

## The Possible Prenatal Origins of Morbid Obesity

Althea M. Hayton, MA

**ABSTRACT:** The rapidly developing science of pre-birth psychology is casting a new light on some old problems. One such is morbid obesity, some aspects of which can possibly be explained in the light of prenatal theory. This article sets out the hypothesis that firstly, obesity may represent a self-destructive personal choice. Secondly, there may be a psychological reason why the possibly fatal consequences of that choice are largely ignored by the obese person. Thirdly, the choice and its consequences comprise a style of eating behaviour that seems to re-construct a particular pre-birth experience. In this case, until the prenatal and birth experiences are fully realized and understood, the over-eating behaviour may persist, even unto death.

**KEY WORDS:** Prenatal, origins, morbid obesity, self-destructive, eating behaviour, pre-birth experience, fetus

### INTRODUCTION

The application of prenatal psychological theory varies a little among practitioners, but the basic principles apply across the profession: firstly, that the foetus is capable of awareness; secondly, that the imprinting of early awareness is in some sense accessible and thirdly that this material can be rationalized and eventually understood as being related to experiences in pre-born life.

For example, one application of the theory is that if the pregnancy is not welcomed, then the attachment to the mother is adversely affected, and this is a cause of Reactive Attachment Disorder of infancy and early childhood (Turner-Groot, 2005). Another suggests that the feelings of the mother are experienced by the foetus via the blood supply to the placenta, in the form of a series of specific

---

Althea Hayton is a writer and qualified counsellor, based in the UK. She is Project Director of Wombtwin.com, an internet-based non-profit organization dedicated to providing information, help and support to wombtwin survivors (i.e., the sole survivors of a twin or multiple pregnancy.) She is editor of *Untwinned: Perspectives on the Death of a Twin Before Birth*. (Wren Publications, 2007). Correspondence to [althea@altheahayton.com](mailto:althea@altheahayton.com)

cocktails of hormones, which characterise each emotion. The foetus has no way of recognising these feelings for what they are, i.e., the feelings of a separate individual entirely, and will continue into born life, believing those feelings are genuine and personal, and creating adopted beliefs that will make some sense of them. For instance, an exaggerated inability to cope with a sudden shock in the born child may reflect a prenatal experience of sharing in a sudden shock, experienced by the mother when the same child was in the womb.

In the last forty years, since we have had available the technology to see into the womb from the earliest stages of pregnancy, we have been able to witness first-hand how the foetus reacts, both to external stimuli and the feelings of the mother. Alessandra Piontelli studied babies in the womb (Piontelli, 2002) and observed them after birth. She saw astonishing similarities between their behaviour before birth and afterwards. Prenatal theory is now widely accepted as a valid concept. Furthermore, the ever-growing literature of successful case studies suggests that this theory has a useful and extremely effective therapeutic potential.

There is some agreement throughout the literature that the way to work therapeutically with pre-birth material - which naturally enough tends to be primitive, wordless and chaotic - is to try and make some sense of it in terms of life in the womb. It is as if these early foetal experiences, perceived by an undeveloped central nervous system, in born life require the application of a well-developed cerebral cortex if they are to be understood. This, in my view, is the therapy. It is not so much a process of remembering, as one of re-interpretation - plus the application of plenty of logical reasoning. It can take a great deal of careful thought on both sides - and a profound understanding of the exigencies and accidents of prenatal life on the part of the therapist - before the truth can finally be uncovered. Once an individual has made sense of their pre-birth experiences, a wide variety of maladaptive behaviours may become redundant. They may either change substantially or be extinguished altogether.

### **MORBID OBESITY**

Obesity is a condition characterised by an excessive accumulation of fatty tissue in the body, which as it accumulates begins to interfere with basic physiological functions such as breathing or walking. Morbidity is a medical term that describes a state of becoming diseased. This association of ideas has led to the description of obesity as a "disease." However, this term does not appear on closer

examination to be strictly true. The excessive accumulation of fat is the result of an entirely natural process, essential to a healthy life. The tendency to store excessive levels of blood sugar as fat is entirely benign and appears to play an important part in resistance to disease and the capacity to survive in times of food scarcity.

Obesity does not just happen. It is directly related to food intake. During my own research study with overweight people for a book about addiction to food (Hayton, 2000) no one disagreed with the self-diagnosis of one participant, who claimed that she was 70 lbs overweight because she had for a long time been “eating too much of the wrong kind of food.”

Clearly then, the long-term cure for overweight and obesity is to carefully define and permanently reduce consumption of “the wrong kind of food.” Slimming clubs define certain foods and set rules that restrict consumption of them. Those club members who stick to the rules lose weight and those who break the rules remain the same weight or may even gain weight. It seems that the foods most often targeted for restriction have as principle ingredients wheat flour, beet or cane sugar and the various components of cow’s milk. A diet completely excluding these ingredients, plus potato, has been found to bring about a profound change in appetite as addiction to some or all of these ingredients is made manifest (Hayton, 2000).

It appears that obese people are addicted to the “wrong kinds of food”. Given the chance to lose weight, which appears to be their greatest desire, they consistently fail to stick to a diet plan. Again and again, the “wrong kinds of food” are eaten to excess and there is little or no loss of weight.

### **CHOOSING TO BE FAT?**

When observing the behaviour of members of any slimming club, one notices that there is full consciousness on the part of the obese person who “breaks the rules.” This has been a choice. One can also observe a family group eating together at a fast food restaurant and see how each individual eats differently. They order differently; one will eat everything, while another will eat only some of the food and leave some chips; the obese person in the group will probably finish the leftover chips and eat dessert as well. There is no doubt that this individual is choosing too much of the “wrong foods” and, if you ask him, he will admit it. The mystery of morbid obesity lies not in whether or not morbidly obese people eat the wrong kinds of food, for that is clear. Rather, it lies in why they sabotage slimming diets; eat

until they are sick, disabled and at risk of death from overeating.

Like all other addictions, addiction to food is ultimately about risking your health and your life. Addiction is slow suicide, because addicts don't care if they live or die. Morbid obesity therefore can be seen as a careless, self-destructive choice: a strange and mysterious choice, certainly, but one made in full consciousness of the potentially fatal outcome of overeating.

### **EATING TO DIE?**

Losing weight and sticking to a diet is a sure sign that an obese person very much wants to live a richer and more fulfilled life. Giving up and gaining weight means they are once again looking towards disability and death. Obese people with a BMI of 40 have a 50-100 percent risk of premature death over individuals with a BMI of 20-25 (Peeters et al., 2003). The death of every obese person is preventable and this makes it a particular tragedy.

Into this picture come the bariatric surgeons, who reduce stomach size with staples so the patient can no longer over eat, or remove chunks of healthy intestine to reduce the absorption of food. Their patients are desperate, and prepared to risk death on the operating table sooner than continue the living death that is being morbidly obese. There are far too many families in the western world where heartbroken parents and siblings look on helplessly while a much-loved family member eats himself or herself into an early grave.

It would seem to be pointless to develop surgical interventions, special diets and drugs to help weight loss if we fail to understand why some people choose to die of an excess of food. There are many ways to commit very slow suicide: one can smoke, starve, or gradually poison one's body with drugs. Eating too much of the wrong food is a very particular, chosen way to die.

### **OBESITY AND CHILDHOOD ABUSE**

Obesity has been found to be strongly associated with childhood sexual abuse, nonsexual childhood abuse, early parental loss, parental alcoholism, chronic depression and marital family dysfunction (Felitti, 1993). We are lead to believe that such abuse leaves the child in a state where food becomes a comfort and the tendency is to overeat the foods that are the most comforting. This appears to be an important factor in whether weight loss can be maintained (Byrne, Cooper, & Fairburn, 2003). This explanation for overeating has become standard in

psychotherapy, despite the fact that there is little or no proof that a direct causal link exists between childhood abuse or neglect and obesity (Fairburn & Brownell, 2002). Any suggestion of a psychological problem appears to be the last thing in the minds of the bariatric surgeons. The focus of concern for surgeons seems to be the psychology behind successful weight loss, rather than any predisposing factors for weight gain (Vallis & Ross, 1993).

A public example of this has been Bethany Walton, who became the subject of a TV documentary as a morbidly obese teenager weighing 34 stones. She was not offered any counselling at all before her surgery (Brierly, 2006). This is strange and probably unprofessional behaviour on the part of her medical advisors, considering the fact that it has been made quite clear in the professional journals and elsewhere that a high level of psychopathology is found among morbidly obese people (Glinski, Wetzler, & Goodman, 2001).

However, while we are focussed on suspected childhood abuse as a probable cause of obesity, we risk missing the point. Morbid obesity is telling us a symbolic story that is written clearly in plain sight. If we can learn to interpret this symbolic story correctly, then we will have some rather more helpful ideas than to carry out drastic surgery on healthy organs. Furthermore, an unsubstantiated implication or “diagnosis” of childhood abuse or neglect by therapists is potentially very destructive of family relationships. Clearly, such interpretations should never be made or even implied by any professional who is not in full knowledge of the facts.

A relationship certainly exists between psychological problems and obesity, but it would be too simplistic to say that one is the direct cause of the other. Childhood abuse has been implicated in virtually all forms of psychopathology, most importantly drug addiction, alcoholism, violent crime and suicide. (Briere, 1992) One study found that self-reported abuse, particularly physical and verbal abuse, was strongly related to obesity (Williamson, Thompson, Anda, Dietz, & Felitti, 2002).

It is tempting to assume that this relationship is in fact the cause. For example, Bethany Walton, the teenager mentioned above, gained a massive eight stones in one particular year but this dramatic change seemed to have escaped the notice of everyone. In that year her grandmother died. Bethany’s first brush with death had triggered a major eating binge. She gained the equivalent weight of a young child. It may have been more helpful to focus on this girl’s response to the death of someone very dear to her rather than to search her family history for signs of childhood abuse or neglect.

### **A STRANGE COMPULSION TO DIE**

Some people feel a strange compulsion to eat foods that will quickly accumulate fat. These are the people who become obese. Within a decade or so they are at risk of heart disease—even teenagers. Yet it seems that they choose “not to be aware” of what they are doing to themselves (Heatherton & Baumeister, 1991). This is critical to bringing about behaviour change. As long as this desire to eat is characterised as a “compulsion” it can take place in a kind of mindless space where there is a total loss of will and self control. This helpless feeling and denial of responsibility for one’s actions is to be found in all addictions.

The first step to overcoming any addiction therefore is to break denial. Obese people commonly don’t want to look in the mirror, but to think this is all about self image would be to misunderstand: the denial is not towards self image but the potentially fatal consequences of their behaviour. This is a compulsion to die, in a situation where there seems to be no control over this desire. Physicians, confronted by obese patients who persistently fail to achieve weight loss despite the physician’s best efforts, tend to see their patients in a negative light. They use derogatory terms like “a lack of will power” (Foster, et al., 2003) but obviously persistent non-compliance is a sign of a very strong will indeed. There must be something else going on.

The only logical conclusion one can reach in the light of this persistent, self-defeating behaviour is that, in some deep way, it serves the best interests of the patient that the situation should not change. In the light of this, it does make perfect sense to consider the possibility that obese people want to die. The mystery then, if why this may be.

### **SURVIVOR GUILT**

Survivor guilt has been described as a feeling of shame that one has usurped someone’s place in the world and is alive in the place of those who have died (Levi, 1988). Closely related to this feeling is existential guilt. If one looks back with regret and remorse to an un-lived life, one feels great guilt at the undone and the unmade, and this is existential guilt (Yalom, 1980). The awareness that one is not living life to the full creates a sense of unease and prevailing shame that is an important component of low self-esteem. The morbidly obese are often stigmatized and this creates psychological distress, including lowered self-esteem, which triggers overeating as a coping mechanism (Myers & Rosen, 1999).

If we examine the crazy logic of existential guilt in the life of the morbidly obese, we see someone who is choosing not to live a full life by choosing to overeat, and who persists in this behaviour and obstructs all attempts to help. The guilt engendered by this self-defeating behaviour fuels the low self-esteem that is the cause of the distress, which drives the behaviour. This is a self-defeating cycle that maintains the feelings of guilt, the un-lived life, the distress and the extra weight. This only makes sense if one assumes that the individual is in charge of the mechanism that creates and maintains the obesity. This argument reveals that it is the assumed “lack of self control” that maintains the eating cycle and that morbid obesity is in fact a very carefully controlled mechanism.

### **THE “THRIFTY GENE”**

Obesity in born life has been related to famine-like conditions in early pregnancy (Odent, 2006). Obesity has been connected to hyperinsulinaemia, which predisposes the individual to “Type 2” diabetes, which is potentially fatal. The over-production of insulin is indeed a protection against famine, because this creates “insulin resistance” which means that insulin locks away excess blood sugar as fat in order to keep blood sugar at a safe level. This predisposes the adult to cardiovascular problems, but in times of food shortage this tendency can act as a survival mechanism (Fernandez-Real & Ricart, 1999), because fat stores are quickly replenished before the calories can be burned off.

Insulin resistance is assumed to be genetic, insofar as diabetes is inherited, but it is mysterious that the genes for such a dangerous condition remain in the population. It would seem that some genes have a prenatal advantage (Rotter & Diamond, 1987). Certainly a moderate tendency to insulin resistance would enable a foetus to survive conditions of marginal nutrition in the womb. This becomes clear almost at once when a baby is a “good doer” and rapidly gains weight. The capacity to live on very little is the principle reason why the severely obese find it hard to lose weight on a normal reducing diet. If you had “thrifty” genes in the Stone Age, then that would have provided a significant survival advantage, but in today’s time of plenty that thriftiness can be the cause of major health problems.

### **FETAL PROGRAMMING**

Sufficient evidence now exists to suggest that various diseases in

adulthood are related to adverse antenatal conditions. This has led to the concept of “foetal programming” which simply means that the foetus, in adapting to conditions in the womb in order to survive, develops an abnormal metabolism that creates diseases in adult life, related to blood pressure, serum cholesterol, plasma glucose, abdominal obesity and lung function, among others (Fall, 2006; Joseph & Kramer, 1996). This means that genetic make up and environmental change are active concurrently when the foetus is in the earliest stages of development.

We have established above that some vague impressions remain of early life in the womb, and a vague and indistinct memory of a “food shortage” may indeed explain the compulsive need to eat as if the food may “run out.” It seems therefore that foetal programming is also psychological and may provide an emotional basis for obesity.

#### **DEATH BEFORE BIRTH**

Foetal programming does not explain the connection of obesity with death and survivor guilt. A closer and more cogent explanation may exist for this condition that will allow for obesity to be seen as a rational, intelligent and indeed loving, choice. To explore this, we need to consider the fact that in 1 in 8 pregnancies more than one baby is conceived but only one is born. This baby is a wombtwin survivor, and is programmed in early pregnancy to be accompanied by another foetus—sometimes more than one. One or more embryos or foetuses die in the womb for various reasons and in various ways, leaving one survivor. Even a pair of born twins may in fact be a naturally reduced triplet or quadruplet set. This is known as “vanishing twin phenomenon” (Landy & Keith, 1998).

My own research strongly suggests (Hayton, 2007) that the death of a twin before birth does leave a marked psychological effect on the survivor. Furthermore, it has been found (Woodward, 1998) in other research that the loss of a twin early in pregnancy causes more distress than losing a twin later in life. Foetal programming appears to be life-long and for many there is a vague sense of “something missing” that is hard to pin down and can become confused with feeling “empty inside” and emotionally hungry.

Now if the conditions in the womb are such that a twin pregnancy cannot be maintained and one twin dies, then, if one foetus has the “thrifty gene”, he or she will be more likely to survive. However unfit the thrifty gene may make you later in life, possession of the gene may make you the fittest to win in this antenatal struggle for survival.



### UNDERSTANDING THE DREAM OF THE WOMB

If we do in fact carry all our lives a vague impression of life in the womb, then wombtwin survivors all carry, at some deep level, a memory of their lost twin. These vague pre-birth impressions cannot be described as a “memory” exactly and are more like a dream: a dream of the womb.

If a co-twin was lost in an unequal struggle to survive, then this may explain why the survivor feels a sense of guilt at having a full life—indeed of being alive at all. If in the Dream of the Womb there is a struggle about the availability of food, and the thrifty gene kept the survivor alive, the result could be a person who gains weight easily and loses it slowly, meanwhile experiencing a deep sense of survivor guilt related to food. This may explain the way obese people fight with food, caught in a guilty cycle of shameful eating habits, and of course they lose the fight again and again. If they win the battle for a while, they know that they will eventually give up and make sure they lose. In the light of the Dream of the Womb there is a kind of rough justice in that.

If in the Dream of the Womb the cost of survival was the death of another, then there may be a deep-seated feeling in the survivor that one does not deserve life, at least not a full life. The result in this case would be a familiar figure: someone who eats and eats without caring if they live or die, and whose eating habits guarantee a shortened lifespan and a restricted existence while they are alive.

### A WAY FORWARD

If we apply the principles of pre- and perinatal psychology to the emotions and general attitudes of the obese person, clarifying the role of guilt about being alive in their self-destructive lifestyles, we may find a new way forward in understanding obesity. New research is needed into new ways of interpreting the symbolic bodily messages of morbid obesity and over-eating behaviour. As our understanding increases of the impact of prenatal life on diseases of mind and body, so we may find some new solutions to this world epidemic.

## REFERENCES

- Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. London: Sage Publications.
- Brierly, K. (Director) (2006). *The 34 stone teenager* (TV documentary). London: Brighter Pictures.
- Byrne, S., Cooper, Z., & Fairburn, C. (2003). Weight maintenance and relapse in obesity: a qualitative study. *International Journal of Obesity*, 27(8), 955–962.
- Fairburn, C. G. & Brownell, K. D. (Eds.) (2002). *Eating disorders and obesity: A comprehensive handbook* (2nd ed.). New York: Guilford Press.
- Fall, H. D. (2006). Developmental origins of cardiovascular disease, type 2 diabetes and obesity in humans. In M. Wintour-Coghlan & J. Owens (Eds.), *Early life origins of health and disease* (pp. 8-28). New York: Springer Science+Business Media.
- Felitti, V. J. (1993). Childhood sexual abuse, depression, and family dysfunction in adult obese patients: a case control study. *Southern Medical Journal*, 86, 732-6.
- Fernandez-Real, J. M., & Ricart W. (1999) Insulin resistance and inflammation in an evolutionary perspective: the contribution of cytokine genotype/phenotype to thriftiness. *Diabetologia*, 42(11), 1367-74
- Foster G. D., Wadden, T. A., Makris, A. P., Davidson, D., Sanderson, R. S., Allison, D. B. & Kessler, A. (2003). Primary care physicians' attitudes about obesity and its treatment. *Obesity Research*, 11(10), 1168-1177.
- Glinski, J., Wetzler, S., & Goodman, E. (2001). The psychology of gastric bypass surgery. *Obesity Surgery*, 11(5), 581-8.
- Hayton, A. (2000). *Food and you: For people with a food problem*. St. Albans, England: Wren Publications.
- Hayton, A., (2007). *Untwinned: Perspectives on the death of a twin before birth*. St. Albans, England: Wren Publications.
- Heatherton, T. E., & Baumeister, R. E. (1991). Binge eating as escape from self-awareness. *Psychological Bulletin*, 110(1), 86-108.
- Joseph, K. S. & Kramer, M. S. (1996) Review of the evidence on fetal and early childhood antecedents of adult chronic disease. *Epidemiologic Reviews*, 18(2), 158-74.
- Landy, H. L., & Keith, L. G. (1998). The vanishing twin: a review. *Human Reproduction Update*, 4(2),177-83.
- Levi, P. (1988). *The drowned and the saved*. New York: Summit.
- Myers, A., & Rosen, J. C. (1999). Obesity stigmatization and coping: Relation to mental health symptoms, body image, and self-esteem. *International Journal of Obesity & Related Metabolic Disorders*, 23(3), 221-230.
- Odent, M. (2006). Obesity from a primal health research perspective. *Journal of Prenatal & Perinatal Psychology & Health*, 20(2), 135–141.
- Peeters, A., Barendregt, J., Willekens, F., Mackenbach, J. P., Mamun, A. A. L., & Bonneux, L. (2003). Overweight and obesity by middle age are associated with shortened lifespan. *Annals of Internal Medicine*, 138(1), 1-44.
- Piontelli, A. (2002). *Twins: From fetus to child*. London: Routledge.
- Rotter, J., & Diamond, J. (1987). What maintains the frequencies of human genetic diseases? *Nature*, 329(6137), 289-90.

- Turner-Groot, J. T. (2005). *Prebirth dynamics in the formatting of relationships & reactive attachment disorders*. [Presented at the 16th International Congress of the ISPPM The Anthropology & Psychology of Pregnancy & Birth, Heidelberg, Germany 2-5 June 2005.]
- Vallis T. M., & Ross M. A. (1993). The role of psychological factors in bariatric surgery for morbid obesity: Identification of psychological predictors of success. *Obesity Surgery*, 3(4), 346-359.
- Williamson D. F., Thompson T.J., Anda, R. F., Dietz, W. H. & Felitti, V. (2002). Body weight and obesity in adults and self-reported abuse in childhood. *International Journal of Obesity*, 28(8), 1075-1082.
- Woodward, J. (1998). *The lone twin*. London/New York: Free Association Books.
- Yalom, I. D. (1980). *Existential psychotherapy*. New York: Basic Books.