

A Search of the Origins of Anorexia Nervosa in Adolescence. A New Treatment Approach

Abstract

Anorexia nervosa is an eating disorder, which affects particularly adolescents. The media coverage of feminine thinness is demonstrated as a token of beauty, with diet food as means to achieve this. However, diet foods are not enough to explain the numerous cases. This disease is the symptom of a psychological disorder and research for the origin must follow-up the psychotherapeutic treatment. Multi-factorial explanations seem dominate in the various case of this article. Family problems and sexual assaults can also explain this transition to anorexia. In the first case, anorexia nervosa is used as a tool for identification and of personalization in the assumption of autonomy and independence. In the second, the anorexia becomes a means of defense in response to aggression. We give a clinical confirmation of the multivariate origins of anorexia nervosa and of the impact of sexual abuse. This paper proposes a new approach of the anorexia nervosa treatment.

Keywords: Anorexia nervosa; Family; Sexual assault; Psychological treatment; Cases Study

Case Report

Volume 6 Issue 1 - 2016

Matt Lacoste*

Psychologist in Private Practice, USA

*Corresponding author: Matt Lacoste, Psychologist in Private Practice, USA, Email: Dr.matt.lacoste@gmail.com

Received: March 01, 2016 | Published: June 08, 2016

Introduction

Anorexia Nervosa is an "eating disorder with a more or less systematized refusal to eat, acting as a reply form to psychic conflicts" (Larousse Dictionary of Psychology, 2000). People with anorexia nervosa (90% are women) have a distorted body image that causes them to see themselves as overweight even if they are dangerously thin. 0.5% to 3.7% of females suffer from anorexia nervosa in their life time [1]. It's the third most common chronic illness among adolescents [1] after obesity and asthma. The 13-14 years old and the 18-20 years old seem to be the most affected by anorexia nervosa. 95% of those who have eating disorders are between ages of 12 and 25 [2]. Anorexia nervosa is a full disease which impact around 1.5% of French women of 15 to 35 years old.

All the social classes are affected with the matrimonial families seemingly to be overrepresented [3]. These subjects tend to deny that their eating behavior is problematic and we estimate that only one third of these people received a treatment. On these 30%, the percentage of people recover completely is low [4]. 4 years after the anorexic period we count 44% of patients with good recovery, but seven and half years after, this number decrease to 33% [5]. Majority of studies find that only 11% to 40% find recovery and 1 out of 2 anorexia nervosa subjects relapse.

Together with Botha's observations [1], traditional understanding of and approaches to diagnosis and treatment for anorexia nervosa seem to be unacceptable, inappropriate and laden with labelling ways, and thus exacerbate these patients' struggles, leaving them dishonored, disabled, powerless and even more distressed.

Thus, as psychologists who treat anorexia nervosa subjects, our questions are why the recovery of this disease is so hard? Why

the majority of treatment is ineffective? What can we purpose to our patient to help them to stop the vicious circle of the anorexia nervosa and find a "normal" eating behavior?

With four cases study, we will try to answer to these questions. The family problematic and sexual abuse seem to be the mains origins of the beginning of anorexia nervosa.

Literature Review

Adolescence and family. A family issue as anorexia nervosa origin

Anorexia nervosa and bulimia are linked to multiples factors usually associated: psychological, family, social and biological influences, which affect each over, contributing to the initiation, the maintenance and to the exacerbation of eating disorders [6].

For Fairburn & Harrison [7] a combination of genetic variables and also environmental should be implicated in the anorexia nervosa development. Friends and family circle are connected to the disorder de facto, by the causes, by the consequences or both. We could find three times more anorexia nervosa subjects in the families whose parents who have history of this disorder [8]. This could confirm the genetic dimension of eating disorders displaying during the 1990s' [9,10]. But, the heritability of liability to eating disorders as Bulimia nervosa is difficult to prove Fairburn et al. [11]. For Collier & Treasure [12], "Increasingly, the consensus is that eating disorders are complex disorders consisting of both genetic and social factors, with a developmental component strongly linked to adult illness".

Even if it seems difficult to define a psychological profile of anorexic adolescents' parents, studies show that the distant

parents would be inclined to neglect their child, to not show affection, and communication is volatile or, conversely, the overprotective parents would be possessive, pervasive and they encourage excessively the family cohesion. These parents' behaviors are typical of the parents of anorexic child. "Many authors [2,13] focus on failures in primary identification process mother/daughter marked with a dependency where the ambivalence dominates. The nature of the primary links would explain the frequent narcissistic breaches in these patients, breaches responsible of wrong perceptions of self-image and of body" [3].

Shoebridge & Gowers [14] found that the mothers of anorexia nervosa subjects reported higher rates of near-exclusive child care, severe distress at first regular separation and high maternal trait anxiety levels than the mothers of control subjects. They also showed that families with anorexia nervosa case, had experienced a severe obstetric loss prior to their daughter's birth. This could confirm that overprotecting parents or high concern parenting in infancy could be associated with the later development of anorexia nervosa.

If the earlier mother's behaviors would have a negative impact on the adolescents' eating behaviors, anorexia nervosa could be considered as bodily inter subjective. The eating behavior and transformation of the subject's body play a role in the family relationship. The anorexia nervosa subject would use as a tool her eating disorder and bodily shape to address others, to manifest her distress or her desire, to put the others, and specially the parents, in a position to answer or to do something for her distress [15]. The study of Rothschild-Yakar et al. [16] indicated that anorexia nervosa type patients presented significantly lower metallization levels and lower quality of current relationships with their parents compared with non-eating disorder controls. When the verbal dialogue seems to be difficult, the adolescent would choose another communication tool. The adolescent could also try to take power from her parents by her eating behavior. Indeed, anorexia nervosa subjects are obviously facing with paradoxical behaviors and thinking. The adolescent who searches for more autonomy, claims with conflict more independence, addresses to their parents to be taken care of by her eating disorder. Anorexia nervosa affects not only the subject's relation to food but also her relation to others [15] and especially to her parents.

If sometimes, adolescents use anorexia nervosa to say something because it's too hard to use words, is it not because they are victims of sexual abuse or rape?

Anorexia nervosa and sexual abuse

The interaction of different factors, with some can be unconscious and difficult to identify, are generally at the origin of anorexia nervosa. Even if it's sometimes possible to isolate a trigger event (injuring comment on her physical appearance, fight with her parents, divorce of parents, romantic break-up,...); it's typically one event too many more rather than an isolated explanation. By contrast, it would seem that sexual assaults can be the (main) explanatory trigger of anorexia nervosa. Even if some researches try to argue the link between sexual abuse and eating disorders (e.g. Smolak & Murnen [17]), several studies confirm the results in our patients in private practice. Favaro et al. [18]

show that physical or sexual abuse of children result significantly in anorexia nervosa during adolescence. Deep et al. [19] found that 27% of anorexia nervosa subjects had antecedent of sexual abuse compared to a rate of 7% in control women subjects and it could be more important for bulimia nervosa patients [20]. According to the Center of Disease Control and Preventions (2007), 1 in 4 of young people experienced verbal, physical emotional or sexual abuse from a dating partner; 8% have been forced to have sexual intercourse when they did not want and nearly 10% were hit, slapped or physically hurt by a boyfriend or girlfriend within the 12 month prior talking the survey [2]. Sexual abuse has been reported to occur in 30% to 65% of women with eating disorder compared to 10% to 30% in rates of sexual abuse in the general population [21,22,19,23]. Faravelli et al. [24] shown that 53% of the rape victims reported current eating disorders symptoms compared to 6% of control subjects. Thompson & Wonderlich [25] found the same results. Fischer et al. [26] specify that a childhood emotional abuse can be a predictor of current disorders symptoms. They explain this result by the hypothesis "that an emotionally abusive environment does not teach adaptive emotion regulation skills, and that the use of maladaptive emotion regulation skills results in eating disorders symptoms". The eating disorder can be a strategy of avoidance or regulation of emotion. Lejonclou et al. [27] confirm that for several traumas, the eating disorders subjects had experienced a significantly larger number of potentially traumatizing events, and they specify that the number of adverse childhood experiences and repeated traumas were associated with eating disorders for adolescents and young women. All kind of child sexual abuse is a traumatic experience and one of the major risk factor in the development of mental health problems affecting both the current and future of victims Collin-Vézina et al. [28].

Lyubomirsky et al. [29] specify that some personality traits like dissociation can mediated the relationships between abnormal eating and sexual abuse. The women with a functional coping could avoid binge eating even in case of sexual abuse, inversely the dissociation associated to others negative affects lead to the most important eating disorders.

In our selected literature review, family and sexual abuse seem to be two important origins of a disordered eating behavior and can be associated in the development of the disorder. What about our patients? Do they confirm these explanations? And how we can clinically explain these processes?

Method

This article draws a new approach in the anorexia nervosa treatment and in patient monitoring. Through the case study, the main goal of this paper is to wonder about the origin of anorexia nervosa as well as the adolescence specificities linked to this eating disorders.

This paper mainly use 4 outpatient cases that were treated with success in our private practice as psychologist.

Sandy (48 years old) suffered with anorexic eating behavior since childhood. Raped at 22 years old, this assault intensified or escalated the eating disorders. The therapy will reveal parents' sexual and emotional abuse since a young age. Now, she's married,

mother, and she's a female entrepreneur who put a lot of time and energy in her job.

Emily (25 years old) was in her 4th year of graduate studies but struggling a burn-out about her studies. The anorexia nervosa began 7 years before, she was an inpatient facility to address this crisis and her endangered health. The numerous inpatient weeks were not satisfactory. The relapses were systematic. She came the first time with her mother who spoke more than Emily about her health and about the importance of her studies and the graduation in 16 months.

Sharone is 17 years old, bright teenager with good results at school. She was living with the anorexia nervosa for almost two years. She has an older sister (24 years old) who is married and recent mother of triplets. Sharone's parents consider her older sister to be a role model and often compare them. Sharone lived with her parents. They were overprotective but since the triplets were born, they focused on the "new babies".

Samantha (16 years old) develops an anorexia nervosa 2 years ago. Her mother manages her own restaurant and Samantha has to regularly help her mother at the restaurant. During the psychotherapy, Samantha will reveal she was raped at 14 years old by one of her classmates, who is also a neighbor.

Data Analysis and Discussion

We introduce a case study of four female patients voluntarily engaged in a therapeutic process. The therapeutic monitoring was organized with one or two weekly therapeutic consultation outpatient sessions. The patients were fully with the disease or in the latter stages of recovery. The patients' comments collected will be confronted with our literature review and discussed.

Adolescence and family in our cases

It's a fact that the cultural and media pressures to be thin contribute particularly to increase the number of eating disorders subjects Fallon et al. [30]. This explanation is confirmed by Emily (25 years old) when she explains "I felt round, I was 117 pounds for 5.18 feet, so I went on a diet and gradually I could not swallow anything and I fell to 81.5 pounds". But going further in our conversations, the family issue came to emerge in the explanation of the disorder origin: "When I eat, I feel fat and guilty because it costs money to my parents. [...] Today I'm desperately ill, I do not want to fight anymore. I have enough of life especially when I see that I hurt my parents". A normal diet is often the facade developed by the person to hide from the others (and from oneself sometimes) the anorexia nervosa process which going on. It is to the others that the anorexia nervosa is addressed, inviting or rejecting them. Emily seems to manifest an alimentary communication by stripping food from its nutritional matter in order to make of it an element of language, Emily would materialize her hunger in her body which is transformed to address it to her parents Legrand & Taramasco [31]. These authors explain that the subject eat, she eat nothing. This "nothing" she eat has not got a nutritional value but a symbolic one. The food or the meal is a communication system, and in this way anorexia nervosa is a food communication. When she eats nothing, the anorexic subject removes the nutritious matter of food to keep the language part only.

Conflicts are numerous during adolescence, they come from parents, family, friends, loves, teachers, studies,... They can be internal to the subject herself who does not accept her body and the transformations related to adolescence. Body changes are sometimes marked during puberty and girls can, by anorexia nervosa, attempt to regain power over this body that no longer suits them and no longer meets their expectations.

Emily (25 y/o) put her anxiety into words for others to understand: "I don't like when there are people at home and this is worsened if it was not planned. At others' home it's just bearable. The more people that are there, the more I fear". But this distinction between home (family home) and among friends does show us an underlying family problem explaining the disorder and the discontent facing this other? She fears this invader who is going to introduce himself into her family cocoon plus to observe and to note her thinness. Maybe, these "foreign family people" could endanger her attempt to take the power on her parents. Anorexia nervosa subjects can maintain the disordered eating behavior and their thinness to preserve the family circle or the family unit Selvini-Palazzoli [32] because anorexia nervosa creates a reason to be helpful, to be together.

The children or the teenager can use anorexia nervosa to avoid growing up. By remaining a child, the person retains the carelessness of childhood and keeps the parenting focus. Like that, Emily (25 y/o) confides: "I live at my parents' home, they shake me all the time. They are unhappy, my father is often angry. I feel guilty. They often tell me "you are almost an adult, it's time you took responsibility for your actions!". Becoming an adult is often perceived as a loss, as a nightmare to face problems, constraints, obligations of life; it's becoming responsible for yourself (and others). "Eat your soup, you'll grow up" can take some teenagers into major anxiety. By not eating, could it not represented for these children the symbolism of the fetal period when the umbilical cord ensured that role for them? Sharone (17 y/o) explained this: "my sister had just had triplets, I struggled with that. Until that time I was the youngest of the family and I used to get all attention. Suddenly all the attention focused on them and the only thing I had left was my diet. And every time I felt alone, I consoled myself by losing a pound. [...] Finally, they paid attention to me, they started to take care of me, they did not leave me alone anymore. [...] This is a part of me, I would like to stop, I don't want to die but it's very hard and I don't know how I can do it." Sharone also fights against this ambivalence of adolescence. This constant quest of other people's look, express what the anorexia subject wants more than anything but what she can't say: Take care of me! Jeammet [31]. Samantha (16 y/o) can blame too sustained attention of her mother and at the same time she maintains this concern by her eating behavior: "My mother always bothers me so that I eat, she bug me! To eat, this is not fun, it became an order". Therefore, her anorexia nervosa would become an opposition to her mother to access some independence, typical of adolescence. At the same time, her eating behavior is a tool to maintain her mother role like nurturing, and to see her like a child. This is another example of the paradoxical relationship of the anorexic subject with others. The social (parental) relationships are frightening and necessary in the same time, frightening because necessary Jeammet [33]. This ambivalence often appears in Samantha's addresses as well when she describes herself. Our one on one allowed her to express

the limits of her behavior, helping to move beyond her disorder: *"I feel that there is a combination of two girls in me: one very ugly and one very beautiful. I think I'm fat and thin [...] I would like to be perfect to please myself but I consider myself too thin now and I'm afraid to go to the beach"*. Samantha confirms here that her fine body bears the traces of her internal trouble and in the same time, her obvious thinness express her uniqueness in the space where others can see these traces and respond Legrand & Taramasco [31]. Relationships with parents are often relationships of dependence. But the anorexia nervosa of the teenager tries to reverse the roles because it's the family who becomes dependent of the adolescent and of her relation to the food. This hold ensures the success of an illusory control of the affective and family sphere. Conflicts with parents become inevitable which reinforce the anorexia behavior. For Legrand & Briend [15] anorexia nervosa subjects struggle with this paradoxical behavior because they fail to negotiate the difference between needs and desire. The desires are often insatiable and whether the parents satisfy the needs, they can't fulfill the unfulfillable desire.

For that matter, Emily (25 years old) confided that *"My cousin is doing the same, we were brought together. From my mother's side is considered quite beefy. My aunt, my uncle, my grand-father are overweight. My uncle, it's the same, he was an anorexic subject"*. Did Emily confirm a genetic role in the explanation of the anorexia nervosa or did she describe a family who cultivate an environment which fosters the development of anorexia nervosa? Did she fight against a family relationship because she felt a subjugation of her subjectiveness? That fear can be a reject of the other, or a call to the other Legrand & Taramasco [31], or both together.

The eating disordered behaviors often lead to a hostage of the family which is undergoing a major anxiety regenerated at each mealtime. The circle, particularly the parents, tend to act and behave according to the wishes and moods of the adolescent hoping she's going to nourish herself. Thereby, a balance of power can be built, the adolescent taking the power on the destabilized and distressed parents, by submitted to this disorder living in a permanent anxiety about each possible future deviant. By playing on the feeling of guilt and on the protective parenthood sprout, the anorexic subject undermines the identity of parents and put their social positioning and their attitudes in doubt. Sharone's mother (17 y/o – At the end of the therapy) thus said: *"I do not think that we could turn the page. There will always be this pall hanging over us at least as long as she lives at home. We'll have a little anxiety to know if she's eating all her meals. Me, I will wonder this, anyway"*.

Sandy (48 y/o) also verbalized after analysis, that she ate during her childhood and adolescence at the level of the perceived parental love. Developing a sense of abandonment, of lack of affection and of reject from her parents, she expressed her feeling of these perceived deficiencies, in the eating deficiencies. She experienced a correspondence between the misery intensity and that of the anorexia nervosa. Sandy cumulated a harmful family environment, sexual abuse and rape.

Anorexia nervosa and sexual abuse in our cases

Our practice confirm a large rate of young girls or women with anorexia nervosa symptoms who were sexual abuse or rape

victims (67 % of our anorexia nervosa patients). Indeed, this physical attack, still in that whole power of the mind over the body, can't it express itself as well in these young girls who have suffered sexual assaults? Because of their hurt body and their stolen privacy, it seems logical that the lack of interest for sexuality is described as a symptom of anorexia nervosa. Sexual assault can cause this eating disorder and the weight loss. Samantha (16 y/o) explained that she fell in anorexia nervosa after she was victim of rape. She said anything to anybody before her psychotherapy, *"after the rape by my neighbor, I felt dirty, ashamed and more guilty than victim. I didn't like the life anymore, I no longer felt hungry, I did not want to do anything. But I kept the secret and live like a robot, a scared robot"*. The rape was clearly the triggering event, but Samantha connected the family problematic when she said *"In addition, my mother always want I help her at her restaurant, I hate that, it make me even more disgusted"*. With the secret of the rape wrote on her body but invisible for the other and with a specific problematic about the food in her family, Samantha seemed to use the anorexia nervosa to express her pain and to reveal her secret in order to wean herself off it. The conflicts with her parents became regular, but it was a paradoxical rebellion, remained under the wraps at the beginning, the secret wanted to be visible to all by her gaunt body. Again, we understand how anorexia nervosa is communication, it's a patient and stubborn building of a body of which his vulnerability is a cry for protection Legrand & Taramasco [31].

The desexualization that results would have the goal to protect the young girl who hopes with that she's not going to create the desire of a man anymore. Kestemberg et al. [34] describe this paradox of the anorexic subject who is struggling with an idealized body (for its thinness), object of desire in one hand and a real body, object of denial in the other hand. Is it the paradox of the anorexic subject or the one of the girl sexually assaulted? Sandy (48 y/o) explain a posteriori that anorexia nervosa *"led me to drive my femininity off myself and to break the mind and the body connection"*. The bodily sensations disappear and this becomes a survival strategy against the sexual assault. Towards the forced use of her body, the goal is to safeguarding her mind, her soul, her Self, I, while doing the division between the body and the mind. After the assault, anorexia nervosa would be the extension of this strategy. This contribute to the euphoric time's explanation and to the feeling that everything becomes cerebral as explains Sandy (48 years old): *"anorexia nervosa causes this phenomenon of rising up, the body forget itself and just the mind exists. It's very exhilarating but very dangerous, I felt I could reach death"*. The fight then ensued between the mind and the body sometimes to the point of living a marked dissociation between the two dimensions of the person. The subject is in denial of her thinness and of health gravity especially because this thinness gives a well-being and a control feeling.

The body of the victim is soiled and therefore rejected, the person exist only with her cognitive skills. What is the use to give food to this body which can cause a credible or perceived attack? Why being physically enviable if it results in becoming a victim of such tragic and violent consequences? Our analysis confirms the Fallon et al. [30] which shown that the sexual abuse victims adopt a restricting eating behavior because they refuse to see their body develop with secondary sexual characteristics during

or after puberty, or because they want to recover some control on their body.

Conclusion and Therapeutic Prospects

As some studies try to identify the risk populations Favaro et al. [18], it seems difficult to bring out definite predictor factors. The person is unable to express or manage other than that food deprivation: *"Sometimes I'm hungry between meals, but I prohibited it myself"* (Emily, 25 y/o). We define anorexia nervosa as the symptom and not as the problem. This perspective will determine the approach and the treatment by the psychologist.

Following Legrand & Briend [15], the psychotherapies could progress if they avoid the dichotomy to focus on the symptoms or to focus on the social and familial environment. Indeed, anorexia nervosa treatment procedures are often focused on the patients' eating behavior and on any weight gain or loss. It's often forgotten to research the triggers of the anorexia nervosa for the subject.

Even if we don't deny the biological and neurophysiological implications of the anorexia nervosa, we consider anorexia nervosa as the expression of a psychic conflict experienced by the person in an opposition posture. This is a symptom masking a discomfort, a trauma, an emotional deprivation, an emotional disorder, an identity disorder, an emotional shock or an internal social conflict... Anorexia nervosa is rooted in this emotionally fragile people or with difficult life experiences. Often, anorexia nervosa is the physical expression allowing the non-verbal expression of a generally important psychological disorder.

The psychotherapy (inpatient or outpatient) remains the crucial element in the anorexia nervosa treatment. The psychiatric protocols with an excessive focus on weight gain are, for us, incomplete and ineffective. The subject builds her personality and exists by means of her thinness. If the psychotherapist's work is focused on the thinness and on to recover weight, he will reinforce the empowerment of the disease. Albert Einstein explained that *we can't solve problems by using the same thinking we used when we created them*. As well for Sullivan et al. [35] this kind of therapy "neglects the detection and treatment of associated psychological features and comorbidity". These authors also note a very high lifetime prevalence of several anxiety disorders. This proves that the problem is not resolved and that the anorexia nervosa was a psychological expression of this problem.

For Jeammet [36] the kind, the quality, the consistency and the duration of the anorexic subject treatment and accompaniment determine the quality of the disorder recovery with the establishment of a social, family and sexual life and an eating behavior close of the "normalcy". We see in our psychological practices, how much it's important for the patient to establish a strong link with his psychologist. We can construct, with this link, a dynamic of work for that healing journey. For this pathway, we mainly use two engines simultaneously: the first is to answer to the question of the why? (Why the patient fell in anorexia nervosa?), and the second is to set goals for short, mid and long-term. But, however the strategies used by the psychologist, the recovery needs a good therapist and a very good relationship with the patient. The psychotherapy needs to be focused on the

patient in a holistic approach. We come back to Rogers [37], in the therapeutic relationship he turned to interpersonal qualities of the therapist, namely empathy, unconditional positive regard and congruence. Thus, focused on the patient, the therapist may provide the necessary conditions for realizing the healing processes and create the ability to bond or develop attachments in future relationships.

The rates of relapse have to alert us to the emergency of improving the treatment for anorexia nervosa. The anorexia disorder being generally the symptom, research of the one or the several causes must be the major goal of an efficient psychotherapy.

References

1. Botha D (2012) No labels: Men in relationship with anorexia. Mooshine Media Editor.
2. Brusset B (1998) Psychopathologie de l'anorexie mentale. Dunod.
3. Marcelli D, Braconnier A (2004) Adolescence et psychopathologie. Liège : Ed. Masson.
4. Herzog DB, Nussbaum KM, Marmor AK (1996) Comorbidity and outcome in eating disorders. *Psychiatr Clin North Am* 19(4): 843-859.
5. Herzog DB, Dorer DJ, Keel PK, Selwyn SE, Ekeblad ER, et al. (1999) Recovery and relapse in anorexia and bulimia nervosa: A 7,5 year follow-up study. *J Am Acad Child Adolesc Psychiatry* 38 (7): 829-837.
6. Rogé B, Chabrol H (2007) Psychopathologie de l'enfant et de l'adolescent. Paris: Belin 298.
7. Fairburn CG, Harrison PJ (2003) Eating disorders. *Lancet* 361: 407-416.
8. Strober M, Morrel W, Burroughs J, Salkin B, Jacobs C (1985) A controlled family study of anorexia nervosa. *Journal of Psychiatry Research* 19(2-3): 239-246.
9. Bulik CM, Sullivan PF, Wade TD, Kendler KS (2000) Twin studies of eating disorders: A review. *Int J Eat Disord* 27(1): 1-20.
10. Grice DE, Halmi KA, Fichter MM, Strober M, Woodside DB, et al. (2002) Evidence for a susceptibility gene for anorexia nervosa on chromosome 1. *Am J Hum Genet* 70(3): 787-792.
11. Fairburn CG, Cowen PJ, Harrison PJ (1999) Twin studies and the etiology of eating disorders. *Int J Eat Disord* 26(4): 349-358.
12. Collier DA, Treasure JL (2004) The etiology of eating disorders. *British Journal of Psychiatry* 185(5): 363-365.
13. Jeammet, P (1993) L'approche psychanalytique des troubles des conduites alimentaires. *Neuropsychiatrie de l'enfance et de l'adolescence* 41(5-6) : 235-244.
14. Shoebridge P, Gowers SG (2000) Parental high concern and adolescent-onset anorexia nervosa, A case-control study to investigate direction of causality. *Br J Psychiatry* 176: 132-137.
15. Legrand D, Briend F (2015) Anorexia and bodily intersubjectivity. *European Psychologist* 20(1) : 52-61.
16. Rothschild-Yakar L, Levy-Shiff R, Fridman-Balaban R, Gur E, Stein D (2010) Mentalization and relationships with parents as predictors of eating disordered behavior. *J Nerv Ment Dis* 198(7): 501-507.

17. Smolak L, Murnen SK (2002) A meta-analytic examination of the relationship between child sexual abuse and eating disorders. *Int J Eat Disord* 31(2): 136-150.
18. Favaro A, Tenconi E, Santonastaso P (2010) The interaction between perinatal factors and childhood abuse in the risk of developing anorexia nervosa. *Psychol Med* 40(4): 657-665.
19. Deep AL, Lilenfeld LR, Plotnicov KH, Pollice C, Kaye WH (1999) Sexual abuse in eating disorder subtypes and control women: The role of comorbid substance dependence in bulimia nervosa. *Int J Eat Disord* 25(1): 1-10.
20. Casper RC, Lyubomirsky S (1997) Individual psychopathology relative to reports of unwanted sexual experiences as predictor of a bulimic eating pattern. *Int J Eat Disord* 21(3): 229-236.
21. Zerbe KJ (1992) Eating disorders in the 1990s: Clinical challenges and treatment implications. *Bull Menninger Clin* 56(2): 167-187.
22. Connors ME, Morse W (1993) Sexual abuse in the eating disorders: A review. *Int J Eat Disord* 13(1): 1-11.
23. Daigneault I, Collin-Vézina D, Hébert M (2012) La prévalence et la prévention de l'agression sexuelle envers les enfants et les adolescents. *Cahier Recherche et Pratique* 2(1) : 20-23.
24. Faravelli C, Giugni A, Salvatori S, Ricca V (2004) Psychopathology after rape. *Am J Psychiatry* 161(8): 1483-1485.
25. Thompson KM, Wonderlich SA (2004) Child sexual abuse and eating disorders, In J.K. Thompson (Ed.) *Handbook of eating disorders and obesity*, Hoboken NJ: John Wiley & Sons, USA 679-694.
26. Fischer S, Stojek M, Hartzell E (2010) Effects of multiple forms of childhood abuse and adult sexual assault on current eating disorders symptoms. *Eat Behav* 11(3): 190-192.
27. Lejonclou A, Nilsson D, Holmqvist R (2014) Variants of potentially traumatizing life events in eating disorder patients. *Psychological Trauma* 6(6): 661-667.
28. Collin-Vézina D, Daigneault I, Hébert M (2013) Lessons learned from child sexual abuse research: prevalence, outcomes and preventive strategies. *Child Adolesc Psychiatry Ment Health* 7(1): 22-30.
29. Lyubomirsky S, Sousa L, Casper RC (2001) What triggers abnormal eating in bulimic and nonbulimic women? *Psychology of women quarterly* 25: 223-232.
30. Fallon P, Katzman MA, Wooley SC (1994) *Feminist perspectives on eating disorders*. New-York: Guilford Press.
31. Legrand D, Taramasco C (2016) Le paradoxe anorexique: quand le symptôme corporel s'adresse à l'autre. *L'Evolution Psychiatrique* 81(2): 309-320.
32. Selvini-Palazzoli M (1986) Toward a general model of psychotic family games. *Journal of Marital and Family Therapy* 12(4): 339-349.
33. Jeammet P (2010) *Anorexie, boulimie : les paradoxes de l'adolescence*. Paris : Librairie Arthème Fayard/Pluriel.
34. Kestemberg E, Kestemberg J, Decobert S (1972) *La faim et le corps*. Paris : PUF.
35. Sullivan PF, Bulik CM, Fear JL, Pickering A (1998) Outcome of anorexia nervosa: A case-control study. *Am J Psychiatry* 155(7): 939-946.
36. Jeammet P (1991) Dysrégulation narcissiques et objectales dans la boulimie, In B. Brusset, & C. Couvreur (Eds.), *La Boulimie*. Paris : PUF 81-104.
37. Rogers CR (1957) The necessary and sufficient conditions of therapeutic personality change. *Psychotherapy* 44(3): 240-248.