Body-Image Disturbances among Obese Adults: Evaluation and Treatment

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This paper describes how to diagnose and treat body-image disturbances by a clinical technique involving direct patient participation. The technique has been effective as a diagnostic barometer uncovering discrepancies between the reality of being fat and some patients' secret belief of being thin

Some overweight people with adult-onset obesity seem to retain an image of themselves as thin—that is, they have a "thin memory." Their body images, fixed in early childhood and their formative years, appear to be immutable despite the obvious truth that they are indeed now obese. [In this paper, the medical term "obesity" refers to a person 20 percent above ideal body weight. When I use the terms "fat" or "overweight" I refer to a subjective patient interpretation. These interpretations do not necessarily relate to the medical diagnostic category.]

The literature on body image and body-image disturbance contains conflicting and contradictory information. There is much disagreement on a number of issues, including: the definition of body image[1,2]; how body image is formulated[3-5]; the relationship of body movement to body image[6-8]; the development of body image disturbance[1]; the effect of weight loss on body-image disturbance (some people who lose weight still regard themselves as fat)[9-15]; and whether it is "pathologic" or "normal" for all populations—normal weight, obese, anorexics—to overestimate[16-21] or underestimate[14,22-24] their body image. In essence, if everyone is suffering a body-image disturbance, can it be pathologic? Other conflicting areas include: the fixation of body-image disturbance and age of onset of obesity[12,18,25]; and the question of whether obese people characterize themselves as fat.[26]

The contradictions in the literature on obesity reflect the nature of the ever-changing variable of body image. Body-image disturbance is so difficult to treat because a patient's body image constantly shifts, depending on the perception of the moment.[2] While the literature traces these disturbances, there has been limited success (outside of long-term psychoanalysis)[13] in

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changing them, helping patients to lose weight, and improving their self-concept.

AN OVERVIEW OF THE TREATMENT PROGRAM

This paper will describe a holistic approach to treating obese patients, including ways to detect the particular kind of body-image disturbance in which formerly thin patients are "blind" to the fact that they are now fat. This form of denial may impair patients' judgment and motivation for losing weight: if they do not unconsciously believe they are fat, why would they diet or join a weight-reducing program? The decision may be prompted by moments of realism rising out of their own unconscious or through outsiders' influence.

Not all individuals suffer a pathologic denial of their obestity. Some may even consciously choose to stay fat. There are a number of underlying psychologic reasons for obesity, eating disorders, and body-image disturbance. I have found that some of these reasons can be uncovered by making the patient understand "How Your Fat Serves You." This is one phase of the treatment described in this paper (*see* Table I) and addresses what becoming thin means to the patient.

My discussion of "How Your Fat Serves You" is designed to unmask and clarify distortions and their etiology, and to help the patient develop a more realistic body image as a step toward treating obesity. Projective drawings are also used to uncover underlying fantasies and to determine the patient's multidimensional body image. These drawings are windows to the unconscious thoughts and fantasies that the obese person harbors.

The projective drawings can quickly pinpoint and verify how patients are feeling about their body. With this technique the obese patients' body-image disturbance can be quantified (do they unconsciously think of themselves as

TABLE I

HOW DOES YOUR FAT SERVE YOU?

Advantages of being Fat	Disadvantages of being Fat	Advantages of being Thin	Disadvantages of being Thin
keeps me protected from getting close to people	keeps me unattractive to ♂ and ♀	attractive to ♂ and ♀	have to admit that perhaps my body size is not the real reason I don't date
strong and powerful--may not feel it, but appear that way	can't buy nice clothing	I will be popular	I have to deal with real fears of people, closeness, relationships
way to express anger and use as a weapon	don't fit well physically (transportation)	can buy nice clothing	finding out that my romantic view of the world may be hollow
use as an excuse for not getting job,lovers	signal to others I'm out of control	I will be healthier	have to confront feelings and instead seek escape with food
show parents I'm my own person	antisocial, keeps me at home	I'm living my life	
	poor health		

thin?). They then can be helped to adopt a more realistic attitude. Additional therapy is often required to work through these newly gained insights. In some cases, this approach works readily with patients. Denial can no longer work for the patients because they are confronted, on paper, with their drawings and they become aware immediately that they have drawn an unrealistic image.

But not all obese patients recognize their drawings as unrealistic. Their problem is more complicated. They continue to believe that their drawings depicting them as thin are accurate. Such drawings enable the therapist to illuminate quickly the patients' unconscious and can actually reveal fantasies which hamper recovery. The drawings also point out what the patients fear in their "thin future." Thus, these drawings can guide the patients' therapy.

STEP ONE: DETERMINING "WEIGHT ZONE"

A common pattern for weight loss among many patients is first to lose a great deal of weight, plateau above goal weight, sometimes give up, sometimes maintain weight, or panic and gain weight back rapidly, only to begin the cycle again.

Having observed these circular and often ambivalent battles countless times, it became clear that different weights have a specific personal meaning for patients; these weight zones take on a quality and life of their own, even though the weight between each zone may vary minimally, as little as one to three pounds.

Before evaluating patients through their drawings and the discussion of how fat "serves" the patient, I instruct patients to determine their body weight according to the weight zones described below. By understanding the meaning and feeling, the patient can move beyond it.

Identifying the patient's zones of weight enables both the therapist and patient to quickly get to the underlying problematic and fantasy material. This process gives obese patients a sense of mastery: they are figuring out what is going on psychologically, getting "permission" to be in a certain weight category, in order to understand it, and then move on. The following scheme indicates the weight zones and shifting weight patterns.

CLASSIFICATION SCHEME FOR WEIGHT ZONES

"Safe" Weight (safe, that is, to the obese person.)

This is the weight at which patients feel secure and safe, what patients describe as a security blanket; they don't have to take risks. While they perceive that others find them unattractive, they can deal with everyday experiences and encounters.

"Panic" Weight (panic at being too thin or too fat)

Getting Too Fat

Weight is getting out of control. Patients are extremely uncomfortable physically and physical symptoms begin to appear: sleep apnea, snoring, shortness of breath, cardiac problems, inability to walk.

Getting Too Thin

Getting thinner is "scary." At this weight, patients perceive that life has changed and that they are expected to function socially, which is frightening and unfamiliar to them. The only way obese people can cope in this state of panic is to cushion their fears by "pushing down feelings" with food in order to gain weight and return to the "Safe" Weight.

"Death" Weight

At this weight patients think they will die from obesity. (Some patients think they will die from getting too thin.)

"Attractive and Available" Weight

Patients perceive themselves as beginning to look good. They feel open and will respond positively to sexuality.

"Dating and Sexual" Weight (applicable to married and single people)

A low weight where patients perceive that they are being seen as attractive and sexual. They perceive that they are now back in competition ("dating marketplace"). They fear they will not know how to act in social situations. Just as they have problems with impulse control vis-à-vis eating, they commonly fear they will have none or little vis-à-vis sex. Married people have problems with this as well. Often, they are fearful that if they lose weight they will want to become promiscuous and have affairs; men fear they will have to "perform."

"Naked Body" and "Let's Have Sex" Weight

At this weight, patients will allow themselves to be seen in bed naked and can have sexual intercourse. Even those who have had sex before reaching this weight fear that now they will have to become intimate with the "appropriate" person.

STEP TWO: SELF-EXPLORATION PHASE

Once it is determined what the individual weights mean for various patients, they are guided through a discussion of their views of self: What do they think of themselves? What do they think of themselves in relation to others? Why do they want to lose weight? How do they think life will be different after weight loss? How do they see themselves as thin persons?

The aim of this exercise is to obtain a diagnostic impression of the patients' reality perception, of their present body image and self-image. The exercise can also determine how patients will perceive themselves in the future, after weight loss, and whether their lifestyle will change. I have found the following progression of questions to be useful:

BOUNDARY ISSUES: WHERE DO I BEGIN AND END?

1. How do I look? (The idea is to be very specific: my stomach blocks my vision of my toes. When I lose weight I will be able to see my toes.)
2. Do I look at myself in full length mirrors? Dressed? Nude?
3. Do I look at pictures of myself?
4. What type of clothing do I wear? Tightly fitted, loosely fitted?
5. Do I touch myself?
6. When I sit in trains, buses or planes do I occupy one seat?
7. When I sit in a chair, how do I fit in it? (Here the therapist can actually have patients sit in a chair and let them describe where the body perimeters are and where they would like them to be.)
8. When I walk through a door, do I enter it straight or sideways?
9. Under what circumstances do I feel the fattest?

ANTICIPATED FEELINGS: HOW WILL IT BE WHEN I REACH MY GOAL WEIGHT?

1. What will my life be like when I am thin?
2. Will it change my relationships with others?
3. How will relationships be different?
4. What else in my life will change?

ACTIVITIES OF DAILY LIVING: WHAT IS MY DAILY ROUTINE?

1. In detail, what is my day like as a fat person?
2. How do I feel about this experience?
3. What will my routine be as a thin person?
4. How will it be different?

MOTIVATIONAL ISSUES: WHY DO I WANT TO LOSE WEIGHT?

1. Why do I want to change?
2. Why now?
3. How does my fat serve me?

This phase of self-exploration should point out any discrepancies in the patient's reality and any areas of denial. Those who vehemently deny change in life may in fact be denying what weight does for them and may be operating in fantasy. The areas of denial are worth further exploration and may indeed point to individual conflicts which block weight loss.

STEP THREE: FAT AS A SYMPTOM OF EMOTIONAL CONFLICT: HOW DOES MY FAT SERVE ME?

This question, the last in the exercise above, is the jumping-off point for the third step in self-evaluation in which the patient is asked: What are the advantages of being fat? What are the disadvantages? What are the advantages and disadvantages of being thin?

For a variety of reasons, some people "hold on to" their fat. They are deriving some secondary gains by remaining obese. For some, it is a way to deny they are aging. Some patients have never considered what a thin life would be like—it is beyond comprehension. By exploring this and the zones of weight fantasies, a therapist can evaluate the meaning of fat for each patient.

Table I shows typical responses to the questions on advantages and disadvantages of obesity and thinness. After this portion of the therapy, patients are instructed to do a series of drawings which, in combination with the weight zones, points to the underlying reason for holding onto fat. These exercises uncover the fears and fantasies getting in the way of weight loss.

I have found that discussion of diets and behavior is helpful to a certain extent. But just knowing the mechanics of weight loss does not seem to help the obese person lose weight because the mechanics do not touch on the problem of self-perception and body image nor do they touch on psychological problems. It is a change in self-perception that my treatment program aims for.

The other issue that must be addressed is patients' quality of life and personality. Have they developed their character along with their body? An obsessive concentration on fat avoids this issue. If people feel "empty," and expect to be spoon fed happiness, they will not be attractive to others, no matter how thin they become.

The therapist should help the patient focus on the reality of what being thin will—and will not—mean for that person's life. Thinness will not give patients qualities or interpersonal skills that they lacked before. Character must be developed. Weight loss does not magically provide it.

STEP FOUR: THE DRAWINGS

This phase of the evaluation is achieved through a basic set of 12 projective drawings (with some variations). The drawings are an outgrowth of the traditional Draw a Person Test. If one were doing a standard Draw a Person Test, the drawings would lend themselves to many different interpretations. But I use these projective drawings strictly as a research and therapeutic tool to evaluate and treat obese patients. They are not used in the way that the Draw a Person Test is used traditionally by clinical psychologists—making a formal, systematic interpretation of the content of the drawings with reference to underlying personality structure and conflict.

The patients are asked to make the following specific full-page drawings (repeated at different stages of treatment).

1. How do you perceive yourself today? (The patient should write down actual weight on the drawing.)

2. How would you like to look when you lose weight? (Patients should write down their ideal weight.) Assure the patient that this is only a "dream-come-true" rendition The patient should be encouraged to fantasize.

3. How do you think you will really look when you lose the weight? (Have the patient indicate that weight on drawing.) In this picture patients should produce a realistic picture of how they will look. There must be no fantasizing here.

4. How do you think people with a positive influence in your life (e.g., a friend) see you? (If patients wish to name that person they can do so. The patient should identify the relationship.)

5. How do you think people with a negative influence in your life (e.g., a parent that the patient does not get along with) see you? (Again, the patient can name that person and identify the relationship.)

6. How do women perceive you?

7. How do men perceive you?

8. How does your lover, significant other, or spouse perceive you? (If these people are different, draw a separate picture for each.) If there is no lover, spouse, or significant person, how do you *want* your fantasy lover to see you? How do you *really perceive* your fantasy lover would see you? (This last drawing must be "stark reality.")

8a. Draw a picture of your fantasy lover.

The next two drawings are concerned with parents' perception. If the parents are deceased, have patients provide drawing of how the parents saw them as children; then, how the patients think parents would see them as adults. (The parents' age, weight, and height during a patients' childhood and at the times of the parents' deaths should be indicated.)

9. How do you perceive your mother sees you: (Have the patient indicate the mother's age, weight, and height.)

10. How do you perceive your father sees you? (Have the patient indicate the father's age, weight, and height.)

Occasionally patients describe their parents as being thin while they may actually be obese. If you suspect this is the case, have the patient draw pictures of the parents.

11. How do you perceive your therapist sees you?

The tactile technique described next gets to the core of self-image as a concept—that is, it allows people to know how their body looks and how they feel about it realistically. The actual body boundaries are often different from obese peoples' attitudes about their bodies. They are often insensitive

to their body shapes, having rarely looked at it objectively or having rarely actually felt it. Hence, many chronically obese patients have no real sense of body boundaries—that is, where they begin and where they end. Forming a genuine picture is critical to successful therapy.

12. This drawing refers to the sculpting exercise, described below.

STEP FIVE: THE SCULPTING EXERCISE

Initially the patient is instructed to relax, using some variations in the methods used by Jaffe.[27] Using Jaffe's breathing exercise, patients concentrate on relaxing specific body parts in a sequential fashion which results in a relaxed state. The rationale for using this technique is based on the notion that people are more prone to introspection when in a relaxed state.[27,28]

Once a state of relaxation is achieved, patients are instructed to "sculpt" themselves. This means literally to feel the contours of the body from head to toe. To feel is to get actively involved in one's body, to gain a sense of it. This exercise helps put obese patients—who do not think of themselves as fat—in touch with their physical boundaries.

Following completion of the sculpting, patients are asked to draw what their body felt like (Drawing 12). In addition, there is a discussion of what they felt; they are asked to describe their positive and negative feelings about their bodies—the specific parts they like or do not like, the parts they would like to change through weight loss.

The following case studies and accompanying highlights of drawings illustrate my technique.

Case 1

A 39-year-old single woman, college educated, artist/entrepeneur who is highly successful has conflicts over her success. She becomes hypochondriacal in reaction to successful experiences. She weighs 195 lbs; and is 5′ 4″ tall; she became obese as a juvenile and was always told she was fat, although her childhood pictures do not bear this out. The oldest sibling, she served as a buffer between her parents who would solve their marital conflicts through her.

She was prevented from expressing anger and could only gain affection through illness. Patient has been a bulimic since puberty. She acted out her anger by physically abusing herself. Soon after treatment started, bulimia and other self-abuse was reduced.

Her dating experiences are limited; her typical sexual partner is a man who is not free to be in an exclusive relationship with a woman The patient skipped over major developmental adolescent steps ("dating and mating"). She has a romanticized view of life, is narcissistic and tries to "have her way" in relationships. Because of her familial training the patient has always been fearful of showing her needs, which were seen as signs of weakness. She is fearful that significant others would be more powerful than she.

This patient considers her "Safe" Weight to be 200 pounds; "Panic" Weight, at

which she will be "too fat and will die is 210 pounds; to her 140 pounds would be getting thinner or anorectic, which is "scary", she also assigns 140 pounds to "Dating and Sexual" Weight; "Attractive and Available" Weight is 120 pounds; and "Lets Have Sex" Weight is 204 pounds. This patient says she may be ready now to have sex. (*See* Figures 1-8).

Case 2

A 35-year-old college educated, single woman who works as a producer is 5′ 4″ and weights 195 pounds. Eating is the only way she knows how to satisfy her emotional needs. Still enmeshed with parents who criticize her and undermine her efforts at becoming independent, she is antagonistic and demanding, much like her domineering, criticial, and competitive mother. The mother demands perfection, the father is passive. (He is a well-established businessman.)

This woman has limited sexual experiences, skipped over adolescent dating and mating, and has never developed an age-appropriate relationship to men; she is frightened of men. This patient is adept at interpersonal distancing and holding on to her weight: she fears giving up control. To this patient, men are either "wimps" or weak. She views the world as a battlefield she is out to conquer. All the drawings for this case were made on the same day (2/17/83) when the patient weighed 195 pounds. (*See* Figures 9-15)

DISCUSSION

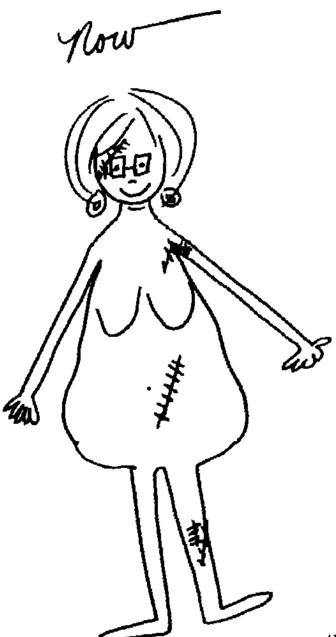
For the clinician, the obesity literature is a thicket of confusion which offers no systematic techniques to help evaluate and treat obese patients suffering body-image disturbances. While developing such techniques, I made the observations that led to the focus on body-image disturbances.

Unconscious denial of being fat, which can block the patient's own conscious wish to be thin, is another major area overlooked in the literature. (Some clinicians call this denial—a refusal to recognize a realistic body image—while others call it a body-image disturbance.)

Traditionally, the accepted definition of body-image disturbance in the obesity literature is an overestimation of actual size and shape coupled with derogatory attitudes towards the self or the misperception.[1] As I cited earlier, I have found that a striking number of overweight people who are adult-onset and were of normal weight during their formative years seem to retain an image of themselves as thin.

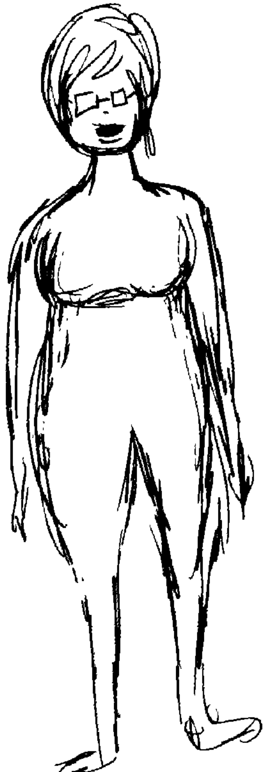
Patients who are presently obese but grew up thin have a "thin frame of reference" which fixes a thin body image in their minds. It is this thin body image which keeps some obese adults from seeing themselves as fat. They suffer a body-image disturbance—an underestimation of body size—which has had scant notice in the literature. A thin body image, fixed during early childhood and adolescence, appears to be immutable despite the obvious truth that the patient is indeed now obese. When asked to depict themselves graphically, these patients draw themselves as thin.

FIGURE 1



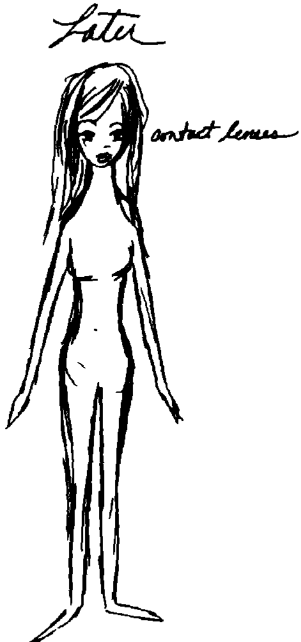
"How do you perceive yourself today?" (Drawing 1)
4/10/80. Wt. 88.1 kg (194 lbs.); Ht. 163.2 cm (64.25")

FIGURE 2



"How do you perceive yourself today?" (Drawing 1)
2/17/83. Wt. 92.7 kb (204 lbs), Ht. 163.2 cm (64.25")

FIGURE 3



"How do you think you will really look when you lose the weight?" (Drawing 3)
4/10/80. Wt. 88.1 kg (194 lbs.); Ht. 163.2 cm (64.25")
Patient has the unrealistic expextation that she will be taller when she becomes thinner, namely, 177.8 cm to 182.88 cm (70" to 72").

FIGURE 4

"How do you think you will really look when you lose the weight?" (Drawing 3)
2/17/83. Wt. 92.7 kg (204 lbs); Ht. 163.2 cm (64.25")
Patient believes that when she is thin she will be powerless and will have a lobotomy

FIGURE 5

"How do you perceive your mother sees you?" (Drawing 9)
3/4/81. Wt. 83.1 kg (183 lbs); Ht 163.2 cm (64.25")
Mother sees patient as "damaged and stupid and not better than anyone else."

FIGURE 6

"How do you perceive your mother sees you?" (Drawing 9)
2/17/83. Wt. 92.7 kg (204 lbs); Ht. 163.2 cm (64.25")
The patient is beginning to work on disentanglement of negative symbiotic tie with mother. Patient looks some what healthier, but still feels powerless against her mother's destructiveness

FIGURE 7

"Draw what your body felt like." (Drawing 12)
2/25/81. Wt. 84.5 kg (186 lbs.); Ht. 163.2 cm (64.25")
Unaccountably the patient draws herself as thin, even after having consciously felt her fat in sculpting excercise.

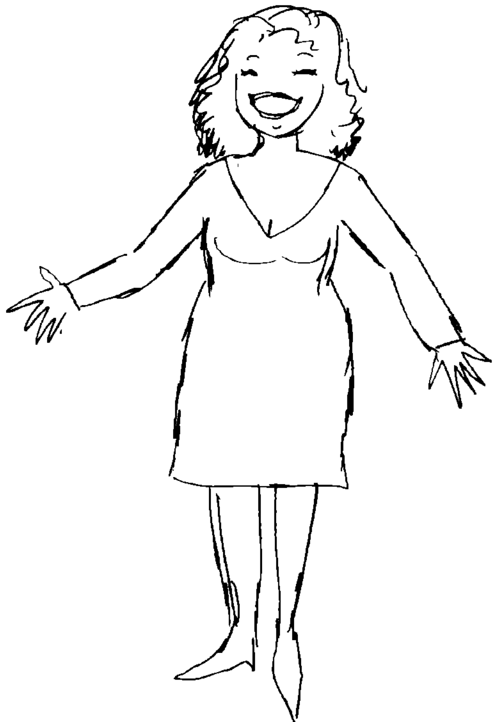
FIGURE 8

"Draw what your body felt like." (Drawing 12)
2/17/83. Wt. 92.7 kg (204 lbs); Ht. 163.2 cm (64.25")
No improvement in body-image disturbance.

FIGURE 9

"How do you perceive yourself today?" (Drawing 1)
2/17/83. Wt. 88.6 kg (195 lbs.); Ht. 163.2 cm (64.25")
This is a realistic representation of the patient.

FIGURE 10

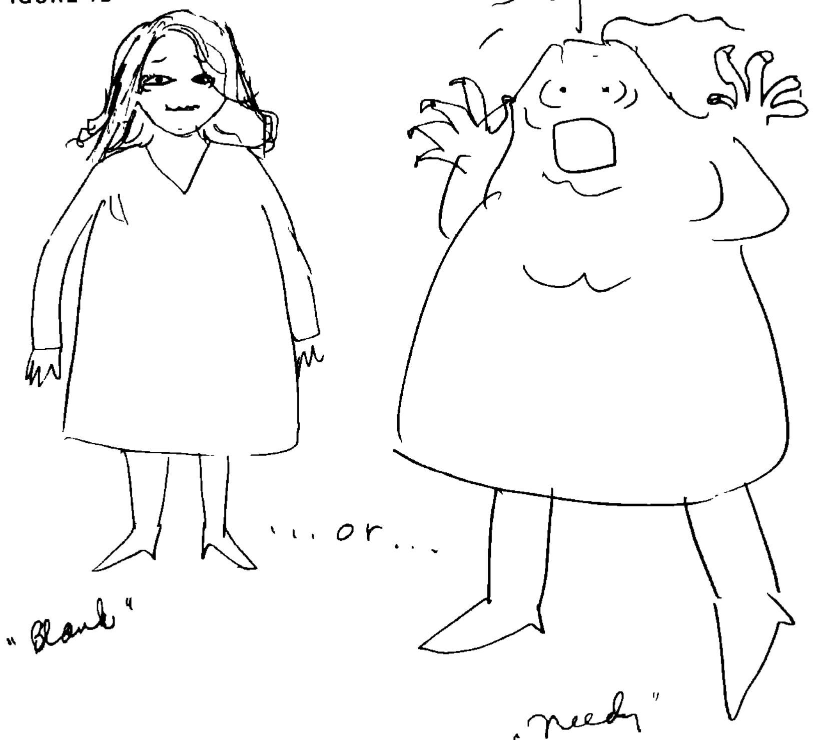


"How do you think people with a positive influence in your life see you?" (Drawing 4)
2/17/83
The patient believes that her friends see her in this way.

FIGURE 11

"How do you think people with a negative influence in your life see you?" (Drawing 5)
2/17/83
(In this case, negative people are "men I have come on to.")

FIGURE 12



"How do men perceive you?" (Drawing 7)
2/17/83
The patient believes that men think of her as either "needy" or "blank."

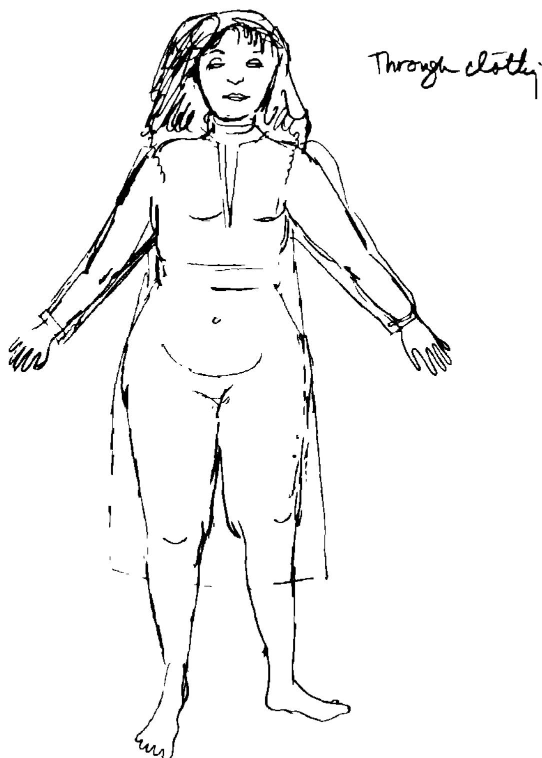
FIGURE 13

"How do you want your fantasy lover to see you?" (Drawing 8)
2/17/83

FIGURE 14

"How do you really perceive your fantasy lover sees you?"
(Drawing 8)
2/17/83

FIGURE 15



"Draw what your body felt like." (Drawing 12)
2/17/83
A realistic portrayal

Of course not all obese people suffer body-image disturbance; Stunkard notes that 40 to 50 percent of obese individuals have no disturbance in either the perceptual or attitudinal aspect of body image.[29] Not all obese patients have deprecating attitudes towards their bodies. And not all obese patients have a body-image disturbance. However, of the patients who do harbor a distorted body image, all suffer some type of emotional disturbance.[25]

Obese patients may consciously see themselves as fat, but unconsciously believe themselves to be thin. This unconscious denial of reality blocks progress toward making clear decisions to diet. I have found that what finally motivates people to lose weight and then to maintain that weight loss seems related to their ability to have a realistic image replace the body-image distortion, i.e. that they truly acknowledge their obesity on all levels and that they have worked through any unrealistic fantasies about their weight zones.

In addition, unrealistic (and sometimes fearful) fantasies of the thin life

retard progress. The patient may think: "If I become thin and attractive I will have to be the center of attention at every cocktail party. I can't handle that so I better stay fat." (Or "I want to be in the limelight and fear that I will not be.")

This is one type of unrealistic fantasy in which the obese patient, who failed to learn social skills during childhood and adolescence, feels unable to function in social situations. Others feel that they will not acquire these traits. Hence, while weight loss is alluring, it is also frightening: a double-edged sword.

A number of researchers contend that, once obese patients have lost weight, they need to continue psychological treatment to explore "idealized or romantic versions of what life is about."[30] The therapist needs to help the patient focus on the reality of what being thin will—or will not—mean for that person's life.

Because of unrealistic expectations, fueled by movies and television dramas, many patients complain of a "hollow victory" after weight loss.[30] Like the brunette who thinks blonds have more fun, they expect "the new me" to be automatically successful, popular, sought after. But when that does not happen, in part because the patients have not developed their ego functions along with their bodies, often they become disappointed, embittered, depressed, angry, and fat again.

Some obese people suffer from grandiose or magical thinking ("What I eat has nothing to do with me") or depersonalization ("My body gets fat, I don't"). I see such disowning of one's body in many obese patients, especially those who are chronically obese and who became fat as children. Altshul[31] speaks of an "externalized body image" which results in an adversarial relationship—that is, "the body as enemy." He says that effective therapy would foster a sense of ownership, a repossession of the body.

CONCLUSIONS

The method described in this article has broad applicability for obese patients and others, and it can be used flexibly in a number of different settings. I have used the method in individual as well as group settings and have found that patients seem to benefit from "spectator therapy,"[32] i.e., observing treatment of other patients and thereby gaining insight into their own problems. Group discussion can be most beneficial for reality testing and feedback.

The method can be a critical indicator for therapist and patient; it cuts down on weeks of preliminary, traditional evaluation and is therefore cost effective.

The technique is a diagnostic tool that acts as a barometer of the emotional and conceptual growth of a patient. This growth can be tracked

by timely drawings, use of the sculpting technique, and analysis of weight zones, all of which should be integrated into the therapy. If there is progress, the therapist can identify potential roadblocks to recovery The graphic representations of body image can clear up blind spots that have posed major barriers in treatment. (It should be noted that those patients who were unable or unwilling to draw, simply wrote impressions or drew symbols of how they viewed themselves.)

Analysis of drawings provides evidence that the areas of denial, negative image, mother, and fantasy lover are of pivotal importance to most patients when roadblocks occur in their treatment. Where denial is concerned, or what may be called "patient blinders," the unconscious, as well as the conscious view of self is exposed.

Denial can occur throughout the obese population. It prevents the patient and therapist from focusing on the real problem—the fact that the patient is hiding under a camouflage, and the therapist often accepts the subterfuge. Why should obese patients lose weight if unconsciously they continue to think and fantasize that they are thin? Such a preception naturally impairs judgment and motivation for losing weight.

In some cases the results of patients' characterizations were startling, for what came through was the notion of a non-person. In such instances, the idea that "I am not a person" reflects not only a weight issue, but sometimes more serious psychopathology. Another group of problems revealed by using this technique was severe developmental and learning disorders.

When used routinely, the sculpting exercise may help patients relearn and reintegrate a more realistic body image. Quite surprisingly, even after the sculpting exercise, some patients exhibited denial. The therapist might reasonably expect that this tactile activity would make patients realize their true dimensions. But the level of denial is so deep in some patients, it prevents them from seeing the contradiction between what they feel and what they draw after sculpting.

These patients could not "feel" their true size and were surprised when others told them that their pictures simply did not depict the truth. The literature does explore the notion of possible primary sensory impairment of proprioception, leading to abnormal development of body image.[7]

With this kind of feedback, many of these patients were able to see how distorted was their perception of reality. Other patients found that the tactile and drawing exercises either clarified or verified their assessment of body image.

When asked to produce drawings of how they felt negative people perceive them, patients' drawings are generally profoundly larger than the drawings of how they believe positive people see them. This seems to confirm observations in the literature about the fluidity of body image among the obese and formerly obese population. The mother image, i.e., "how

mother perceives me," operates in the same way. Patients who have incorporated or internalized the negative mother image project it into their everyday lives—it dominates the patients' thoughts and actions.

Often, older patients produce drawings that depict themselves and their fantasy lover as adolescents, which projects not only a desire to be young, but may indicate their emotional age in this area. Their development may have been arrested in adolescence and these drawings provide a window into the unconscious fantasies, an excellent example of the "sublimity of thinness".[30] Such drawings point to the direction their treatment must take. The drawings also seem to illustrate in a graphic form the traditional psychoanalytic view of the unconscious.

The sculpting exercise grows out of the literature on childhood development in which body movement and action have been shown to shape body image.[6-8,33-35] Despite these studies, there is little indication in the obesity literature that body awareness, movement, and tactile techniques are used in the treatment of obese adults. Remarkably, there are only a few references, some of which are unpublished, to the use of relaxation, guided imagery, and meditation techniques that promote prositive attitudes and eating habits.[36,37]

It should be emphasized that the fullest diagnostic analysis of each patient involves the following elements: the preliminary verbal exploration and discussion of weight zones, the sculpting, and the total drawing exercise.

It becomes clear then that weight therapy is not just about losing weight and fat. Body image and self-image must not be accepted at face value where obesity can be used as a decoy or camouflage to obscure deeper problems. The individual meaning of the patient's obesity must be understood comprehensively. Perhaps what this method underscores best is that we should never assume we understand our patients, nor should we accept their beliefs about their body image, until we have seen their drawings.

SUMMARY

The article reviews a form of denial which blocks weight-loss efforts. It appears that some obese patients who were thin as children and adolescents, retain an image of themselves as thin—that is, they have a "thin memory" and actually underestimate their size. This body-image disturbance is scarcely discussed in the obesity literature.

The author has formulated a treatment program designed to uncover this particular form of body-image disturbance and to use patient participation to treat the problem. The obese patient is led by the therapist through a process of self-discovery, specific to obesity. The steps in this process include: discussing "How Your Fat Serves You"; identifying various weight zones and their meaning for each patient; a tactile technique called sculpting in which patients familiarize themselves with their body boundaries from head to toe; and a series of projective drawings aimed at revealing the

patient's true body image. These drawings can be a graphic depiction of a patient's roadblocks to weight loss.

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