization, but to emphasize the avoidance located in the reported cases. They do not, for the most part, suggest that anorexic and bulimic manifestations may be related to structural issues of the human essence, that is, to the discomfort always present in the encounter of the subject with the civilization that, at each different moment, presents itself in a distinguished way. Neither do they make reference to the processes of imprisonment of the subjects to the current diagnoses that do not provide any contribution to the recognition of singular psychic conflicts.

As we have seen, such health conditions are always built around the status of psychiatric disorder, prioritizing diagnostic criteria to the detriment of possible causes. This conduct keeps the manifestations even more restricted to the biomedical discourse, leaving other theories, such as those of the Social Sciences and that of Psychoanalysis itself, in the periphery and avoiding discussions that could contribute to the approach of these subjects.

Authors' contributions

Alexandre Costa-Val participated in the work design, data outlining, collection, analysis, discussion and interpretation, as well as in the writing, revision and approval of the final version of this paper. Vívian Andrade Araújo Coelho participated in the collection, analysis, discussion and interpretation of data, as well as in the writing, revision and approval of the final version of this paper. Marília Novais da Mata Machado participated in the methodological design and analysis, discussion and interpretation of data, as well as in the writing, revision and approval of the final version of this paper. Rosana Onocko-Campos e Celina Maria Modena also participated in the work design data outlining, collection, analysis, discussion and interpretation, as well as in the writing, revision and approval of the final version of this paper.

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