

SOCIO-PSYCHOLOGICAL ASPECTS OF ANOREXIA NERVOSA

IVAN HARINGA

Faculty of Arts, Department of Romance Studies and German Studies
Constantine the Philosopher University
Trieda A. Hlinku 1, 949 01, Nitra, Slovak Republic
E-mail address: ivan.haringa@ukf.sk
ORCID: <https://orcid.org/0000-0001-6447-6903>

LAURA JANÁČKOVÁ

College of Applied Psychology
Akademická 409, Terezín, 411 55, Czech Republic
E-mail address: janackova@vsaps.cz
ORCID: <https://orcid.org/0000-0002-0868-5580>

KAMIL KARDIS

Department of Philosophy and Religious Studies
Greek Catholic Theological Faculty, University of Prešov
Ul. Biskupa Gojdiča 2 08001 Prešov, Slovak Republic
&
The State University of Technology and Economics in Jaroslaw
Czarnieckiego 16, 37-500 Jaroslaw, Poland
E-mail address: kamil.kardis@unipo.sk
ORCID: <https://orcid.org/0000-0002-2457-6667>

MARIA GAŽIOVÁ

Faculty of Theology, Theological Institute
Catholic University in Ružomberok
Spišská Kapitula 12, Spišské Podhradie, Slovak Republic
E-mail address: maria.gaziova@ku.sk
ORCID: <https://orcid.org/0000-0003-4262-5618>

APAKINA LIUDMILA VYACHESLAVOVNA

Russian Language Department, Institute of Russian Language
Peoples' Friendship University of Russia (RUDN University)
Miklukho-Maklaya 6, 117198 Moscow, Russia
E-mail address: apakina-lv@rudn.ru
ORCID: <https://orcid.org/0000-0003-2595-2641>



ABSTRACT

Aim. The main aim of the research is to identify and evaluate the quality of life of patients with an eating disorder – anorexia nervosa. In an analytical and descriptive way, the authors determine the level of various areas of life of patients who suffer from anorexia nervosa.

Methods. The subjects of the study were participants suffering from anorexia nervosa. Based on qualitative research through unstructured interviews, the authors carried out causal case individual investigations, which they classified according to anamnesis, diagnostic tools and areas, which they evaluated based on the statements of the participants.

Results. The analysis shows that anorexia nervosa affects different areas of life. It is a lifelong problem that has a huge impact on the physical, psychological, and spiritual side of a person.

Conclusion. The study deals with the various elements of anorexia nervosa, which ultimately affects a person for life. Through definitions and interpretations of the authors' research results, we can confirm that it has multi-problematic consequences for the categorised areas of an individual's life, for the family and the groups in which they live.

Keywords: anorexia nervosa, case report, manifestations, eating disorder, psychosocial consequences

INTRODUCTION

Anorexia nervosa (and - no, without: orexia - appetite, effort) is one of the most serious eating disorders. Anorexia nervosa is a disorder characterised mainly by the deliberate reduction of body weight (Krch, 1999; Pápežová & Hanusová, 2012). Sufferers of this disorder try to reduce food intake to the absolute minimum. In the beginning, the appetite is consciously suppressed. Subsequently, absence of appetite, the feeling of hunger is weakened, and only then does the lack of appetite set in. The disorder commonly occurs in girls aged 13 to 20 (Budayová, 2021; Ladishova, 2006;).

Girls with this disease are mostly adaptable, successful at school, perfectionists, but after a while they get into trouble with their parents, lie more often and refuse to admit that they have a problem. We can consider the case when a ten-year-old girl suffers from anorexia, but also c, a forty-year-old woman, and nowadays, we meet boys with this eating disorder. However, for boys or men who suffer from anorexia, the term "Manorexia" is more frequently used.

CONSEQUENCES OF EATING DISORDERS

Eating disorders can cause a wide range of health and social complications, which are primarily related to weight loss. Physical problems of an insufficient diet or the desire to pass as quickly as possible interferes with everyday life (Marádová, 2007). The consequences of anorexia nervosa are individual.

Their severity depends primarily on the extent and intensity of the patient's outbreak and how underweight she is. It is generally reported that a third of anorexic patients die. Another third will be completely cured and a third will stick to diets for life (Krch, 2002). The effect of anorexia nervosa can be divided into two main categories. These are health and psychosocial consequences.

Physical consequences:

- increased sensitivity to cold, danger of hypothermia (Dušek et al., 2010; Tkáčová et al., 2023);
- dry, yellowed, cracked skin, increased hair growth all over the body, hair loss. Different rashes can form, bruises are very frequent. About a quarter of people have thin, scaly to dry skin with reduced collagen;
- metabolic changes, slowing of gastric emptying;
- increased tooth decay;
- changes in the cardiovascular system (anemia, low blood pressure, increased blood cholesterol level);
- various sleep disorders (scary dreams, insomnia), sensitivity to light and sounds (Krch, 2002; Maturkanič et al., 2022).

PSYCHOSOCIAL CONSEQUENCES OF ANOREXIA NERVOSA

Anorexia nervosa also significantly disrupts the psychological system, the personal and social life of the patient. According to František D. Krch (2003, 2005), these are primarily the following consequences:

- changes in mood are dependent on body weight and degree of self-control. Initially, anorexics tend to be very active and lively, their moods are low, depressed and even irritable;
- uncertainty, anxious feelings (even small problems seem insoluble) (Doner & Plog, 2000).

THE SOCIAL WORKER AND HIS PLACE IN HEALTH FACILITIES

Anna Tokárová (2007) defines a social worker as a professional (professional, qualified person) who deals with social assistance to individuals, groups or minorities who temporarily or permanently find themselves in a problematic social situation that requires social intervention. Through its ordinal activities, it helps to improve the life functionality of an individual, group, or minority by contributing to the mobilisation of resources that are necessary for such a solution. According to Martina Mojtová (2008; Judák et al., 2022; Marková et al., 2006; Petrovič & Maturkanič 2022), the work of a social worker in healthcare facilities consists in helping to improve the patient's conditions during and after hospitalisation, in solving disturbed relationships and situations that arose in the individual's life as a result of injury, illness, harmful habits, social conditions and old age.

Stages of a social worker's work in healthcare facilities according to Martina Mojtoová (2008):

- *1st stage - First contact with the patient.* The social worker must first familiarise himself with the patient's medical documentation. He keeps his opinion about the patient to himself. During the first meeting with the patient, the worker introduces himself and explains what help he can provide. This first meeting actually serves to establish a therapeutic relationship. In this relationship, the patient must understand the mission of the social worker notwithstanding in what circumstances the mutual meeting took place (whether at the initiative of the social worker or from the client, or at the recommendation of another health worker). At this stage, the method of individual interview is used;
- *2nd stage - Establishing a social diagnosis.* We utilised the structured interview method, in which the social worker detects psychosocial anamnesis, key information about the problem, about the client and his family, school, work, partnership achievements and problems identification data, family background, hygiene, eating habits, client's relatives, education, economic and social support, place of residence:
 - a) information about the impact of the disease on the client's life and his family;
 - b) noticing non-verbal expressions (crying, laughter, aggression, emotional behaviour).

The social worker adapts to the client's language. For the purpose of adaptation to client he utilises conversation, listening, observation and paraphrasing.

- *3rd stage - Solution proposal and assistance plan.* In this stage, the social worker develops a plan according to which social assistance will be provided to the patient and applies it to the therapeutic plan. He must further inform other members of the medical team about this activity;
- *4th stage - Intervention and social therapy.* This method is based on the needs of the client as ideal, and the social worker is responsible for finding solutions that are beneficial for the client. Frequently, intervention is established on the needs, possibilities and abilities of the client and the possibilities of the organisation (Bursová, 2021; Kondrla et al., 2023). The social worker uses the whole range of social work methods, he must accept the confidentiality of information as well as the anonymity of the client. However, a social worker cannot differentiate between clients, he should approach them individually and should use their strengths (Judák et al., 2022; Mojtoová, 2008);
- *5th stage - Termination of cooperation:*
 - a) control the effectiveness of social work methods used;
 - b) complete or partial solution of the given problem;
 - c) termination of cooperation between the social worker and the patient;

- d) referral to another expert in the given field (Králik et al., 2022; Mojtoová, 2008).

CASE REPORT 1

In the first case study, we present a single man aged 21, a 3rd-year student at the University of St. Cyril and Methodius in Trnava.

Personal History

His psychomotor development was adequate, without characteristics. L attended kindergarten and elementary school. He completely graduated from gymnasium and is currently studying at university without any problems. As a child, he disliked team sports. Respondent was engaged in swimming, diving, skiing and ballroom dancing. Due to the regularity of movement and the rigours of training, his weight decreased, but it was normal.

Medical History

L was born in February 2002, he was a baby born by choice. His mother did not suffer from serious diseases during her pregnancy, she was healthy. The birth itself took place without problems or complications. He went through the usual illnesses in childhood, but nothing serious. Later, at the age of 4, our respondent was diagnosed with toxoplasmosis due to contact with animals.

Family History

- The mother is 47 years old, works as an entrepreneur in Trnava, devotes herself to cynology, healthy eating and swimming. She is healthy;
- Father is 48 years old, works as an entrepreneur with company headquarters in Topoľčany. He is engaged in competitive shooting, diving and skiing. He is healthy;
- L grew up in a complete family in a harmonious environment. The coexistence of the parents is described as beneficial. The relationship between the parents and the child is friendly. None of the relatives suffered from eating disorders and none of them received psychiatric treatment.

Course of the Disease and Intervention by a Specialist

The school environment at primary school was not a problem for him and the preparation for teaching was optimal. Food intake was regular. Participant L had lunches in the school canteen and home-cooked dinners. "A significant change in weight occurred, when L enrolled in gymnasium," states L. Our participant had an enormous issue with physical education, where students had to weigh and measure themselves in front of the whole class. This caused him enormous stress and hence L tried to reduce his body weight by various means. L's weight was 65 kg with a height of 156 cm (BMI-

26.71). During this period, his diet was reduced to only lunches, which he had in the school canteen. With the onset of puberty, interviewee faced the influence of a popular idol who weighed 50 kg at his height of 170 cm (BMI 16.33). Participant wanted to get a more serious acquaintance, but he did not succeed and began to fall into depression. It was during this period that our male interviewee had a significant turning point. All the stress started building up and L lost extreme weight. L reduced his food intake to a vegetarian diet, excluding breakfast and dinner. Our interviewee had to practice eating lunch with his family accounted the fact that L was under the supervision of his parents. Our male participant stopped using the school canteen, he hid homemade food in the absence of his parents and threw it in the bins. His temperament changed to melancholic and his behaviour to submissive. The weight dropped from 65 kg to 45 kg. A significant weight loss was noticed by the district doctor during a preventive check-up. L The doctor instructed and explained to him the consequences of this disorder. Our male respondent recommended the parents visit a clinical psychologist. Based on the interview method, he concluded that family therapy and self-help are necessary. In this case, there was no need for psychiatric hospitalisation and setting the patient up for pharmacotherapy. During this phase of weight loss, L was unable to lift normal objects and had trouble handling wind gusts. The consequences of this disorder were significantly reflected in his height, which was interrupted at the age of 15, changing to 161 cm. L realised what other consequences could occur if his weight continued to drop. Based on the appeal, regular check-ups by his parents and a clinical psychologist, his weight increased to 50 kg with a height of 161 cm (BMI-19.29). Meanwhile, his eating habits returned to normal. Gradually, L began to eat regularly, but he had a problem with eating in public.

Current State

Currently, L has no problems with eating, our male participant is stabilised. L weighs 55 kg with a height of 161 cm (BMI-21.22), which represents the optimal weight, considering his age and height. According to the recommendation, he continues to visit a clinical psychologist who, using the interview method, motivates the patient towards a healthy lifestyle. Our male respondent manages his studies at the university without any problems and likes to be involved in volunteer activities of a non-profit organisation to help animals. Nowadays, he practices a vegan diet, has no health problems and has been in a loving relationship for three years. In the future, he will not have the prerequisites and opportunity for relapse.

CASE REPORT 2

In the second case study, we present a single woman aged 31 hospitalised in a psychiatric ward with a medical diagnosis of anorexia nervosa. She is

a student of an unnamed university, informed about the treatment regimen and her acute condition.

Objectively: The patient is calm, the mood rather depressed, oriented in place, time and person. The patient's contact and answers are adequate, the speech is slow, quieter, serious, the psychomotor pace is adequate. The patient is tense, furthermore there is also impaired concentration of attention and fatigue. Critical of the disease, she is interested in undergoing treatment and solving her problem. Vital signs: BMI: 100/55 Height: 169cm P: 62/min., regular Weight: 39.5kg D: 15/min., clean BMI index: 14 TT: 36.4°C

History: The patient was admitted to the psychiatric ward on 5/1/2014 as an acute condition. B came accompanied by her mother based on the recommendation of an outpatient psychiatrist. Patient repeatedly treated in a psychiatric ward. A depressed mood dominates at reception. At home, our participant is often irritable and conflicted. A significant deterioration has been observed for a month. The patient eats very small amounts because she has dyspeptic problems after consuming even a small amount of food. Participant reports a fear of gaining weight, while she often has remorse after eating and the urge to exercise. Secondary amenorrhea is also present.

Personal history: 20-year-old patient, single, childless, student, comes with 4 siblings, from a divorced family. Overcame more serious illnesses: common children, without consequences Hospitalisations: 1x in the psychiatric ward, lactose intolerance.

Family history: Mother and siblings are healthy. The father is addicted to alcohol without other serious illnesses.

Social anamnesis: The patient currently lives with her mother and siblings in a 3-room apartment. The patient states that she misses her father very much accounted the fact that she moved away from them. Family relations are otherwise good, everyone tolerates and helps each other. Her eating problems started in high school when she started going to pageants and experiencing stressful situations. At that time, she weighed 52 kg, and within 3 years she had lost 13 kg. B began to have problems with learning, lacked the ability to concentrate furthermore felt significant fatigue. The patient started to be explosive, while she screams every time, she gets upset even over little things.

Therapy: Mirzaten 30mg 0-0-1 Seroxat 20 mg 0-0-2 Degan 1-1-1 half an hour before meals. *Assessment:* According to the patient, health is currently one of her most important values. She admits her mistake and is determined to change her lifestyle. B states that she had "no energy for the usual activities of her daily life. She liked to swim, play tennis, which she can't handle at the moment."

Nutrition and metabolism: The patient has significant problems with eating. The patient eats in limited portions because she is afraid of gaining weight and that her friends will consider her fat. Lately, I've also had trouble keeping down the food I've eaten, she stated. Within an hour after eating even a small amount of food, she feels heavy and subsequently vomits everything. The patient does not use laxatives.

Excretion: B has diarrhoea more often due to lactose intolerance. Otherwise, she does not state any problem.

Activity, exercise: The patient has remorse after eating and frequent urges to exercise. Otherwise, in her free time, she draws and likes to go for walks in nature.

Sleep, rest: I usually have no problem with sleep, states B. Sometimes she can't fall asleep, but otherwise without difficulty.

Perception, cognition: The patient is person-, place-, and time-oriented. She reports difficulty with memory and also has issues with concentration. Respondent often forgets and cannot concentrate.

Self-perception, self-image: The patient currently perceives herself as "normal", but she is afraid of gaining weight. B is worried that she will be fat and, that people will stop talking to her. Now she is happy with herself. The patient states that she could gain 2-3 kg, but she always has a stomach ache after eating and throws up everything.

Role, relationships: The patient is single. She had one more serious relationship, which she ended, but she does not want to communicate further on this topic. Respondent has a positive relationship with her mother and siblings. She had not seen her father for a long time. B has moved away and is not interested in establishing further contacts. The patient has one very good friend with whom she spends most of her time. B generally has great relationships at school.

Reproduction, sexuality: She refuses to communicate on this topic.

Adaptation, resistance to stress: B started to feel stressful situations in high school, when she started going to competitions. Subsequently, she started having problems with eating. Participant refused food, isolated herself more from her surroundings.

Value orientation, religious beliefs: The patient is religious, but does not go to church. The greatest value in her life is her family.

Table 1

Entrance test before hospitalisation in a psychiatric ward

Question	Patient	
	Yes	No
1. Do you know the reason for hospitalisation in the psychiatric ward?	Yes	No
2. Do you feel that you suffer from this mental illness?	Yes	No
3. Do you feel tired?	Yes	No
4. Do you know ways to manage and prevent fatigue?	Yes	No
5. Do you have a positive attitude towards your appearance?	Yes	No
6. Do you feel lonely?	Yes	No
7. Are you satisfied with your relationships with people around you?	Yes	No
8. Do you know ways to alleviate loneliness?	Yes	No

Source. Own research.

Analysis and Interpretation of Data: After previous hospitalisation in the local department, the patient was re-admitted in an acute condition for an eating disorder. In the first days, the patient is under constant supervision when consuming food. Observes regularity and adequate amounts of food. From the beginning with difficulties, because after every meal our female respondent has dyspeptic problems. In laboratory parameters, pronounced hypokalaemia, which was subsequently saturated by infusions with the addition of KCL. Gradually, there is an emotional recovery, relief of dyspeptic complaints, a slight increase in weight. The patient is involved in occupational rehabilitation. The patient completed an individual interview with a psychologist. She keeps a food diary, where she writes down everything she ate during the day, how she felt before and after eating. The patient gradually managed the regime treatment without major difficulties. In the case of the patient, based on the entrance test, we found that she is critical of her illness and understands the reason for hospitalisation. However, she does not have sufficient knowledge regarding ways to relieve fatigue and also does not have a positive attitude towards the appearance of her body. The patient feels lonely, dissatisfied with relationships, with people around her and does not know ways to alleviate loneliness.

SUMMARY OF CASE REPORTS

After reading the case reports of individuals suffering from anorexia nervosa, we can conclude that the disorder brought them more than one social consequence (Martin et al., 2022). As a result of the case reports, we selected the most common social and personal consequences that affected the respondents and influenced them.

The Area of Family Relationships and Relationships with the Environment

From this particular survey, it follows that family and relatives can be one of the factors that trigger anorexia nervosa. Respondent L had a positive relationship with his family since childhood. His parents taught him basic things, prepared him for teaching, built his relationship with animals and society. In a way, they helped him socialise. His relationship with society is quite positive, his relatives respect him. In the case of L, we would not see disturbed relationships in the family. However, that was not the case with respondent B. She comes from a dysfunctional and divorced family, where she was not noticed much. Nevertheless, she has a positive relationship with her parents, even if she has her own opinion about them. When B was three years old, her parents divorced - we could consider this as the primary trigger of anorexia nervosa. This action could also be described as childhood trauma. B's relationship with the environment is quite positive, even though society does not take her very seriously due to her primary

and serious disorder. The social consequences here are broken bonds in families and deteriorating relationships with the closer environment, which can lead to social exclusion (Budayová et al. 2022).

Impact on Partner Life

We learned from the participants that during puberty they wanted to establish serious relationships, but they did not succeed and fell into depression. L does not have a partner relationship, as our male participant has had it for three years and even sees its future. In the case of B, we were not convinced that this is the case. B told him that she still has a problem and is not able to establish a partner relationship at all. This problem is attributed to her by society and the family environment, where she sees a kind of boil in her mother. Since as a child she had to face the divorce of her parents, our female participant subconsciously wrote down a certain unreasonable ideal of women, and despite this, she built a relationship with a man, which, however, deteriorated after a year. In the case of our male respondent, L can predict that B will continue to have a problem with establishing a relationship with a partner. Problems also arise with the so-called multiplication of problems, which accumulate and can cause multiple problems in any aspect of life (Budayová & Ludvigh Cintulová, 2021; Lešková & Uhál 2020).

The Area of the School Environment and Contact with the New Environment

In both cases, we noticed a problem with contact from the school environment. They considered the very interaction with their classmates stressful and thus became the target of ridicule. As we have already mentioned above. L had a big problem with physical education, where they had to change clothes in front of the whole class. It had a stressful effect on him, so he tried to lose weight as quickly as possible so that the future weigh-in would not be depressing moreover he lacked the ability to face ridicule from his classmates. Case B was not so stressful from the side of physical education, but she also suffered a setback from the side. However, the difference between the case in this area lies in the fact that only at first she used extremely reduced weights and excessively lavished fitness centres practiced drastic diets during which B lost extreme weight. Contact with classmates was negative for both and even conflicted with B and L, in contrast to case L, continues his education at university, where he no longer has a problem with the relationship with his colleagues (Kondrla et al., 2022; Petrikovičová, 2022). They respect him, motivate him so that there is no relapse. After graduating from high school, B started her own salon, where she gets along well with clients. Here we can point out how negative relationships from the school environment affect specific cases. The specific effects of mocking classmates were reflected in the psyche of individuals through mental anorexia.

Health Area

We can also consider their health as the result of anorexia nervosa in both respondents. During anorexia, their growth stopped at a height of L-161 cm and B- 165 cm. Furthermore, their anorexia was also manifested in their body hair. After being cured of the disorder, they are no longer able to accept food in public, but in the case of L, it has improved. Since B regularly consumes sedative medications, her sleep cycle takes too long and she cannot wake up on time and goes to work only after two o'clock in the afternoon. L also had a problem with his sleep cycle despite not taking medication.

Social Area

There are certainly many more social consequences associated with anorexia nervosa. In the interview, we focused on the areas that we consider the most important and where these consequences were most visible. At the end of the practical part, we can state that the first case will not relapse, but second case B may relapse in the future. The situation of these social work clients also worsened sharply during the Covid-19 pandemic situation, as the reduced availability and low availability or even non availability of social contact, and hospitalisation facilities could cause a deterioration of their physical and psychological condition (Ludvigh Cintulová et al., 2022; Maturkanič, Čergeťová, Králik et al., 2022; Maturkanič, Čergeťová Tomanová, Majda et al., 2022; Tkáčová, Pavliková, Jenisová et al., 2021; Tkáčová, Pavliková, Tvrdoň et al., 2021).

An expert in the field of social services should ensure and suggest suitable treatment for the sufferer after consultation with another expert. It should be a kind of support for the client, whom he represents and accompanies during resocialisation and inclusion in society with normal eating habits. When contacting a client suffering from anorexia nervosa, bulimia nervosa or another eating disorder, the social worker should also provide suitable equipment for treatment. However, there may be a problem, because Slovakia, compared to the Czech Republic, does not have social facilities or helplines aimed specifically at helping those suffering from eating disorders. In the neighbouring state, the Anabell Civic Association has even been established, which provides various types of services, such as counselling, telephone and crisis assistance, therapy, and others. Employees of the association provide clients of the department with medical and social assistance and, upon agreement with the sufferer, also possible treatment (Roubalová et al., 2021). Authors such as Libuša Radková et al. (2022; Kobylarek et al., 2022; Lešková et al., 2022; Ludvigh Cintulová et al., 2022; Tvrdoň et al., 2022) also point to unfavourable socio-pathological phenomena that occur even in a war conflict and which may have an unfavourable increasing ratio among the youth.

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