VOLUME-7, ISSUE-10, OCTOBER-2018 • PRINT ISSN No 2277 - 8160

Original Research Paper

Psychology

SYMPTOM TRANSFORMATION AFTER BARIATRIC SURGERY INTERVENTION A COMPARATIVE STUDY OF PSYCHOLOGICAL EFFECTS IN BOTH LEBANESE OBESE MEN AND WOMEN

Elise Bitar — Masters In Clinical Psychology, Clinical Psychologist, Psychotherapist, Trainer At ECRD.

Jeannette Abou Nasr-Daccache* — Associated Pr., Psychoanalyst, Author, Associated Professor In Psychoanalysis And Fundamental Psychopathology (paris 7) .*Corresponding Author

ABSTRACT

The number of candidates for the bariatric surgery is increasing massively in Lebanon with little research on post-operative psychological effects of this surgery on obese individuals.

For psychology, eating beyond the physiological need is a symptom and this study aims to observe the fate of this eating symptom.

The quest is conducted with three Lebanese men and women through a clinical interview and a projective test, the TAT.

The results show that all the candidates experienced excessive post-operative emotional fragility. The symptom persisted in two cases, displaced to another symptom in other cases and for the rest, they suffered either from depression or decompensation or a feeling of persecution.

KEYWORDS : Anxiety, Addictive Behavior, Displacement, Hyperphagia, Obesity, Object Relation, Symptom, Eating Disorders.

INTRODUCTION

« A full mouth can illustrate the internal emptiness and the rage» Fédida 1977

The comprehension of the eating disorders involves not only the esthetic but also the body's image on a social scale as well as positive and negative identifications on the archaic level.

The obesity is the subject of limited studies among endocrinology, esthetics, surgery and psychoanalysis. The basis of this disrupted behavior lies on a clinical symptomatology and on the comprehension of symptomatology and obesity.

Fierceness, compulsiveness, terrorism in order to lose weight as well as a conformity to an ideal image to reproduce integrally, all include a symptom bearing injunction to lose weight, to separate, to mourn his identity, with an imminent anxiety that leads to incapability of all control of compulsive behavior.

The cure to obese patients allowed us to apprehend the phenomenon of the negation of the body through an archaic problematic related to survival. These analysants helped us detect unconscious fantasies behind external behavior. As a result, it becomes necessary to understand and to listen, because this symptom is tied to the present considered as reality. So it is the need to transform the listening of the symptom behind a psychic necessity to understand and to listen, because this symptom tightly knits between the real pressure and the symptom that forges a psychic reality, that each speaker with bulimics must be forged to understand, because this remains a lack of knowledge in the psychic life, sometimes a censorship, which will be able to destroy the evolution of the treatment in these operations. Because the symptom of eating and filling the stomach belongs to the Freudian formula of the «other scene», this symptom translates a desire and a role «tailor made», the obese express then their intentions by their repetitive eating behavior; an associated phenomenon with the anxiety of death because the process of incorporating their own psychic identity is at failure. The symptom allows the person to live without the fear of death, because the symptom can replace person in this way, it will disappear all capacity of person in alienation, and we can hear all this symptom when patient describe his suffer « I feel in aphonic on my voice and I feet suffocated in my breath.

After the acting out, an analyzing gaze will persist on the intentions and desires as well as a role of representation in which he will be the unique master of the play in a psychic reality; in the « I » (Mcdougall, 1982).

The eating disorder translates this metaphor of survival in the secrecy of these subjects who are confronted to the impossibility of feeling really alive, but feel the need to be operated and to record their experiences chronologically in a real and imaginary space. But this will lead to pure situations of cleavage. The eating disorder can sometimes create a refusal of the origins, linked to the fantasies of self-generation or accompanied by a fantasy of fusional body and a drive to destruction.

One must kill the other to live and should close off the symptom by an operation to survive.

This fantasy is expressed in males and females bulimics by the « I eat to kill the mother » or the « I eat to feed her » configuring an undefined separation or in some extreme cases expressed by «A body for two» or finally, expressed by an undeclared aggressiveness. All of which are linked by the impossibility to get away.

The symptom will carry in him this desire to forget, or disappear or die by failure of swallowing routes. The symptom and the need to crawl back to the operation will bear a psychic meaning that needs an understanding to avoid any psychic deteriorations after the operation, because for the subjects the symptom is an act of their own recreation at the moment it was constituted.

We perceived important pathological dietary patterns in some patients to be noted: defecation, sexual abuse and overeating; rage and anxiety.

The male analyzed patients showed a particular state, a form of hatred and a threatening character of destruction. It is important to understand before deciding to be operated that afterwards a strong state will emerge, like a bursting and an impossible separation of the fat banning the option of an operation that will lead the patient to say: «I'm still the same and nothing happened» and when the operation is carried out in this direction he will continue to think : «I am going to shut off the origins and everything that i have lived », which makes the annihilation close to the destruction of the patient and the physician too. Therefore, this clarification requires an awareness and a global study in order to understand the reverse role of the transformation of the symptom and in the analysis of the feminine elements in unidentified men who do the operations for the «I wish to seal the definitive link with her » and after the operation they feel guilt and a symptomatic outbreak that turns into pathology.

There is an ambivalent relationship with the food: a restorative and

destructive bond and a rewarding and persecuting bond. It actually is what is found in the obese, a link where guilt, aggressiveness and self-destruction mingle. The food compulsivity extends to a bipolar state, on the one hand an internal lack to repair or to fill and on the other hand a representation of the desire to cancel or to destroy, because behind the obesity symptom a voracity an avid request for exclusivity.

Thus, bariatric operations in obese patients carry a narcissistic meaning which leads to modulate the economic meaning where, in the reparatory cases, it is this constitution of this stifling narcissistic image, and in the persecuted cases it is about killing this negative image which can lead to a turn against oneself causing a clinical danger which one must be wary of.

Nowadays, obesity emerges as a contemporary and urgent research subject. In fact, the numbers show in 2014 more than 1.9 billion adults are overweight and more than 600 million suffer from obesity. (World Health Organisation, WHO 2014)

The candidates of the bariatric surgery are increasing too. In Canada, in 2012-2013, more than 6 000 operations were noted (Canadian Institute for Health Information, CIHI 2014). In 2003, 146 000 surgery (Bariatric Surgery Worldwide) were done without being able to talk about systematic pre and post-operative preparations.

Many theories and psychological studies (Grangeard 2010, Lauru 2013, Mariage, Cuynet & Carvelli-Roussel 2005, etc.) about the obesity show its big clinical diversity. It draws resources in the psychosomatic troubles, the psychopathological and the eating disorder.

Glinski & al. (2001) assert the need for a psychological follow-up associated to the medical follow-up. A pre-operative psychological evaluation favors a healthier post-operative follow-up since this operation can have side effects on the medical level but especially on a psychological one; In 2011, Gael notes that the suicide rate after the by-pass intervention is increasing.

For these obese individuals trapped in the repetitive and uncontrollable eating behavior for which the relationship to food belongs to their history with their first objects of love, the operation forces a categorical stop of the usual eating behavior. What will then become the future of this suddenly arrested relationship?

1. Problematic and hypothesis

These obese subjects eat for several psychological reasons: they eat for the quest of a lost object (Klein, 1946), they eat for preserving an object so they do not risk losing it (Rubin 1997), they eat as a self-destruction move (Decherf, Knera & Darchis, 2003), they eat by guilt and they eat by addiction (Grangeard, 2010 ; Apfeldolfer, 1991; Brownell K.D, Gold M.S. 2012).

For them, the act of eating is much more complicated than a simple physiological need and does not stop by a simple biological order of satiety. It is a relationship with the food that settles very early and carries a lot of meaning.

The meaning that the person gives to this behavior has been the main subject of many authors in many disciplines.

The psychosomatic authors agree that this eating behavior is an archaic somatic expression that replaces the symbolic representations in the event of their failure.

In psychopathology, many authors linked the obesity to the melancholy (Vargioni, 2001) and to the depression (Simon et al., 2008). A study done in 2008 by Sansone, Wiederman & Monteith, confirms the prevalence of a limit state personality type within obese surgery candidates.

The cognitive perspective refers to a conscious food restriction that leads to a total loss of control once this restriction is violated (Herman & Polivy, 1975).

The psychoanalysis refers the relationship with the food to the relationship with the mother at the oral state given its nature. We will be able to study this relation to the food through the development of the object relationship.

That said, the surgery will not solve the problem, the symbolic representations will remain absent and the established relationship does not disappear so the psyche will look for a new manifestation.

If after the surgery, the patient can no longer express his discomfort by the eating behaviors, how would he express himself?

Once this behavior is canceled, another will replace it so that the subject does not destabilize and rebuild another symptom to perform the same preliminary functions.

We asked ourselves previously that if the operation will suddenly stop this behavior how would the patient express himself? Is there going to be a relocation of the eating symptom to another? Will these operated patients go through stages of emotional destabilization or depression? Will they develop other addictive behaviors to replace the old ones?

The bariatric surgical intervention will significantly reduce the weight of the patient that suffers from obesity but it will also prevent him from yielding to his food orgy which until then had helped him momentarily as an emotional release, a mechanism of security and a regulator of emotions.

The purpose of this study is to be able to see what happens with the food symptom after the surgery. Since obesity has unconscious psychological roots and since a surgery will only change the symptom without curing the syndrome and since the act of eating carries psychological signification, the hypothesis will be stated as follow: Dietary symptom in the obese subjects is a fight against depression; after surgery this symptom will: either persist, or relocate, or cause the subject to fall into depression.

2. METHODOLOGY

a. Approach

This research studies the future of the dietary symptom after the bariatric surgery in obese males and females where obesity is not related to a medical illness. It takes part in the clinical psychology because of our need of a follow-up and a projective test to understand the structure of the personality and its defense mechanisms and in the psychoanalysis since it deals with displacements and with the object relationship.

b. Instrumentation

This research doesn't take part in a longitudinal study. The instruments needed to be able to reveal the side effects of the bariatric surgery are a semi-guided interview and a projective test which is the Thematic Apperception Test of Vica Shentoub (TAT).

The interview is structured to reveal three essential themes for our research: the history of the obesity and the motivations for the surgical intervention, the familial relationship, and the emotional and behavioral changes that were manifested in the post-operative period.

The T.A.T will allow us to show two important problematics through the fifteen administrated sheets, on one hand the identity and the identification and on the other hand the representations of the object relationship. In the results, we will focus on the object relationship which refers to the evolutional phases mainly the oral phase which is tightly linked to our research.

c. Population

The patients included in this study presented a common trait; they

live in the shadows, they are drowning in the desire of others, they find difficulty in loneliness, they permanently need to feel the emotional and sensorial experiences to feel alive. In other words they need to be included in the perceptions of others. Feeling invisible and foreign are highly marked in men.

The patients participating in this study are three men and women who did the bariatric surgery between 6 and 18 months ago and are obese for no medical reason. This time interval was chosen for medical and psychological reasons. On a medical scale, the body needs a minimum of six months to be able to establish a balanced metabolism. The choice of the maximum duration, 18 months, is based on avoiding a lack of reliability of the restitution of the post-operative events.

The inclusion criteria are:

- Lebanese women aged between 20 and 40 years
- Lebanese men aged between 20 and 40 years
- Their obesity does not result from medical problems
- More than 3 trials of a dietary control with no weight loss
- Repetitive surgical intervention for weight control

The exclusion criteria are:

- Male or female newly operated
- Male or female receiving medication in pre-operative period that eliminates the side effects of the surgery mainly those causing a weight gain

3. PERSPECTIVES

The work will be divided in two parts.

The first theoretical part will be about the definition of the obesity, its causes while focusing on the relationship with the food object and its role of a protector against the depression and its link with the other psychological troubles. We will mainly focus on the object relationship.

The second practical part consists of six cases; three men and three women operated since a minimum of 6 months and maximum a year and half did the projective test, the T.A.T followed by a semi guided follow-up to understand the future of the food symptom and the quality of the relationship of the individual with his surroundings.

1. Scientific interest

Actually the scientific interest in the obesity is rather recent and although the number of bariatric surgery is significantly increasing, the psychological studies remain vague and many fields are left to explore especially on the psychological level of the operated person in the post-operative period. We will focus on the fate of the food symptom in these patients to be able to demonstrated that the surgery does not solve the problem, but that it should be accompanied with a psychological follow-up for better results and to reduce the risk of recurrence or the appearance of new pathological manifestations in these patients.

2. RESULTS

The obtained results are as follow:

A lot of researchers questioned the presence of a common personality with all the obese patients (D'antin, 2011). In fact the results of these 3 men and women can show a common profile though each one of them has its own particularity in his personal development, in his relationship with the food and mainly in his reaction to the external ban on yielding to eating habits.

Case #1

During the interview, Mrs C. tells that after the surgery she experienced a compulsive need to spend money. The test result shows a limit structure, this food compulsion could not be stopped by internal restrictions; she needed an external law, an external real element (the surgery), and an auxiliary superego that will cut the dependency relation to the food object.

This anaclitic relation (Bergeret, 1974) that is resumed by a dependence relationship that is tinged with the ambivalence love-hate is clearly in her protocol.

In Mrs C.'s case, the act of eating was replaced after the surgery by another act that was manifested by the compulsive purchases stopped by a personal effort, she said and with the usage of Prozac by fear of a destabilization. This acting out protects her against a lack and the confession of the loss of the object.

Facing an incapability of acting by eating, Mrs C replaced her symptom to another compulsive act which is the compulsive purchases since the cause of the problem was the feeling of abandon and this endless quest for the love object that were not resolved after the surgery. To be able to stop the compulsive act, she had to resort to an antidepressant (one more time an external regulator and not an internal one) to be able to escape the depression.

The hypothesis is verified by the displacement of the food symptom.

Case #2

Mrs. A. tells that some days, in moments of solitude, she has compulsive needs to eat aggressively which end up surely by vomiting.

For Mrs. A., the T.A.T shows a personality of a borderline type with a high emotional liability. The T.A.T of Mrs. A., read in its details, describes a person in a melancholic position. Klein talks about the melancholy as a failure of the depressive position. Mrs. A. can situate herself in the borderline structure and regress to the melancholy position when faced to a painful situation.

Mrs. A. took a long time to get used to this new body, this new shape to a certain time where she « went crazy ». This inspires a disorganization of the I. When she can't stuff, fatten herself with food she pricks crying crisis, and despite the difficulty of offering herself a food « orgy » she ate more than her new limit, with her new body, and vomited afterwards. Mrs. A. eats to feed an incorporated mother. She eats to feed the incorporated object but also to survive. Mrs. A. was not able to displace the symptom; she yielded to the compulsive eating by fear of dismantling.

The hypothesis is verified by the persistence of the food symptom.

Case #3

Mrs. E., a young woman, is characterized by a big affective inhibition and a suspicious character.

She says, during the interview, that she is thin as she wishes but she does not have the pleasure to live.

The personality structure of Mrs. E. is in the anxiety register with defenses of the order of inhibition, narcissistic investment and dramatization.

She eats to introject a failing mother in the process of identification. She eats as a fight against depression (Simon and al. 2008) as if the act of eating counter-invest the feeling of loss. She eats to hide her femininity, a femininity that will risk her losing her mother and fall into the paternal grip on her woman's body.

When the operation made her yield to the eating behavior as an antidepressant mechanism, she found herself facing the loss of the food object, she could not develop new defensive conducts against this internal emptiness, she fell into depression.

The hypothesis is verified by the appearance of depression.

Now the different cases that resulted from the male patients:

Case #1

During the interview, Mr. F., says that after the surgery he felt a compulsive need to harm himself, he then takes a knife and self-harm his stomach. The test result showed a limit structure, this compulsive eating could not be stopped by internal restrictions. The T.A.T did in fact translate a very destructive hatred regarding the mother. He has difficulties expressing his needs, he feels guilty to sadden his friends, very submissive to others. The operation would allow him to recognize the aggressiveness by a state of psychic unbinding, and yet when the operation is over, he falls into a narcissistic return to harm himself. The surgery carries a desire to surpass the internal aggressiveness and recognize it by being operated, though this aggressiveness is turned against the patient who had cut himself by savage effects to be able to surpass this relationship of passive dependence to the mother.

In Mr. F.'s case, the act of eating was the acting out that was replaced after the surgery by another act which is the self-harm. This new act protects the patient since it consists of denying the aggressiveness and being able to return the loss of the object considered as ideal.

Mr. F., faced to an incapacity of acting by eating, displaced his symptom to another compulsive act that is the self-harm, this food symptom hides behind it a latent symptom, defense mechanisms such as persecutory introjection that which determines the first fixation in the psychic reality and that the individual tries to overcome it by a short circuit and that the psychic sense is taken to the relief which from where an element of psychic decompensation has been raised.

The hypothesis is verified by the displacement of the food symptom to another decompensation.

Case #2

Mr. L. tells that some days, in some moments, he would feel corporal impressions, some contractions in his body, and sometimes feel he is in a state of transparency, his body seems heavy and when he fatten himself with food, he ends up thinking that it's the hand of the mother that is filling him this way.

For Mr. L., the T.A.T shows a borderline type personality with an affective liability. The T.A.T of Mr. L., taken in its details describes a person in a schizo-paranoid position. Klein talks about the relationship with the secondary narcissistic object and a state of Symbiosis to the mother. (Melanie Klein , Essais de psychanalyse ,Payot, 1980)

Mr. L. is situated in the borderline structure and regress to the position of schizo-paranoid when facing a painful situation. Mr. L., took a long time to get used to this new body, until one point where he felt like someone was following him and wanted to kill him, when he's out he feels like the girls he's dating is scheming against him. This shows a disorganization of the " I " .When he can't fulfill himself with food, he's scared that this person will follow him and kill him , and when he does eat he considers the food as poisonous and toxic. Mr. L., eats to maintain cleaved link between mother and food in a persecutory relationship and the persecutor is a delusional projection on a feeling of persecutionMr. L., the symptom moved to a persecuting state by an anxiety of persecution.

The hypothesis is verified by the transformation of the food symptom to the persecution.

Case #3

Mr. S. is a man who refuses his body and isolates the internal part of it. He describes it as monstrous and would like to be in a relationship with a woman. He considers himself in conflict with God and that all his fear from his body and his eating compulsiveness is due to an identity problem; he feels weak in front of women and that his big and fat belly gave him the impression of being a pregnant woman; an obsessive image that invades his mind and he is incapable of discarding it.

He says during the interview that he feels foreign to his body, he desires to be with a woman but even after the operation he's still facing his identity problem as a man.

The personality structure of Mr. S. is located in the obsessional domain, and his defenses are mainly his isolation and an inverse reaction.

He was eating to incorporate a masculine identity in the identification procedure as if the act of eating would resolve the failure of meeting the mother and that in a spiritual link the women is sacred; and the failure of identification to the father who is monstrous just like his body. He was eating to hide his lost masculinity too.

When the operation obliged him to give up the act of eating as a mechanism of isolation, he found himself facing his separation from the food object, he could not develop new defensive habits to fight against his internal emptiness, he turns to the confrontation of what holds the gavage eating. It's his masculine identity problem that pushes him to eat without stopping and he wanted to say that « Nothing happened and that the operation didn't make any change ».

The hypothesis is verified by of the appearance of the identity symptom and the persistence of the food symptom.

3.The limitations

The limitations of this study are described as follow:

- The cases studied are very restricted and do not represent all the population of obese males and females that were operated.
- The choice of the type of the intervention is limited to the Sleeve gastrectomy and it is possible that other interventions might show other psychological effects.
- The relationship with the population involved in this study is restricted to a unique interview so the relationship with the examination is minimal and the collected information is not enough plus the passing of a single projective test may not be conclusive.
- The studies concerning this topic on Lebanese fields are non-existing

4. Comparative analysis of the research samples

The Transformation of the symptom in woman	Mrs. C. says that after the surgery, she produced a compulsive need to spend money.	Mrs. A. says that some days in solitary moments, she feels the compulsive need to feed herself a lot which ends up with her vomiting.	Mrs. E. was unable to develop new defensive behaviors against her internal emptiness so she fell in depression.
The Transformation of the symptom in men	Mr. F., after the surgery, felt a compulsive need to harm himself and took a knife and started harming his stomach.	Mr. L., after the surgery, had his symptom move to a state of persecution with an anxiety of constantly being persecuted.	Mr. S. feels weak in front of women and his fat belly gives him the impression of being a pregnant woman ; an obsessive image that invades his spirit and he can't get rid of it.

The compulsiveness	The endless quest of the love object. The solitude. • Self-image deteriorated. • Negative comparisons to others. • Low self-esteem which implies tendency of depression.	• Self-contained with paranoid ideas. • Mistrust of other. • Reduced and unappreciated interpersonal relationships. Paranoïde ideas.	The compulsiveness is an identity problem
Women	The hypothesis is verified by the displacement of the food symptom.	The hypothesis is verified by the persistence of the food symptom.	The hypothesis is verified by the appearance of the depression.
Men	The hypothesis is verified by the displacement of the food symptom to the decompensation.	the hypothesis is verified in by the transformation of the food symptom to the persecution	The hypothesis is verified by the appearance of the identity symptom and the persistence of the food symptom.
Defense mechanism for the women	Displacement.	Incorporation. Introjection, fear of dismantling.	Introjection, inhibition, dramatization. -Need of the feeling of having all the power.
The Nature of the anxiety in men and women	• The fear of abandon which affects the integrity of the psyche in men.		- Anxiety of loss
Women's structure	Limit, anaclitic and the dependency. Depressive regression.	Borderline with an affective lability. Melancholic regression.	Neurotic, anxiety Depressive regression.
Men's structure	Limit. Narcissistic and melancholic.	Borderline with an affective lability. schizo-paranoid regression.	Obsessional. Identity regression.
Adaptation	• Difficulties in adaptation.	• Difficulties in adaptation.	-Difficulties in adaptation.
Link between the meaning of food and the psychic functionality	Weak control over the impulsions.	Weak control over the impulsions.	Weak control over the impulsions.
Object Relationship	Pre-objectal.	Purely narcissistic objectal and symbiosis with the mother.	Objectal.
Defense mechanism for men	Persecutory introjection.	Projection, suffocated	Isolation, the reaction formation
Samples	Mrs C., Mrs A., Mrs E.	Mr F., Mr L., Mr S.	

5. Recommendations

Even after the surgical operation a food symptom is not lost it is transformed. As long as the unconscious motivations of the appearance of this symptom remain without being transformed, the symptom will reappear under other forms to be able to transmit the same message.

For these reasons, it is highly recommended to extent the field of scientific researches about the post-operative side effects and to have multidisciplinary centers to take care of the candidates for this surgery to be able to reduce the bad psychological side effects and ensure a better quality of life.

1- Sensitize the medical team to the psychological aspects of the obesity.
2- Participate in a clinical and diagnostic function to be able to understand the psychological infrastructure of the bulimia or the obesity. Avoid doing the surgery for individuals with a psychotic or bipolar nucleus and be aware that there are risks of decompensation after some slimming treatments.
3- Follow-up with psychotherapy and a detailed follow-up of the state of the patient.
4- Before the operation we should understand with the patient experiences such as introducing into the body, in strategic plan how the patient can accept all changes about the results of operations detaining or expelling, acquiring or keeping or losing, signaling the patient's ability to lift and strengthen these experiences to reduce any risk of decompensation, and reduce risques for this surgery, and reduce pathological effect in psychological.
5- Understand that for the obese there is a psychic fault and that the use of speech in psychotherapy helps psychologically rebuild this fault to be able to fight the emptiness. It is not equivalent to filling it but to understand it and be able to place words for every emotion.
6- Help understand the defense mechanisms in the obese such as incorporation and introjection.
7- Understand the notion of time and subjective, wait and accept to represent the wait without an insecure flood.
8- The obesity is a lost fantasy in the psyche to understand.
9- Understand the perverse notion and effect of the masochistic contract and clash it with psychic impotence with the symptom of obesity.

6- CONCLUSION

The decision of having the surgery to get thinner is a decision to be thought about it profoundly for different medical and psychological reasons.

The eating behavior, with all the affective charge that he has, is faced to many transformations after the surgery and the psychic balance of the operated person is under risk. The food symptom has a lot of significations and is found in all the structures of personality.

Therefore, it is important to respect the role it plays in an obese person while analyzing the causes of the obesity to be able to help the candidate reduce the risk of an affective destabilization and ensure him corporal and affective treatments for his survival.

When comparing men and women, we find that in men, behind the meaning of the symptom is a hate and a dangerous regressive turn against himself that threatened his psychic integrity; while in women, the symptom is restricted to a depressive loss , and that is why there's a necessity to understand the meaning of the symptom because this can endanger the person and if we want to explain this risk, we would do a detailed analysis about the importance of the symptom in a psychic reality, and that for men it is an identity problem, and by the way the symptom is criminalized in a

destructive and reparative link in its psychic function.

7. REFERENCES

1. Anzieu, D. (1987). Les enveloppes psychiques. Paris: Dunod.
2. Apfeldorfer, G. (1991). Je mange donc je surpoids. Surpoids et troubles du comportement alimentaire. Paris: Payot
3. Bergeret, J. (1985). La personnalité normale et pathologique. Paris: Dunod.
4. Brownell, K.D. & Gold, M.S. (2012). Food and addiction: A comprehensive handbook. Oxford: Oxford University Press.
5. D'antin de Vaillac, A. (2011). Peut-on dresser un profil psychologique de l'obésité ? Etude clinique de la violence dans la dynamique psychique de personnes obèses (Master thesis, Université de Toulouse le Mirail). Retrieved October 5, 2013, from http://www.reseauprevios.fr/resources/DANTIN.pdf
6. Decherf, G., Knera, L., & Darchis, E. (2003). Souffrances dans la famille: Thérapie familiale psychanalytique d'aujourd'hui. Paris: In Press.
7. Dumet, N., & Porte, P. (2008). Quand l'ombre de l'objet perdu est tombé sur le corps du sujet... Deuil, somatisation et incorporation. Cahiers de Psychologie Clinique, (30), 129-145.
8. Glinski, J., Wetzler, S., & Goodman, E. (2001). The psychology of gastric bypass surgery. Obesity Surgery, 11(5), 581-588.
9. Grangeard, C. (2012). Comprendre l'obésité. Une question de personne, un problème de société. France: Albin Michel.
10. Grangeard, C. (2010). Vers une psychanalyse de l'obésité. La Clinique Lacanienne, (18), 141-150.
11. Herman, C.P., & Polivy, J. (1975). Anxiety, restraint and eating behavior. Journal of Abnormal Psychology, 84(6), 666-672.
12. Lauru, D. (2013). Le poids du surmoi. Le Journal des Psychologues, (311), 23-26.
13. Mariage, A., Cuynet, P., & Carvelli-Roussel, G. (2005). L'obésité chez l'adulte à l'épreuve du Rorschach. Bulletin de Psychologie, (476), 207-219.
14. Mcdougall, J. (1982). Théâtres du Je. Paris: Gallimard.
15. Rubin, G. (1997). Cannibalisme psychique et obésité. Neuchatel, Switzerland: Delachaux & Niestlé.
16. Sansone, R., Wiederman, M.W., & Monteith, D. (2000). Obesity, Borderline Personality Symptomatology, and Body Image Among Women in a Psychiatric Outpatient Setting. International Journal of Eating Disorders, 29(1), 76-79.
17. Simon G.E., et al. (2008). Association between obesity and depression in middle-aged women. Gen Hosp Psychiatry, 30(1): 32-39.
18. Vargioni, J. (2011). L'obésité féminine comme incarnation du féminin Mélancolique. L'Evolution Psychiatrique, 76(1), 109–115.