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Psychological Aspects of Obesity in the Adolescent

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I selected the problem "Psychological Aspects of Obesity in the Adolescent" because I have felt that the obese adolescent presents a problem of individual significance. His problem is an exaggerated personality difficulty due to his environmental conditions primarily. While I do not teach physical education or any like subject where the problem is likely to be brought out very definitely, I am still confronted with the anti-social obese child. His maladjustment problems are some that I can feel very strongly, because I was one of those children. Granted that he is definitely in the minority, his moral worth is of the same value as any other child, and his development is greatly hampered by his gross physical state.

Obesity inserts itself into every phase of this individual's life; namely, the physical, spiritual, social, and economical. Though not ill, the fat person is potentially ill, due in no small part to his difficult social adjustments. He often becomes the center of attention and ridicule, and in many ways, he never quite recovers from his complexes.

As a contrast, the thin child, who is probably more in

evidence, remains in the background of anonymity due to his very smallness. He also may have his emotional problems, but the very fact that he is generally accepted puts him on a more stable footing, and children, cruel as they are, quite frequently do not accept the overly obese child unless he is extremely well-adjusted. This we do not find in many cases, and if the predominate reason for his maladjustment is his environment, it behooves the school to do what they are able in developing within this child the desire for normalcy and the means of accomplishing it.

As I looked for material on this subject, I found that this problem, naturally, is not considered by very many authors as yet. As time goes on, I feel that much more will likely be done, and more professional people will consider this problem in the light of their own profession. Of course, this may just be wishful thinking on my part, but I cannot help feeling very strongly on this subject. These children need the help that I failed to get, or perhaps I failed to see, when I was a child. Being "fat" is certainly no fun.

Since our school system is a public institution, we must guide and protect the needs of all adolescents. The school must take into account the social adjustment, the vocational selection, the physical growth and development, and the learning of academic subjects. Every child wishes to be a member of the group, and thus it is the youngsters' responsibility to adjust himself to the patterns of his group and to fit into

to his own social environment.

The obese child presents a challenge to the teacher. His illness is not truly a recognizable illness, and his infantile ways will try the patience of most everyone who comes in contact with him. Very few of his tendencies are moderate; his growth is exaggerated, his personality is frequently warped, his physical activities are sedentary, his interests are one-sided, and so on and on. The known fact, however, in the obese child is that both the physical and mental factors are at the base of the problem. It is difficult to determine which comes first. Does obesity cause the emotional conflicts, or is this emotional instability the cause of obesity. It truly does not matter. The fact remains that something constructive must be done about it. Since the school's function should be that of perpetuating a pattern, it would be well to approach this problem from the social adjustment angle, realizing that if the child is to become part of his group, his physical growth and development must of necessity be more normal so that he may better fit into the pattern.

The following general characteristics will aid in picturing the similarities and dissimilarities between the obese and nonobese child. I will use exclusively here the two studies and findings by Wexler, one of which he completed by himself and the other with Bronstein, Brown, and Halperin. The tests used were the Stanford Binet Intelligence Test, The Pinter Aspects of Personality Test, and The Terman Miles Attitude Interest Analysis Scale. The Terman Miles Scale was dis-

guised as a masculinity-feminity scale.

The intelligence represents a higher intellectual level than the average although it is generally thought that the obese child varies very little if any from the normal child of a like capacity. The mean I. Q. was 109 showing a tendency toward superiority; 48 percent were superior and 25 percent below average. The reading scores were--44.4% above average with 33.3% retarded. This bears out the fact that most obese children are prolific readers. Mathematics, in general, showed a like picture. The superior children were advanced, the average children were up-to-grade and the dull were retarded.

It is generally understood that every human being, whether male or female, shows a tendency in one direction or the other. The obese children observed and tested were no different than like normal cases. They were about average showing no specific deviation.

The personality tests explain to a better degree the variation from the normal. As was previously stated, the obese child shows definite exaggerated traits, and this was proved conclusively in the personality ratings. A large majority showed definite traits of ascendancy, submissiveness, extroversion, introversion, and emotional instability. Those few with no exaggerated traits showed marked tendencies in one direction or another.

It was found that most of the children were definitely sensitive about their overweight condition, but were not

sufficiently anxious to do anything about it. Since food held an exaggerated place, as far as security was concerned, it was more comforting and satisfying to hide behind a fat, clumsy body.

The lack of interests may possibly be explained by the parental attitudes. Since the children are rarely, if ever, pushed toward any specific goal or achievement, and since parents foster infantalism to a degree, we find that their chief interests are sedentary, consisting of the already developed modes of leisure. These are reading, (many times on the comic strip level), the radio, and the movies.

There is very little, if any, self-creativeness. No ingenuity or initiative was demonstrated. They accept the type of pleasure they can enjoy by themselves. Only 20% showed any specific individual interests.

The finding on friendship was strictly subjective due to the necessity of taking the child's or parent's word. Approximately an equal number claimed they had many griends or few friends, which if accepted, would probably be due to the personality traits of extroversion or introversion. Many, however, selected younger friends but not a sufficient number for conclusive evidence.

The obese child was found to dislike most forms of activity. Activity, instead of being a source of satisfaction and pleasure, was closely associated with danger and insecurity. Ridicule and failure aggravated his fears and feeling of in-

feriority. Of the number in the study 68% of the girls and 76% of the boys were inactive.

As the studies used chiefly clinic cases, the majority were foreign families in the lower income groups. These families as a rule produce large families, but in these specific cases, the family was small, the average being less than two children. Fifty percent of the families had two children, and 25% had one child. In 40% of the families, the obese child was the youngest.

Over 50% of the cases were reported as having "very good," "big," or "voracious" appetites. Those reporting small appetites illustrated distorted beliefs as to small appetites, as it was found that practically all of them consume in the neighborhood of 3500 calories daily.

The organic condition of the overweight child is frequently thought to be the cause of his obesity. However, there seems to be very little evidence of endocrine disturbance in the obese child, and the causes are chiefly environmental and psychological. The organic conditions will thus show more marked similarities than dissimilarities.

There are no specific existing differences between the obese and non-obese in the energy expended. The Basal Metabolic Tests have shown that many obese children will have an equal or higher metabolic rate, which proves to some degree that hypo-thyroidism is not the cause of adiposity.

As far as growth requirements are concerned, Bruch found

that the energy requirements for growth are the same as for the normal child. Fundamentally, there is no difference between the growth pattern of the obese child and the early maturing normal child. The gross size is merely regarded as a growth pattern which produces different types of body build. The individual differences follow an hereditary pattern which includes intensity of growth, and duration of individual periods of growth. The endocrine system and environmental conditions may also influence the growth pattern, but since the food intake of the obese child is so high above his needs, the excess food is stored as fat after energy requirements for growth have been supplied, regardless of other pre-existing conditions.

The great variation in energy requirements of different persons arises chiefly from the difference in muscular activity. The obese person conserves his energy by diminished muscular activity. Any physical signs of retardation are likely due to retardation in independent behavior which is likewise due to a delay in assuming normal responsibilities and a dislike of muscular activity. This delay in reaching independence, which in turn conserves energy, is partly explainable by the relationship of the child to the family. The fact that 70% of the cases were either youngest or only children, or that the age difference between the siblings was from five to ten years may possibly illustrate the dependence of the obese child upon the members of the family. In the last analysis, this conserva-

tion of energy is probably due to the slowness, the clumsiness, the poor coordination, and the varying degrees of aimless restlessness.

Appetite tends to reflect body needs, but there comes a time when appetite becomes a habit, and likely a retreat. Then, appetite must be curtailed, as people will eat enough to become fat if enough palatable and highly nutritious food is available.

The fat child may also complain about undue fatigue, but this is merely related to lack of initiative and listlessness. The physical activity has very little, if any, relationship to fatigue.

During the period of puberty and growth, it was found that the obese child showed advanced skelatal growth and early maturation. It is the impression of Bruch, that puberty will follow a more rapid course in patients at this age period, if they lose their excessive weight, and that such loss of weight and achievement of normal body proportions seems to be a more complex problem than mere social maturation.

Deviations in the behavior patterns, whether they are due to environmental conditions or not, present the problem of immaturity, overdependence, rejection, lack of security, personality conflicts, interpersonal relationships, etc., and are frequently the cause of maladjustment. These deviations occur so frequently with such great similarity and regularity that this phase of obesity has led to the belief that such problems

are at least of equal importance to organic causes.

The overweight child presents many adjustment problems. He suffers from a tragi-comic appearance, a conspicuous size, and a slow-moving body. Many are so ashamed that they refuse to take active part in activities which may explain their shapeless bodies.

The emotional factors within a personality are definitely tied up with food, for after all, we are, to a certain extent, what we eat, and if we eat more than the body actually requires, no matter how little, we will become fat. The emotional significance of food maintains a place of great importance in the life of the obese child. The wish to be fed is identical with the wish to be taken care of, to be helped, or to be loved. Food stands for health and security. A child often uses food as a comfort in combatting unpleasant circumstances. From the standpoint of physical growth, he matures rapidly, but from the angle of mental growth, he remains static, enjoying his parents love and protection, and demanding more and more of them. He develops a sense of dependence in every detail of life, failing to develop motor skills according to his age, gradually losing interest, and passively accepting the services of others.

He is submissive and unagressive in regard to overt behaviors and activities. His basic attitudes, however, are not submissive. He is not passively resigned. He makes demands upon the family, and his mother offers food so lavishly that he finds appeasement and gratification. This mother-child

relationship represents a precarious balance contrary to the natural processes of biological and emotional maturation.

The inordinate expansion of body size also reveals the child's desire to be big and powerful. Although passive and quiet, he is not inconspicuous. In his insecure and unstable relation to his surroundings, size gives him a certain feeling of safety and strength.

Some children become obese after a serious illness, after a death in a family, or even following a birth of a sibling. However, since most children undergo these experiences with little change it may be assumed that the obese child possesses a certain readiness to respond in this way to anxiety-provoking situations. If the anxiety is sufficiently severe to distort previous behavior and body appearance, it is likely that the inner stability and security of the child was precariously low before the event.

The Rorshach records reveal the obese as preoccupied with problems of size which suggests an emotional and symbolic importance to obese largeness. The second finding in regard to Rorshach is that the obese interpreted the symetrical figures as boy and girl, or man and woman, significant perhaps of their advanced growth and maturation. Hamburger also made one other symbolic finding that was unique to the obese child. He reports that the child will construct buildings which resemble the outlines of their bodies.

One well-known psychologist explains the mental relief ex-

perienced by over-eating. "There is a constant fight between the belly and the brain for blood. The full stomach demanding more blood at the expense of the brain lends a sense of composure, of relaxation and even happy indolence and repose to the emotional centers. Seeking this outlet habitually, despite increasing weight, the tensive individual becomes the calm, jolly, roly-poly fatty."

It is believed that obesity is a manifestation of neurosis in which the patient's suffering is of a peculiar intensity and highly distressing. It is destructive in the sense that the patient suppresses part of his personality in order to function better with the remainder. This neurotic tendency is characterized by anxiety, proudness, guilt, or depression. Food becomes an addiction--obesity serving as a protection and eating as a substitute gratification in order to cope with other frustrations. Obesity is a component of neurosis and the physical expression is the accumulation of fat.

The reasons for overeating are thought to be due to the distorted belief in the relationship between fat and strength, the exaggerated place that food takes above other interests, and the development of an inferiority complex.

There is a type of obesity which may be clinically earmarked as having mental and psychological components. However, a certain predisposition of this type of obesity may be necessary, as circumstances involving mental stress and be the underlying cause. This compulsive eating, or oral gratific-

ation, may be a substitute for frustration of other drives.

If a child at puberty is to outgrow his physical fatness, it is believed that any treatment, if successful, depends upon the mental adjustments he is able to make during this critical period of his life.

A child quite often finds that school presents on of his first stumbling blocks. He frequently does not fit into the group and this conflict involved in social adjustment to the group increases with age. The child is exposed to rejection by the group, and, being unable to hold his own, he will resort to overeating, since food is a never-failing source of comfort and satisfaction. This explains the frequent onset of obesity when a child first enters school. In overeating, the child finds an outlet for his agressive and hostile feelings. The obese child within the school situation frequently meets his traumatic experiences of failure and disappointment by attracting attention to himself through boisterous behavior, as clowning or talking, temper tantrums, or sulkiness, and he may become bossy and agressive toward younger or weaker children. Shy unagressive, and withdrawn tendencies, over-sensitivity to possible insult and injury, and lack of self-reliance and self-confidence may be explained by his response to rebuffs repeated daily which isolate the obese child from normal social contacts.

The fear of bad moral influences through contact with other children is also significant in the development of, or onset of

obesity. Thus "threat" and "danger" of activities or contacts cause a certain withdrawl from, and sensitivity to others.

After reading the periodical, "The Family Frame of Obese Children" by Hilde Bruch, I am convinced that such overweight conditions are due to a great degree to the parental attitudes, and influences within the background of the parents' childhoods. This is probably due to the fact that the parents project their own lives into those of their children by attempting to overcome their own childhood inadequacies in the light of their children's lives.

Because the parents' background plays such an important role in the home environment of the child, and due to the fact that environmental factors and parental attitudes are the most instrumental factors in childhood obesity, I feel that some time should be devoted to "problem parents" in solving the child's dilema. This study of Dr. Bruch, in the main, deals with the lower income groups who were mostly of foreign extraction. She recommends that a similar study be made of the middle and higher income groups. The findings are as follows:

Economic and Living Conditions

These families were clinic cases, some on relief, or who had at some previous time been on relief. In general, an attempt was being made to raise the family's social status. This attempt was most specifically noted on the mother's part by her provision of a abundance of food. This represented a luxury the mother could afford, and gave her a feeling of

affluence in the community.

The environment was generally good but was exclusively the mother's creative expression of comfortable living. The child, however, was somewhat ignored. There was a lack of space for the child and his interests, his activities and his friends. The desire for orderliness on the mother's part left no place for the child. There were few social or cultural contacts and very few educational and social advantages. The presence of relatives in the household also limited the space for the child which led to friction and tension as the discipline of the child was frequently taken over by many of the relatives.[1]

Parents in Relation to Their Background

The emotional development of the parents was greatly hampered, as their attitude toward life had been passive, due to lack of security, inability to raise family status, bitterness toward dominating parents, and so forth. The mother, in general, therefore, developed personality complexes, as self-pity, lack of sincerity, resentfulness, incessant preoccupations with their misfortunes, and condemnations of others. The mothers, in general, felt that they had been deprived of affection and security too early in life. Only a few obtained self-satisfaction from their present situations as every burden was an unwanted burden. None had developed a mature, vigorous, and secure personality, and they were afraid of the progressive

1. Hilde Bruch, "Psychiatric Aspects of Obesity," American Journal of Psychiatry, Vol., 99. (March 1943), pp. 752-757.

world with its adjustments and necessary adaptations.

The interpretation of the above is that the parents in their impeded emotional development, and their frustrated longings for a happier childhood, which in turn provokes a desire to create this Utopian childhood for their child (actually for themselves) may be sought in the source of their attitude and reaction toward their children.

Parental Relationship[2]

In most families a relationship was quite unstable with parental domination being on the mother's part. There was a lack of common interest, and participation in social life except perhaps in the mother-child relationship, thus there was a lack of companionship. The degree of compatibility within the family circle was very low, and the rearing of the children and competition for the affection of the child was frequently a family problem.

Attitude of Parents to the Obese Child[3]

The attitude to the parents, usually the mother, showed marked inconsistencies by overt display of protectiveness, rejection and hostility. The insignificant position of the father could not combat the close bond of mother-child dependence, even though he recognized the danger of the thwarted development of the child. The mother's need of expressing and

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2. Ibid.
3. Ibid.

receiving affection demanded the affection not received as a child; thus the child did not develop personal independence, nor did he establish satisfying relations with others. The mother also showed signs of devotion to justify the not wanting of the child, by prolonging the infantalization, providing of all desires, and yet at the same time showing her disappointment in the child by outright rejection.

The interpretation of the parent's attitude is therefore, that the manifold expressions in which conflicting attitudes manifesting themselves, create an environment of emotional confusion and insecurity which might be hidden below overt demonstration of indulgence, and overprotection. The fundamental need of each child of being loved and accepted as an individual in his own right, and of growing and developing at his own rate, was frustrated and called for special safety devices.

Attitude Toward Health, Obesity and Food[4]

Obesity in the child very rarely aroused the interest of the family, and the appearance of the child and his personality difficulties gained importance only in relation to society outside of the home. The parents were willing to accept the diagnosis of glandular difficulty, but such acceptance blocks the way for recognizing the underlying psychological problem. The exaggerated concern of the parents was over acute physical dis-

4. Hilde Bruch, "Obesity in Childhood," "Physiologic and Psychologic Aspects of the Food Intake in Children," American Journal of Diseases of Children, Vol., 59, (1940), pp. 739-781.

orders, or the question of threat and danger through contact or activities with others.

I should like to include some other authoritative beliefs at this point without any comment of my own at the moment.

Bauer----------The disorder of glands frequently results in influences on the nervous system. Mental and emotional shocks act as a regulatory mechanism on the body and that disturbances effecting the weight, appetite, and energy are often successfully treated by treating neurosis.

Leroy----------Many people who complain of insomnia or attacks of mental depression or both can develop an obese condition, despite a low food intake, and exercise, and paradoxically there will be a decrease of weight following complete physical and mental rest.

Maynadieu------Functional disturbances play an important part. The role played by the endocrine gland has decreased in importance as compared with that of the central nervous system in the development of obesity.

More-----------Obesity results from nervous exhaustion, severe mental conflicts, or maladjustments often inducing a neurosis which may result in serious metabolic changes. Cases which are not reduceable by proper diet and medication may be strongly influenced by mental fluctuations.

Lichtwitz------Psychic factors are directly associated with obesity. These factors present a typical neuresthenic picture characterized by poor memory, decrease in mental power, exhaustion and melancholia. Such cases may result from emotional shock and frequently do not respond to diet or medication.

Passanisi-------Mental shock is responsible for the hypo-
and function of the thyroid, pituitary, and
Amercarelli----gonadal glands.

Wittenberg-----Obesity is not primarily due to any metabolic disorder. Many are not happy-go-lucky but emotionally unstable. Food likely furnishes the excape and gratification that others find in cigarettes and alcohol.

Crohn----------Abnormal hunger or appetite disturbances are a manifestication of a gastric neurosis, and may be classified as a psychoneurosis, the will and act of compulsive eating. If mentally contented, excessive craving for food and psychic strain will disappear.

Myerson--------Eating has become a social as well as a physiological and psychological habit. The gratification of desire for contentment and peace of mind gives vent to restlessness and an overindulgence of food.

Alexander------During early infancy the wish for love, the striving for security, possessiveness, greed, jealousy, and envy, all become linked with the hunger drive and the process of nutrition.

I stated that I would quote these authorities with no comment, but I am not able to do it. I have to say that I do not believe that all obese persons are neurotic. I am inclined to agree with Donald G. Cooley who said: "You are you! You're different. You inherit a body build that is distinctly your own. All your life the way you're built exerts a powerful influence on weight gain, personality, sexuality, energy, disease susceptibility--just about everything that is personal to you."[5]

There are several common fallacies in regard to obesity. I have included in my paper six of the most common:

1. Childhood obesity is more common in boys than in girls. The obese condition is merely more abnormal in boys.
2. Sexual maldevelopment is more prevalent in the obese than in the non-obese.
3. There is preponderance of Jewish patients. They are slightly in excess of other groups but not as marked as commonly assumed.
4. Endocrine plays a large part in abnormal weight.

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5. Donald G. Cooley, "The Magic Diets," Today's Woman, (July 1952), pp. 29-35.

5. The obese boy shows a tendency toward feminity.
6. The overweight child in general eats no more than the average child.

Psychotherapy is of primary importance in the prevention and management of obesity. It is also recommended that psychodiagnosis be used in the treatment of obesity. An attack on the problem, therefore should consist of the following:

1. Cut down on the unphysiological desire for food by attacking obesity through the psychological mechanism.

2. Evaluate the patient's habits, environment, and insecurities.

3. Mitagate adjustment problems and anxieties by assurance. Strive for mental contentment.

4. Adhere to the necessary physiological treatment after a sense of well-being has been established. Take note of chronic fatigue for it may possibly be a neurosis.

5. Combat laziness, and reinforce the patient's will power by tactful persistance, occasional severity, and patience.

6. Relate the treatment to the social and economic disabilities of the obese person.

7. Prolong the psychiatric treatment, especially in younger people, when obesity or accompanying neurosis presents a severe handicap in the process of living.

8. Understand the physiological or psychological etiology of the condition.

9. Strive for good patient-doctor relationships in order to secure the patient's cooperation in controlling the food

intake.

10. Investigate into the developmental history of the obese, thus arriving at a better understanding of the underlying emotional disturbances. This insight is of practical value because psychotherapy aims at more than temporary loss of weight and attempts also to help these children to become happier and better adjusted.

11. Develop some active giving, instead of passive receiving by assigning tasks compatible with the age.

12. Provide children having poor muscular development and postural defects with a program of muscular training, not to include dull, tedious tasks.

13. Help the child to grow independent and self-reliant by making constructive use of his good mental and physical endowment so he can find more dynamic outlets for his creative drives than through his static form of physical largeness.

14. Safeguard against a recurrence of the obese condition after normal weight is reached by carrying a follow-up program at three to five year intervals.

After reading and studying for this paper, I have come to some conclusions that are not very original, perhaps, but here they are:

1. Excessive intake of food and muscular inactivity represent the most obvious factors in the mechanism of disturbed energy balance.

2. Training and life experiences determine the amount of

food intake and muscular activity or inactivity.

3. Approximately 95% of the cases of obesity are of the alimentary type.

4. No endocrinological evidence was found as a basis for obesity.

5. Achievement tests show little if any variation from children of a similar capactiy.

6. Families are generally small.

7. Parental attitudes are contributing factors.

8. Exercise, food intake, and muscular inactivity are expressions of poor social adjustment and delayed emotional maturation.

9. The obese child shows no greater tendency toward masculinity-feminity than any other similar group.

10. Personalities in the obese show tendencies of emotional instabilities.

11. Severe cases of obesity are more common among the marginal economic group and the foreign nationality group.

12. There is no valid evidence that energy requirements are lower in the obese than in the normal.

13. Growth in stature is in excess of the average normal child, but in harmony with the height and development of children who mature early.

14. Skelatal maturation is normal or advanced but not delayed.

15. Abundant nutrition intensifies the growth pattern.

16. Pubertal development takes a more rapid course in patients of this age group if they lose their excessive weight.

17. Because of exposure to a prolonged period of over-protection, the child exhibits signs of immature behavior in eating habits and other infantile patterns.

18. The offering and receiving of food represents an important emotional tie in the mother-child relationship.

19. Obesity is a disturbance in maturation of the total personality, and is a somatic compensation for thwarted creative drives. Thereby, the total size of the body becomes the "expressive organ" in the conflict.

20. Many obese children are unwanted children.

21. The type of diet is influential in building excess adiposity.

22. Obesity is a condition in which few patients apply for treatment.

23. While there are some general tendencies that we should watch for in the obese child, we must at all times remember that we are dealing with an individual and his problem, not a type. It should be recommended that the patient be told more of the scientific background including the cause (as much of it as he can understand), dangers, and treatment of obesity. Israel Bram has used twenty-two informative questions to acquaint the individual with the necessary simplified information. I feel that a better understanding and more cooperation will be secured in this way.

Education is concerned with preserving the physical and mental health of the individual. This involves more than mere exercise. It includes an understanding of body structure, and functions, proper diets and factors of emotional balance. Once this general fact is known, the relationship that exists between physical condition and habitual attitudes and behavior is better understood. Unhygienic living is more likely than not to result in serious maladjustment. It is our job to see that each student understands these things, and to see that he wants to improve his own position in the community. He must want to straighten out his physical imperfections and illness (for I believe that obesity is an illness), or he cannot be helped either by himself or others.

Modern civilization places many demands upon the human body which were not faced by primitive man. High industrial specialization demands that adjustments be made to meet these new conditions. When activity is changed, even for recreational purposes, the body is at once thrown out of balance and is confronted with the problem of adjustments and balances. Education can help the individual make adequate adjustments. Play is used for the purpose of maintaining an internal balance and internal harmony, thus securing the desired physical competence. The school should help the student achieve a scientific understanding of the laws affecting these body conditions. If that is to be done for each student, I feel that the obese child who has more adjustments to make because of his size should have

and deserves more individual attention. Those who have few adjustments to make probably can either ask for help, or manage for themselves. The child who cannot understand why he is as he is, or why he looks as he does, or why he is rejected by the group or his parents, must be helped. His plight may be desperate, or if it is not, it is sure to be most uncomfortable. It is up to us, not to make disparaging remarks or jokes, but to try our best to help this child.

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