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PSYCHOLOGICAL FACTORS INFLUENCING THE FORMATION OF ANOREXIA NERVOUS

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Annotation
Over the past decade, there has been a significant increase in the number of patients with eating disorders, which is a very serious problem. This issue attracts great attention of scientists, since, according to the results of a ten-year observation of the follow-up data of patients, due to multiple somatic disorders, the patient's life ends in death.

Keywords. eating disorder, anorexia nervosa, girls diagnosed with anorexia nervosa, aggressive behavior, mental disorders, personality disorders, health psychology.

Once upon a time, anorexia nervosa was still unknown; it was isolated as a separate disease only at the beginning of the 20th century. However, even Avicenna in 1155 cited a case of curing a young man, whose condition was very reminiscent of anorexia nervosa. In 1689, R. Morton described under the name "nervous consumption" the disease of an eighteen-year-old girl, who first had a depressed mood, then lost her appetite, and then the patient began to induce vomiting and stopped monitoring her appearance. The end of the disease was extreme exhaustion and then death.

The name of the disorder contradicts its essence: as a rule, appetite disappears only at its late stage; typical for patients is just an all-consuming passion for food, indicating a single mechanism for anorexia and bulimia as two forms of food addiction. The classic triad of symptoms of anorexia nervosa is amenorrhea, body image distortion, and strenuous struggle for thinness. There are two types of anorexia.With the "restrictive" type, patients do not experience regular bouts of "gluttony" or they do not resort to forced "cleansing" methods. With the "cleansing" (bulimic) type, patients regularly experience bouts of "gluttony", they use methods of forced self-purification; they are more likely to have kleptomania, alcoholism and drug addiction. Selvini Palazzoli considers anorexia as a monosymptomatic psychosis, which is characterized by the patient's conviction that his own body must be destroyed by rejecting all oral desires. She considers the condition to be familial and describes the "anorectic family" as having the following characteristics:

1) no one explicitly assumes leadership, the motivation of behavior is attributed to external factors;

2) open alliance is contrary to family morality; 3) no one takes responsibility for the family problems that accumulate as a result.

In a system where communication is so likely to be rejected, not eating is in perfect harmony with the style of interaction in the family. In particular, it is consistent with the masochistic attitude of the members of the family group, according to which the best strategy in the struggle for superiority is suffering. S. Minukhin (1998) notes other typical features in an anorexic family.

• There is a rigid model of family relationships in which loyalty to the family and its protection are placed higher than independence and self-realization.• The family is usually child-oriented, so the girl does her best to get love and attention, and ends up in a perfectionist obsessive-compulsive stance.

• The development of autonomy is retarded. Everything that the girl does is under the caring and "selfless" control of the family. Objections and own initiative are regarded as a betrayal, selflessness and loyalty to the family are encouraged.

• Relationships outside the family are not encouraged, approved, controlled.

• The boundary between the family and the outside world is clearly marked, although the boundaries within the family are not defined. The same applies to the boundaries with the families from which the parents came. Often a coalition is formed with the older generation, the child is involved in these relationships and is used as a means of avoiding conflicts.

• Much attention is paid to nutrition and somatic functions in the family.

Vanderaken identifies four vicious circles in the psychogenesis of anorexia nervosa: two at the level of family relationships and two intrapersonal.

1. Fasting is an effective means of dealing with parents. Failing to achieve attention as an exemplary child, the girl makes her parents worry and beg her to eat.

2. Excessive attention of parents to nutrition, especially if punishments and force-feeding are used, provokes vomiting and loss of appetite in the girl.

3. Appetite is reduced by.

Patients have dichotomous thinking of the "all or nothing" type, as in borderline and depressive individuals. Therefore, for example, the patient evaluates herself in the mirror either as ideal, or as fat and ugly, and on this basis considers herself weak-willed and disgusting in general. Patients with anorexia are characterized by significant emotional restraint and cognitive retardation. They prefer an ordinary, orderly and predictable environment, do not adapt well to change, and treat others with increased respect and obedience. They tend to avoid risk and respond to stress with marked arousal or strong emotions. Focus solely on the process of self-improvement. These personality traits make it difficult to adapt to puberty and life changes that are characteristic of adolescence. The course of anorexia is divided (Korkina et al., 1986; Marilov, 2004) into the following stages.

Stage 1 - dysmorphophobic, begins with the appearance of overvalued ideas of excessive fullness and fear of ridicule about this. The mood decreases, the patient has a conviction that others are critically examining him, exchanging mocking glances and

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remarks. Patients are regularly weighed, avoid high-calorie foods. This stage of the disease usually lasts 2-3 years.

Stage 2 - dysmorphomanic. Dysmorphomania manifests itself in a delusional belief in the "excessive fullness" of one's figure or its parts. Patients often look at themselves in the mirror and complain to others about their fullness.Ideas of attitude (bad attitude of others) disappear, depressive experiences decrease, attempts to actively correct the figure are observed. An important symptom is dissimulation: patients hide from others their refusal to eat and the motives for this: they pretend to have eaten all the food, but in fact they discreetly shift it to other plates.

Stage 3 - cachectic (Greek kachexia - general depletion of the body) can occur 1.5–2 years after the onset of the disease. Appetite disappears, because due to constantly induced vomiting, which can also occur reflex immediately after eating, the acidity of gastric juice decreases and general dystrophic disorders appear.

Anxiety about somatic disorders can lead to hypochondriacal feelings, which also contribute to malnutrition. Thus, a kind of vicious circle arises in the form of anorexic cycles, when chronic starvation causes changes in the internal organs, leading, in turn, to food restrictions. In some cases, patients begin to be actively examined by various specialists, exaggerating the severity of somatic disorders and avoiding consultation with a psychiatrist.

With adequate treatment in a psychiatric hospital, as patients recover from cachexia, asthenia and adynamia decrease, psychopathic manifestations come to the fore, especially in relationships with loved ones.In the absence of treatment, almost half of the cases have a chronic course, in 10–20% of cases death occurs as a result of exhaustion, heart failure, secondary infections, and suicide. In men, anorexia occurs with severe senestopathic hypochondriacal symptoms, often with the formation of persistent hypochondriacal delusions that have lost their thematic connection with previous dysmorphomanic experiences. There is also a pronounced psychopathic syndrome and secondary alcoholization. Sick men are much less likely than women to induce vomiting and never get physiological pleasure from it. In premorbid men, a combination of schizoid and asthenic character traits is noted, while asthenic and hysteroid traits predominate in women.

Despite significant exhaustion, patients with anorexia nervosa appear bright, cheerful, energetic and indefatigable. In addition, most are unaware of the threatening nature of their eating behavior. Common signs of anorexia nervosa are an obsessive fear of losing control, lack of anxiety about stopping periods, constipation, and classic "good girl" behavior. Obsessional disorders are also manifested in the girl's desire to remain passive and dependent. Although poor appetite and weight loss may be due to severe depression, depression is not required in patients with anorexia nervosa. The patient's family has frequent cases of depression, alcoholism or eating disorders.

Cognitive therapy can also be recommended. Cognitive therapy has the following goals: the patient must learn to register her own thoughts and understand them more clearly. She must be aware of the relationship between certain dysfunctional thoughts,

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wrong behaviors and emotions; analyze their beliefs and check their correctness, form realistic and adequate interpretations and gradually modify misconceptions. The therapy is especially effective in cases of marked tendencies towards the chronic course of the disease; it should focus on dysfunctional ideas about appearance, nutrition, and weight. At the same time, the cognitive foundations of low self-esteem, feelings of inferiority, and a deficit perception of oneself are being corrected.

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