The Emotional Significance of the Preferred Weight

By HILDE BRUCH, M.D.*

WEIGHT, for scientific discussion, has been defined in so many different terms, that I hesitate to add one more, the "preferred weight."[1] *De facto*, it is not an addition but a contrast. The existing adjectives, such as "standard," "ideal," "average," "expected" or "predicted" weight, refer to some calculated figure derived through manipulation of large-scale observations. These figures are often presented as a measure of a desirable normality for a given individual, with the implication that calculations are proven facts—something they are *not*.

We all know that people in real life do not follow scientific calculations, but have a stubborn way of clinging to their own figures. It is with this real, individual weight that I shall concern myself. I call it "preferred weight" because it represents the weight the organism, in its mysterious self-regulatory capacity, *prefers* as its pattern of adaptation. It often does not coincide with what *we* prefer, or even with what the individual who carries the excess weight professes to prefer. But it seems to be necessary to consider this true weight. The first step in scientific investigation is the establishment of facts as they are, not as we want them to be or claim that they ought to be.

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Presented at a Symposium on Nutrition and Behavior held at the Laboratory of Physiological Hygiene, University of Minnesota, April 27, 1956, with the cooperation of the National Vitamin Foundation, Inc., New York and under the sponsorship of the School of Public Health, University of Minnesota.

By way of illustration I wish to describe briefly weight curves of a few overweight individuals who have been exposed to extensive clinical treatment and study.

Figure 1 represents the weight of an Italian boy who came to the attention of Vanderbilt Clinic at 11 years of age with a weight of 265 lb. There were several periods of great loss in weight up to 100 lb, under hospital observation. As soon as he returned to his own home he would not only go back to his former weight but continue to gain at the previous rate. He had been unable to find work on account of this weight. If one connects the high points of this curve it proceeds at a steady rate as if these interferences with the natural pattern had not taken place. This man died at the age of 23 of pneumonia.

The next case (Fig. 2) is that of a young man of Irish descent who weighed 100 lb at eight years of age. There was a short-lived effort at reducing. The family's attitude was: "The bigger he is the better we like it." The second period of reducing was carried out under the threat of sexual maldevelopment, with simultaneous endocrine injections; incidentally, this was done against the advice of the Clinic. In retrospect he referred to this period as "the most miserable time of my life." After puberty the increase in weight proceeded in a way remarkably similar to the average for his height and age. There were a few efforts at reducing, associated with a loss of efficiency and a decrease in well-being. He did not like being so heavy but accepted it as the way he and his family were built. He was successful in his work, married and had two children.

In the following case (Fig. 3) there was marked anxiety about his weight and, even more, about possible sexual maldevelopment.

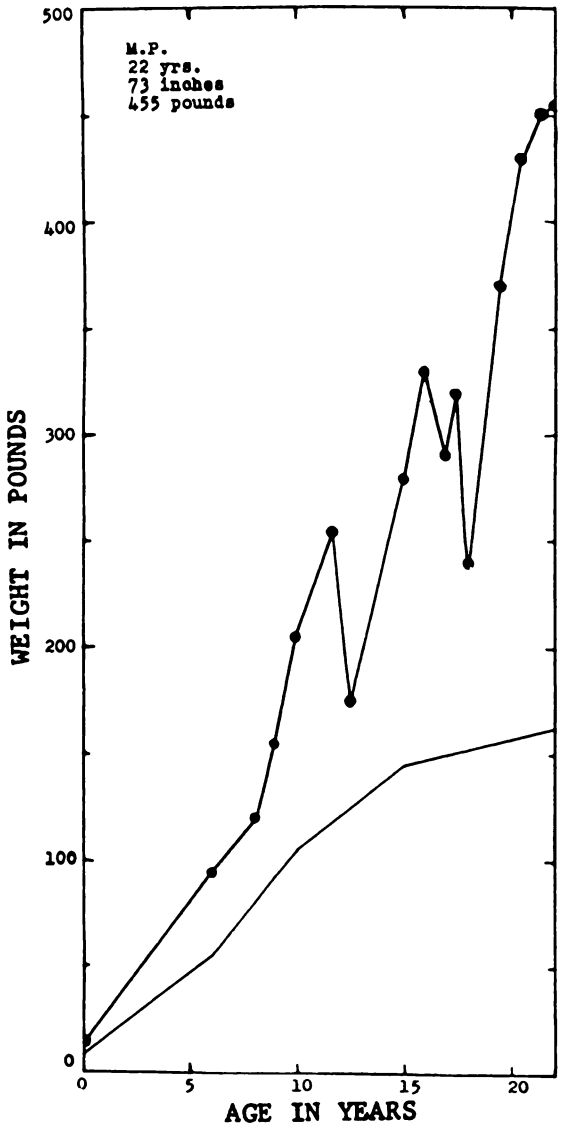

Fig. 1. In this and the following figures the upper, heavy line represents the weight of the patient and the lower, thinner line the average weight for height and age.

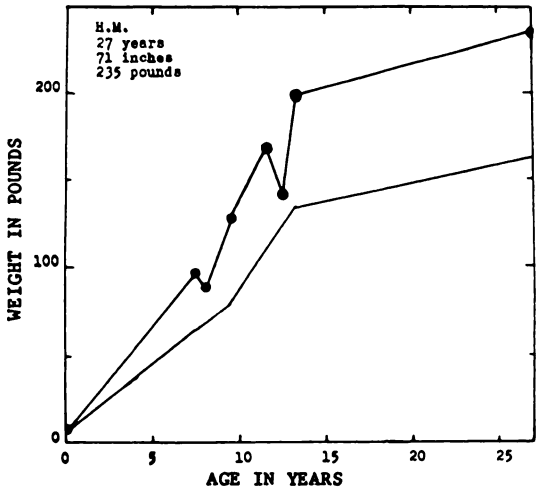

Figure 2

There were also many behavior difficulties for which, however, psychiatric treatment was refused. Instead the boy was taken for endocrine injections and he received a variety of products until his entry into the Armed Forces at 19 years of age. The rapid spurt in growth, when he was 10 years old was precipitated by injections of testosterone. While in service he lost 50 lb but had regained 15 lb on his return from Korea. His vocational and social adjustment was marginal.

The case illustrated in Figure 4 represents an example of the always hoped-for "outgrowing" of obesity. During this young man's early life there was much strife between the parents. The mother overpowered the young child with her devoted care and her efforts at keeping him quiet by stuffing him with food. After the family conflicts were resolved, the child was allowed independence appropriate to his age. At no time was food restricted because the mother objected to the very idea of a diet. He had a good high school record, felt socially at ease, and had adjusted well to the Navy, when last heard of.

Figure 5 represents the weight chart of a colored woman who had been a patient at Presbyterian Hospital for the first time in 1917. She had been recently married and moved to New York from one of the Caribbean Islands. She was concerned because she had gained some weight during the preceding months. This was when she was 23 years of age, was 5′ 4″ tall and weighed 148 lb. This was the only time that the patient complained about her weight. She returned to the clinic five years later with a broken finger. Her weight was 196 lb and she reported that it had been 207 lb the year before. From then

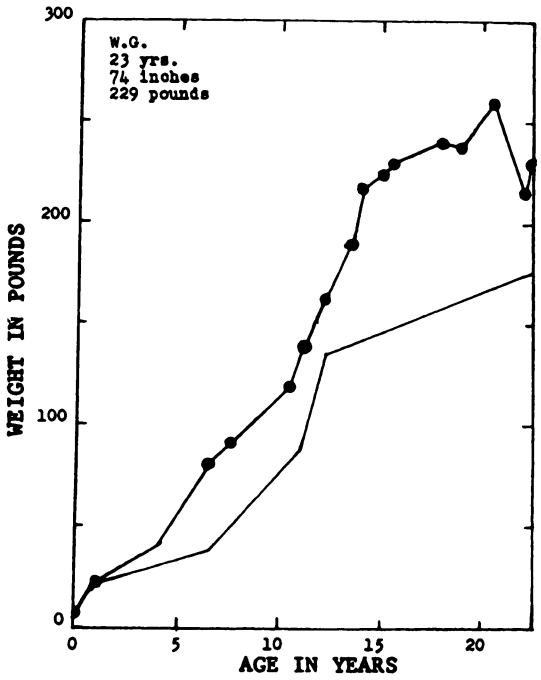

Figure 3

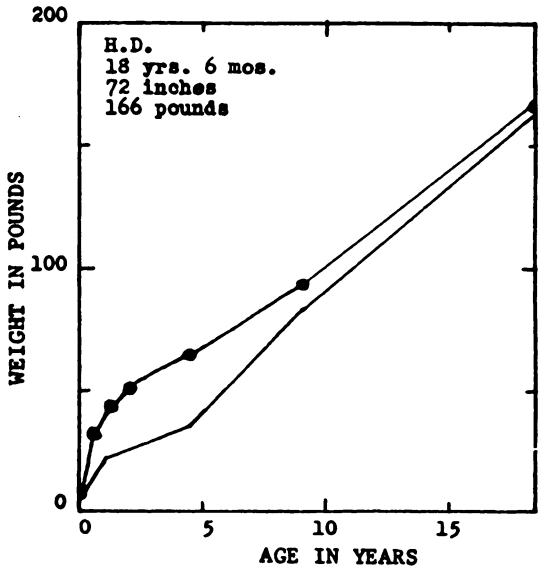

Figure 4

on she came to the clinic for a variety of complaints and minor accidents. When 38 years of age a cholecystectomy was performed after long standing abdomina discomfort. Except for this operation she was sent, for whatever ailed her, to the Food Clinic. She made repeated efforts to follow the prescribed diet and ost as much as 10 or 15 lb. Her lowest weight was 185 lb, one year after the operation, and her highest, two years later, was 220 lb. At that time the patient made a definite statement that she could not diet, that it made her feel weak and irritable. Nevertheless, several more attempts at reducing were made, producing various comments from her physicians about the "hopeless situation" and "the absolutely uncooperative patient." At the last examination prior to some minor surgery, when she was 63 years old, her weight was 198 lb. Otherwise, she was given a clean bill of health. As far as we know she has lived an adequately satisfactory life, having made a new adjustment to the weight she had gained during her early twenties when she moved to New York.

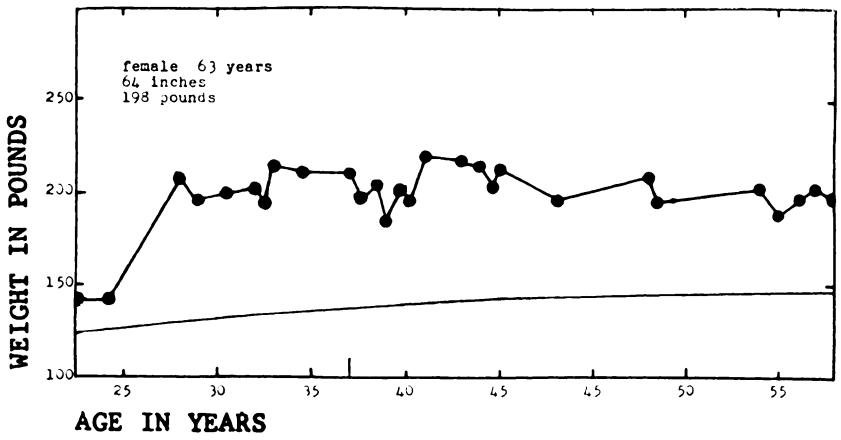

Figure 5

An entirely different picture is represented by the next patient (Fig. 6). Deliberate efforts at reducing, self-imposed by this patient as well as medically supervised, became the outstanding symptom of severe maladjustment. For 20 years he had made many strenuous efforts at reducing, with a total loss of more than 450 lb. He was the youngest child in a large family, more than ten years younger than the next older brother. He had been a fat child but nothing was done about it until he was 16 years old and weighed 265 lb. At that time an older sister took him in hand, insisted on treatment, and supervised his diet during the next year, whereby he lost nearly 100 lb. When he graduated from high school he weighed 169 lb and he felt he was perfect. He considered this year "the golden age" of his life. But he could not maintain the lower weight. Whenever he was confronted with difficulties in his job, trouble with his family, marital difficulties, disappointments during his army career, accidents, etc., he would gain enormous amounts of weight. Any decision to make a new start in life was associated with strenuous reducing at record speed; he would recite the exact figures, like having lost "50 lb in as many days." The hectic weight curve reflects the many shifts in his efforts to find a better adjustment to life. He was haunted by the fear of failure, of not living up to expectations, and the feeling of being an object of ridicule. He sought psychiatric help when it became clear to him that his problems in living could not be solved by reducing.

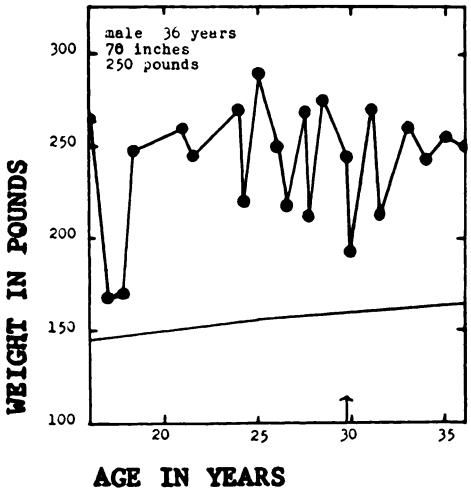

Figure 6

DISCUSSION

These are just a few examples of different patterns in which weight functions in the total adjustment of an individual. To determine the percentage deviation from an assumed normal and to designate a certain deviation as abnormal, is a completely arbitrary and misleading procedure. It says nothing about the competence with which an individual functions. Weight needs to be looked upon, like many other biologic functions (such as gait, pulse rate or manner of speaking) as something which each organism uses in its own preferred pattern. There are wide individual variations in these patterns which, however, are normal constants for a particular individual. Interferences with this preferred pattern, or changes by voluntary decision, result in a sense of discomfort or disatisfaction, a feeling that something is wrong. In weight control this is experienced primarily as chronic hunger with its many by-effects, but also as inability to cope with the stresses of life.

It seems to me an inescapable conclusion that the current approach to the condition of overweight is based on an erroneous assumption, namely, that it is always an abnormal and harmful condition that should or could be removed by dietary restrictions. Whether we like it or not, consider it attractive or ugly, we must recognize it as an undeniable fact that for many people weight is an important factor in their adaptation; it may serve as a protection against more serious illness. There is need to differentiate between overweight that is an expression of a normal variation of body build and that which is pathologic, the expression of a dysfunction, determined by a variety of factors. In either case, interference with the weight pattern of the organism should be preceded by an exact diagnosis of the underlying condition.

There is no doubt in my mind that eventually the physiologists will provide the means of an

exact metabolic diagnosis, or even cure, of the different conditions now lumped together as obesity. Careful clinical evaluation permits classification according to different reactive patterns and thus makes more meaningful treatment possible. This approach is, of course, decidedly less simple than the statistical classification according to percentage overweight; but it has the advantage of coming closer to the true complexity of the problem with which we are confronted. Of greatest importance is an assessment of the psychologic factors that have contributed to the development and maintenance of the excess weight. Their significance can be understood only by relating and integrating them with physiologic data.

I shall focus here only on one aspect, namely, what it means psychologically to have a body weight that is socially and medically condemned as ugly and as indicating self-indulgence and lack of will power. This is painful and embarrassing for an adult. If this social rejection takes place during childhood and adolescence, it has disastrous consequences for the personality development. A feeling of harmony and integrity about one's self and one's body is an important, central experience for a healthy emotional development. The hapless youngster who according to his constitutional make-up is inclined to grow heavy is continusouly exposed to a negative critical attitude and derogatory comments. His concept of self, as well as his body image, is built during childhood from all sensory and psychic experiences. If there is continuous insult to a person's physical make-up, he will be unable to develop a valid feeling of self-esteem and of unity between his psychic and physical self.

The serious and deep-seated emotional disturbances, which are frequently associated with obesity in childhood and adolescence, result not only from the stresses that led to overeating and obesity, but also from psychologic injury to which being fat exposes an individual. It seems to be significant that in the group of fat children followed over 20 years, those had done best in their total adjustment who had been accepted the way they were; the most serious emotional disturbances, including schizophrenic development, were observed in those in whom there had been the most persistent and hostile preoccupation with their weight. For such individuals reducing is commonly recommended as a means of solving their difficulties. The denial of the desire for food, a desire which is deeply interwoven with unfulfilled needs for affection and security, becomes an additional psychologic trauma. In this age of large scale weight control programs, it is necessary to keep the mental health aspect in mind, namely that it is dangerous without having first assessed and corrected the underlying disturbances to interfere with the weight which the organism has used as one of its adaptive patterns.

REFERENCE

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