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Reflections on patients diagnosed with anorexia and bulimia nervosa in the context of subjectivity, self-acceptance and freedom as sources of dignity

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Summary

The aim of the article is to draw attention to problems of patients diagnosed with anorexia and bulimia nervosa in the context of dignity. While considering the patients' problems from the philosophical perspective the author of the article pays attention to such sources of dignity as self-esteem, subjectivity, self-acceptance and freedom among others. The author also analyses chosen terms that patients and some therapists use and raises questions concerning the meaning of narration in the therapy of patients with eating disorders. The article is of demonstrative character. The author bases her reflections on the chosen philosophical concepts concerning dignity and violence. Another source of the author's opinions is many years of clinical and therapeutic practice.

As a result of the conducted analyses the author demonstrates that the symptoms of anorexia and bulimia, considering their specificity, may hamper, limit or prevent experiencing dignity.

Anorexia and bulimia nervosa may violate patients' dignity. Within the scope of personal dignity, they violate the sense of self-esteem. They disturb the ability to self-control and objective self-assessment as well as the ability to analyse achievements and failures within the scope of an active attitude. On the other hand, within the scope of freedom, they hamper or prevent the freedom of choice: in the sphere of thinking, emotions or behaviours.

anorexia nervosa / bulimia nervosa / dignity

INTRODUCTION

Anorexia nervosa (AN) and bulimia nervosa (BN) are disorders which have multi-factorial basis and occur mainly in girls during puberty and young women. The causes of the condition include biological, psychological, personality and socio-cultural factors. As multi-factor diseases, AN and BN are described in different contexts: medical, psychological or socio-cultural among others. The author of the article has decided to analyse the aforementioned eating disorders (ED) considering the problems of patients diagnosed with AN and BN in the context of dignity from the philosophical perspective. While taking the patients' problems into consideration from this perspective the author analyzes such sources of dignity as self-esteem, subjectivity, self-acceptance and freedom among others. The notions of subjectivity and self-acceptance are the dimensions most often described in the psychological context. The author of the article by assumption does not focus her attention on the described psychological reports because she intends to draw attention to psychological problems of the patients in the ethical-philosophical context including the narrative aspect. One of the author's goals is among others to draw at-

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tention of therapists to factors that may violate the sense of dignity of patients with ED in the process of therapy. She has been inspired to examine eating disorders in the context of dignity by many years of clinical and therapeutic experience in working with patients diagnosed with AN and BN. For over twenty years, the author has been working therapeutically in a team and individually: at the Child and Adolescent Psychiatry Clinic, Poznan University of Medical Sciences and the Eating Disorders Outpatient Clinic. She conducts individual, group and family therapies of child and adolescent patients, specialising particularly in the therapy of patients diagnosed with ED. The author works in the systemic paradigm. Her therapeutic work is supervised by the Polish Psychiatric Association supervisors.

DIGNITY

Human dignity (dignitas hominis) may be considered as a philosophical and psychological notion as well as in a legal sense. The first ideas of dignity were formed in ancient Greece. Dignity was discussed by Aristotle, the originator of the term „ethics", Immanuel Kant and Friedrich Nietzsche among others. Kant wrote among others that autonomy is the basis of human nature dignity. Nietzsche emphasised that the utmost good is life and all actions contributing to dynamic development of an individual [1]. In the Renaissance the issues of dignity and freedom, including the freedom of mind, were also brought up by a French writer and humanist philosopher Michel de Montaigne [2]. Karl Theodor Jaspers, a German psychiatrist and philosopher, a major exponent of existentialism concentrated in his philosophy on existence describing it as the experience of freedom and possibility which constitutes the being of an individual who is aware of "the encompassing" by suffering, conflict, guilt, chance and death. The Jaspers' concept includes discovering one's own "existence" by experiencing such values as: courage, dignity, faithfulness, solidarity, responsibility, autonomy [3, 4]. Jaspers considered the so called „boundary situations". According to him, the basic boundary situations are: being always in some kind of a situation, suffering, fighting (including the so-called fighting for love), guilt and death [3, 4]. Jaspers argues that our own death cannot be experienced by us, it is absolutely unknown and the perspective of our own death helps us understand the hierarchy of values which is characteristic of "existence". „At death's door differentiating between what is less important from what acquires greater importance takes place. What is significant belongs to "existence", thus the authentic dimension of human life. On the other hand, what is solely connected with empirical being diminishes in importance" [4]. Attitudes towards death are accompanied by anxiety. „Jaspers mentions two types of anxiety – corresponding with two dimensions of human life: empirical and non-empirical. They are: "empirical" and "existential" anxiety. The former is caused by the fear of non-existence […] Existential anxiety, on the other hand, through realising that empirical being is only a certain manifestation of reality which is realised in different ways, is reflected in the fear of complete annihilation, also in a non-empirical dimension" [4]. According to the author of the article, within the framework of Jaspers' philosophical concept hypotheses emerge that are connected with functioning of patients with ED, particularly the ones diagnosed with AN. Patients with this disorder often function "between life and death", thus the hypothesis may be put forward that they experience "border situations". The author notices, basing it on clinical experiments, that the majority of patients do not verbalise either the sense of a life threatening situation or fear of death, whereby it does not mean that they do not experience this fear. It happens, however, that patients with a very low BMI, below 13 BMI, report anxiety and sometimes fear, not so much of death but rather of "further life", in connection with felt drop in strength. In the context of the Jaspers' concept, a tempting hypothesis emerges that due to egosyntonicity of AN patients may experience existential anxiety in fear of complete annihilation. According to the author of the article, a detailed overview of approaches from different periods and movements in philosophy that have delineated the subject of freedom and dignity as well as the analysis of the chosen philosophical concept would be a very interesting and inspiring discourse, however, at the present moment they go beyond the scope of this arti-

cle. The issues concerning dignity and freedom have been interesting to not only philosophers but also sociologists, psychiatrists, psychologists or psychoanalysts. One of them was Erich Fromm, a German psychologist, psychoanalyst, philosopher and sociologist who paid a lot of attention in his writings to the issues of freedom and dignity. In his famous work, Escape from Freedom, Fromm pays attention to the fact that „in order to understand the dynamics of social processes we need to understand the dynamics of psychological processes taking place inside an individual; similarly, if we want to understand an individual we need to see him or her in the context of culture which shapes him or her". The thesis of the book is that „a contemporary man, released from ties of preindividualistic society which guaranteed him safety and constricted him at the same time, has not gained freedom in the sense of positively realising his own "self" – thus, expression of his intellectual, emotional and sensory abilities. Freedom, even though it has brought him independence and the power of reason, has made him lonely and, because of this, fearful and powerless. This isolation is unbearable and he can choose between either to escape from the burden of freedom into new dependencies and submission or move forward to the full realisation of positive freedom which is based on the uniqueness and individuality of man" [5]. In his book, Fromm also emphasises the meaning of the process of individuation, considering it in developmental and social contexts. In the opinion of the author of the article, Fromm's views, which concern perceiving and understanding man in the cultural context and social systems, can also be considered nowadays in the context of psychotherapy within social constructionism and systemic paradigm. In the Fromm's idea concerning the escape from freedom to new dependencies the author notices analogy in functioning of patients diagnosed with ED, especially AN. Patients diagnosed with AN, by aiming at independence and strong will, are paradoxically deprived of their own will, autonomy, freedom and independence through submitting to the dominance of symptoms.

Thirty years ago, Józef Kozielecki, a Polish psychologist, the originator of psychological concepts of man among others, also wrote about human dignity in psychology. In his essay entitled „On human dignity" professor Kozielecki wrote: „What is dignity? Although this notion is vague to some extent, like the sense of beauty, although each person constructs a different definition of dignity, in this variety of notions some common, characteristic features can be found (…) Dignity is a permanent conviction of an individual about his or her true value as a human being that is an indivisible whole: it is a moral element of the personality of each one of us. (…) Despite the fact that the notion of dignity has always played an important role in the life of an individual, its meaning and manifestations have changed along with the character of time. (…) The notion of dignity is not fixed once and for all, it changes historically like the sense of freedom or responsibility" [6].

Kozielecki distinguishes two types of dignity, that is: human dignity, connected with human rights and personal dignity as a trait of character [6].

In contemporary ethics the third type of dignity is distinguished, which is described as social or professional dignity and is connected with one of the roles performed by a person [1].

Human dignity – is described by humanists as the utmost value. Moralists and legislators form norms considering observance and abidance of dignity. The rights of civilized countries guarantee an individual physical safety, personal freedom, freedom of speech, freedom of association as well as civil rights, the right to education and work. Human dignity is described the fullest in the Universal Declaration of Human Rights from 1948.

Personal dignity – refers to the sense of self-esteem as a person who follows in one's life the preached system of values and ideals and keeps a degree of criticism in relation to him or herself and others. Personal dignity is also understood as an attitude of openness to what is new and worth appreciation. Personal dignity is described also as an attitude and a trait of character. Additionally, it is connected with the problem of subjectivity. Subjectivity is understood here as a subjective activity, forming individual „self" and making independent choices as well as searching for the meaning and sense of one's own life and values among others [1,7].

Social dignity, defined also as professional dignity – is connected with one of the roles per-

formed by a person, i.e. with a social-professional role. Social dignity refers to the model of behaviour stemming from the social-professional role of an individual and the social position he or she takes. In this sense, the individual's own dignity is connected with ethical norms included in professional ethics in general and ethical norms of particular professions. Professional dignity means respect and protection of social identity by an employee [1, 7].

In human, personal and social dignity, three sources of dignity are distinguished, i.e. the moral strength of an individual, an active attitude and the sense of freedom.

The moral strength of an individual is described as conformity of conduct with recognised moral norms and permanent self-control of one's own behaviour. In the history of philosophy moral strength has always been understood and described differently. Aristotle, presenting the thesis that man by nature is a social being, claimed that ethical courage is a certain kind of moderation and a permanent disposition of a human being. According to Kant, the utmost rule of morality is autonomy of will, which is the basis of human nature dignity and any other rational nature [1, 7, 8].

Active attitude is the second basic source of dignity. As Janusz Gajda writes, active attitude may be directed towards a person himself or herself or outside. Both forms are equally crucial [1]. Active attitude directed towards a person himself or herself is based on conscious working upon oneself, which may be manifested through contemplation, meditation, self-education as well as creative work or production. In this attitude, the ability to self-control, making demands on oneself, ability to analyse achievements and failures are important. The crucial issues include objective self-assessment, self-acceptance and respect for oneself and others. On the other hand, active attitude directed outside is connected with the act of giving. In giving oneself a person is strengthened in his or her abilities and suitability [1].

Freedom is the third condition of human dignity and the source as well as the basis of dignity. Freedom is placed very high in the hierarchy of values and ideals of a person. Positive and negative freedom can be distinguished [1].

Positive freedom, that is freedom „to" concerns leading one, attributable lifestyle that depends on the source of power and taken rules. Negative freedom, that is freedom "from" concerns the area of freedom in being and acting according to one's own will. Thus, coercion means here depriving a person of freedom. As professor Gajda writes, the essence of freedom can be described as freedom of choice, regularised by law and established norms, conditioned on a sociopolitical situation and imposed by one's own conscience. Freedom is the awareness of necessary external limitations, independent of a person as well as internal limitations defined by an individual himself or herself. Thus, freedom can be considered both in objective categories with external conditions and subjective categories with internal conditions. This distinction is based on realising the state described as "be free" and "feel free" [1]. The range of freedom in objective categories depends on such factors as socio-economic system, the form of exercising power and applicable law. Freedom in subjective categories is internal freedom in the intellectual and emotional sphere as well as making choices.

It is a completely autonomous range of freedom, without an external control and interference. This type of freedom allows for creating mechanisms of self-defence and may protect from depression and loss of dignity in extreme situations such as deprivation of liberty [1]. A particular factor violating freedom in AN and BN can be „violence" in understanding proposed by a philosopher prof. Jacek Filek. J. Filek thinks that „our participation in violence is possible in four ways: we can be a subject of violence, an object of violence, we can be both a subject and object of the same act of violence. Finally, we can be a witness of violence, not being either direct subject or object of it. The witness of violence becomes an unintentional accomplice in violence" [9]. As J. Filek writes, considering diversity of violence towards man we can talk about „physical violence, that is violence towards body, intellectual violence, that is violence towards mind as well as spiritual violence that tries to overcome one's most own existential designation. Nevertheless, it should be remembered that the most destined object of violence is will. The point is to break it" [9]. In his analysis of the „violence" phenomenon J. Filek pays attention to the grammar of the term „violence" stating that the noun „violence" in a verb form is „to overcome". And the reflexive form of the verb

"to overcome" means "that I can overcome myself, that I can constantly overcome myself" [9]. Considering violence further, J. Filek writes that „our struggle against our weaknesses is so often hopeless because these weaknesses can paradoxically have great strength. The so called weakness is often strength which the language only enchants, calling it weakness" [9]. While quoting J. Filek's views on violence, freedom and will the author of the article finds many references to intrapsychic and interpsychic struggles of patients diagnosed with AN and BN.

CHOSEN FACTORS VIOLATING THE DIGNITY OF PATIENTS DIAGNOSED WITH AN AND BN

Sharing her reflections on the dignity of patients diagnosed with AN and BN, the author of the article bases on experience and thoughts that stem from clinical and therapeutic practice. Conducting a therapy with patients diagnosed with AN and their families the author considers as particularly close to her in the systemic paradigm complementary concepts, such as: the Minuchin's concept, where a family of an anorexic is understood as a psychosomatic family, the Selvini Palazzoli's concept considering the disorder as a result of a family game and the Weber and Sterlin's concept, describing anorexia in the context of tying, delegating and the idea of sacrificing oneself, where the attention is paid to the sociocultural context and the White's concept describing the disorder in transgeneric and narrative approaches. On the other hand, in psychotherapy of patients diagnosed with bulimia the author uses among others the concept of Reich and Cierpka, where bulimia is understood as a manifestation of dual reality, contradiction and mysteries and the concept of Roberto, in which the disorder is considered in the context of intergenerational losses and legates. In the therapy of patients diagnosed with BN the author finds as particularly close to her the concept of Margret Gröne, who, in a therapy, refers to systemic thinking, social constructivism and a feminist movement paying attention among others to numerous mechanisms of a vicious circle in the functioning of patients [10, 11].

While considering dignity in the context of ED the author of the article does not so much bear in mind unseemly behaviours of patients as rather their difficulties in experiencing dignity. These difficulties concern personal dignity understood as the attitude and feature of character and are connected with the problem of subjectivity. They also concern sources of dignity such as active attitude and the sense of freedom.

The author of the article distinguishes three external factors – interpsychic and internal factors – intrapsychic which may violate the dignity of patients suffering from anorexia and bulimia. The external factors include control, criticism, lack of understanding and limitations while internal factors are described as hiding, the feeling of guilt, the feeling of shame, the feeling of failure, inner control, and alienation.

EXTERNAL FACTORS WHICH MAY VIOLATE THE PATIENTS' DIGNITY

External control and limitations are mainly based on controlling patients by parents and significant others and concern the amount of food. In AN patients are observed and controlled, their bags, lockers are very often searched through in order to find uneaten food. On the other hand, in BN, external control concerns excessive consumption of food and vomiting. In extreme cases, bulimic patients are denied access to a fridge or pantry which sometimes makes them take up humiliating behaviours as breaking into basements to eat preserves, stealing food in stores or searching for food in garbage bins. Patients are also controlled during private practices while being in the bathroom. Controlling patients who suffer from eating disorders seems to be a specific factor making it difficult to lead a decent life.

Increased external control and lack of understanding may disturb the processes of individuation, autonomy and separation. Increased and developmentally inadequate control is conducive to regressing a patient and may disturb the feeling of independence, subjectivity and free will, with using physical abuse – towards body and mental abuse – towards mind.

Criticism and lack of understanding are based on the fact that patients very often hear from their close relatives that their behaviour is reprehensible or "abnormal", that they should pull themselves together, that they waste food, that

they do not love and respect their relatives, "why they are doing this to the family", "you must have no heart" or "conscience" to behave like that, someone from the family "loses health" because of the eating disorders of a patient. Criticism and lack of understanding may influence or increase the feeling of guilt, shame and lowered self-assessment.

INTERNAL FACTORS WHICH MAY VIOLATE PATIENTS' DIGNITY

Hiding

Both in AN and BN patients hide the symptoms for a longer period of time, which is connected with a dishonest behaviour towards the closest relatives. Patients most often describe such behaviours as a „fraud" which causes the loyalty conflict towards significant others and the feeling of guilt. Hiding or „cheating" may concern both eating, that is reducing food in anorexia nervosa of restricting type or periodically excessive eating in anorexia nervosa of purging/binge-eating type. In AN „cheating" most often concerns also compensatory physical exercises and hiding the loss of weight. On the other hand, patients with BN hide key symptoms of the illness that is binge eating and vomiting. They also often hide emotions they experience, showing their environment contradictory emotions, which is conducive to feeling guilty. Feeling dissatisfaction, anger or sadness they show to environment satisfaction and happiness while experiencing at the same time lack of honesty towards their close relatives, what is connected with the feeling of guilt. Clinical observations prompt the author to raise the question whether emotions presented by patients with BN, inconsistent with the ones they experience, perform the function of a defence mechanism of reaction formation type [12].

Feeling of guilt

In addition to behaviours and situations which patients describe as „cheating", the sense of guilt makes it difficult for them to live a decent life. The sense of guilt may concern hiding symptoms and emotions from close relatives, thus it is connected with interpersonal relations. In AN and BN, the sense of guilt is also of intrapsychic character because it concerns inner conflicts and mental discomfort connected with behaviours towards the patient herself. In patients with AN the sense of guilt paradoxically triggers off the lack of symptoms, that is departure from a restrictive diet, i.e. allowing oneself to eat. It probably stems from the fact that patients suffering from AN identify themselves with symptoms while denying the illness. It means that they are satisfied with being underweight and very often its consequences while they do not feel ill.

On the other hand, in BN the sense of guilt concerns the symptoms, that is binge eating and vomiting, which patients feel responsible for, because, as they often say, they feel to be "perpetrators" of the symptoms. These behaviours, at certain stage of being ill, are accompanied by the awareness that they are incorrect and harmful behaviours and should be changed. Moreover, the dignity of life of bulimic patients is violated by identification with the illness. This identification is accompanied by weakening the feeling of subjectivity which manifests itself in belittling former achievements and resources.

Feeling of shame

Patients diagnosed with AN very often report shame concerning looks, which probably stems from the distorted perception of their body. Shame is most often connected with perceiving oneself as being too fat in general or in particular parts of the body. Another source of shame is the fact that patients deny reducing the amount of food which causes the feeling of shame towards significant others.

On the other hand, in patients diagnosed with BN shame is connected with binge eating and vomiting. Because these symptoms are connected with specific behaviours the patients feel responsible for and are ashamed of them. Patients diagnosed with bulimia are also very often ashamed of eating in the presence of other people because, in connection to the symptoms, they ascribe a negative connotation to eating food. Such functioning leads to avoiding meals during a day, what is conducive to intensifica-

tion of natural physiological hunger and may be one of trigger factors of the symptoms.

Feeling of failure

In patients diagnosed with AN, similarly to the feeling of guilt, the feeling of failure causes giving up the reduction of food, that is consuming meals. It means that the lack of symptoms is experienced by patients as a failure. Thus, a failure is weight gain, which is another departure from symptoms. It stems from the interviews with patients that they often identify refraining from eating as a manifestation of strength and will as well as "perfection" and because of that they experience giving up eating restrictions as a failure resulting from weakness, lack of will and feel "average".

On the other hand, in patients diagnosed with BN the sense of failure is most often connected with taking up a fight with symptoms as a way of dealing with the illness. However, systemic understanding of bulimia and therapeutic practice show that fighting bulimia, with strong identification with the illness, is actually a strategy based on the patient's fight with herself. Such an attitude is a source of continuous struggle with oneself and recurrent experiencing the feeling of failure.

Control

In AN patients activate inner control. However, in connection to the patient's identification with the symptoms of anorexia while denying the illness, a hypothesis may be put forward that the "inner control" paradoxically causes a situation in which a patient is deprived of free will and gives in to the control of the illness and in fact loses control over her life, emotions and behaviours concerning eating or physical exercises among others. According to the author of the article, a hypothesis may be put forward that an adolescent patient suffering from anorexia who developmentally advances in the process of individuation and separation towards freedom while at the same time suffering from anorexia "escapes from freedom" submitting herself to the authority and pressure of symptoms.

In BN, on the other hand, patients have the feeling of lack of control concerning behaviours connected with eating. The sense of lack of control is identified by the patients with the feeling of humiliation, loss of will and freedom. Generalising, the patients are convinced of the lack of influence on their own life. On the other hand, during a therapy it most often occurs that the loss of control concerns particular time, space and behaviours.

Alienation

Persons diagnosed with AN gradually resign from interpersonal relations with their peers, narrowing down their contacts to family relations. They also stop functioning in many psychosocial roles, limiting themselves mainly to the role of a daughter and pupil [11]. At the same time, aiming at independence by refusing to eat, they paradoxically become more dependent on and controlled by their parents and thus, they limit or alienate themselves from social relations [13]. On the other hand, patients diagnosed with BN, despite the fact that formally they function in different psychosocial roles, such as a woman, student, worker, friend or partner among others, actually identify themselves mainly with the role of a person suffering from BN. This identification is very often manifested by the loss of subjectivity, and is expressed in the form of thinking and speaking about oneself as a "bulimic". Patients with BN admit that even when being among people they feel alienated and mainly focus on the problem of eating.

QUESTIONS ABOUT FACTORS VIOLATING THE DIGNITY OF PATIENTS DIAGNOSED WITH AN AND BN IN THE PROCESS OF PSYCHOTHERAPY

The question arises whether psychotherapy can somehow violate the sense of the patient's dignity. The question seems both important and sensitive because, on the one hand, it concerns feelings of a patient and, on the other one, effects of professional interactions conducted in order to help a patient. While raising questions and trying to answer them hypothetically the author does not base on methodologically worked out studies that concern the issues of the sense of dignity in therapy. For many years, the issues of the sense of dignity, subjectivity and the mean-

ing of narration in therapy have been interesting to the author of the article from the clinical and therapeutic perspective, especially with reference to patients suffering from ED.

The first question concerning factors violating dignity in the process of psychotherapy is connected with the issue of subjectivity and the meaning of narration in therapy [14, 15]. These factors are usually revealed during the first therapeutic contact and the way in which a patient introduces herself and talks about her illness. It often happens that patients, when introducing themselves, say "I am an anorexic" or "I am a bulimic" or "me like anorexics" or "with me like with bulimics". Analysing these expressions from grammatical and psychological point of view several ways of talking about oneself in the context of an illness can be distinguished: "anorexic", "someone (a person) with AN", "a person diagnosed with AN" and analogically: "bulimic", "someone (a person) with BN", "a person diagnosed with BN".

It can be assumed that the expressions „anorexic" or „bulimic" are nouns identifying a person with the illness, not leaving any place for the subjectivity of a person. In expressions "a patient (person) with AN/BN" the noun referring to a person is distinguished, thus the area/place concerning subjectivity is designated: "patient-someone-person". In fact, these expressions do not indicate the range which belongs either to a subject and illness or the time in which the illness "accompanies" a person, however, they can be a basis for therapeutic work. On the other hand, the expression "a person diagnosed with AN/BN" clearly distinguishes the area, which belongs to a subject-person who suffers from a particular illness. It can also suggest "temporariness" of diagnosis.

Thus, the question arises if a therapist does not violate the subjectivity of a patient and consents to or strengthens the phenomenon of "self-labelling" when he or she does not correct the patient's way of talking about her or, what unfortunately happens, uses expressions such as "anorexic", "bulimic". The author uses the term "self-labelling" in order to emphasise the tendency, which is often observed in patients diagnosed with anorexia and bulimia, to identify oneself with the symptoms of the illness and the group of people suffering from this disorder.

In AN identification with the term "anorexic" is often accompanied by a positive connotation based on the feeling of exceptionality [13, 14]. On the other hand, clinical practice shows that patients with BN perceive the identification with the illness in a negative connotation, as a shameful behaviour, failure and loss of control.

QUESTIONS ABOUT FACTORS VIOLATING IN THE PROCESS OF THERAPY THE DIGNITY OF PATIENTS DIAGNOSED WITH AN

Does it reinforce the dignity of a patient when, during a therapy, a therapist omits subjects connected with the patient's way of eating and does not pay attention to weight gain? It seems that irrespective of the paradigm of therapeutic work omitting the subject of eating and weight gain is a reflection of the attitude and behaviours of a patient. Aren't avoidance of eating, avoidance of conversations on one's own eating and avoidance of weight gain indeed pivotal symptoms of AN? Thus, if a therapist does not bring up subjects of weight and eating, irrespective of the fact whether he or she works within the psychodynamic approach or cognitive-behavioural approach or conducts a family or group therapy, does he or she reinforce either building of the patient's dignity or symptoms of the illness? [14]

If a therapist does not bring up a subject of weight and eating, then the next question arises concerning the period of time during which a therapist agrees to omit pivotal symptoms of the illness.

Or maybe in the therapy of AN it would be important if a therapist entered into a contract with himself or herself concerning how long he or she plans not to bring up the subjects of weight and eating? And, when a therapist does not intend to pay attention to patient's weight maybe it would be favourable for the somatic and mental state if a patient was in another specialist's care, e.g. an internist?

Another question concerns the connection between not bringing up the issues of eating and weight and the risk of mortality or chronicity of the illness, which is at the same time an increased risk of mortality. On the basis of clinical practice I will take the liberty to put forward a hypothesis that the patients with AN prefer ther-

apists who do not contract and contrast subjects of eating and weight. Then, another question arises, if the situation in which a patient with AN attends psychotherapy, which very often takes from several months to several years and her weight and way of eating do not change or, what is worse, she loses weight, is not an additional threat. This threat is based on the fact that, on the one hand, it reassures the family because the patient is treated but, on the other one, it is the patient's excuse towards her closest relatives that she is in therapy and does not require care or anxiety from them. Facing the fact that AN is a life-threatening disorder, a question about professional and ethical liability of a therapist who in his or her work with a patient suffering from anorexia does not show any interest in a visibly bad condition of a patient seems relevant.

The remaining factor which may violate the dignity of a patient with AN is lack of motivation to be treated that is connected with egosyntonicity of anorexia and thus, with the sense of violating the patient's autonomy. Egosyntonicity is the reason why patients feel that the illness is their identity, source of pleasure and provides them with subjective advantages which in consequence causes denying the illness and unwillingness to be treated [16, 17].

The symptoms of AN very often regress the patient's behaviours which may cause the increase of the external control and thus, weaken autonomy, separation and individuation. Therefore, a question arises to what extent the treatment, which periodically may be connected with the increase of the external control within the scope of eating and weight, violates the "will" of a patient and to what extent omitting in therapy the subject of weight and eating, that are the reflection of the patient's attitude, violate the "will" or "self-will".

Another question concerns the period of time in which possible violation of the patient's will can take place, whether it will be a specific period of therapy until gaining expected weight or a period of therapy without paying attention to eating and weight. The author of the article, in the psychotherapy of patients with AN, pays attention to what extent "will" or the so-called "strong will" of patients is their "will" and to what extent it is the "will" of the illness depriving the patients of their own "free will".

The question also arises if after finished psychotherapy, after which too low weight and incorrect way of eating have not changed, we can talk about finishing treatment. Can we say that the patient is healthy, can finish the therapy and live with dignity if her functioning in different aspects of life improves, but weight and way of eating will differ from the norm set in classifications?

The author, due to many years of work at the Child and Adolescent Psychiatry Clinic, has had the opportunity to co-author a therapy program for patients diagnosed with AN which includes the complementary use of various methods, such as individual, group and family therapies and different therapeutic paradigms, such as cognitive-behavioural, cognitive or systemic approaches. As therapeutic practice shows, a behavioural contract that is offered to patients and their families during the initial stage of the therapy raises controversies and sometimes even causes resistance stemming from the sense of limiting independence. However, during the next stages of the therapy it has turned out to be a method that has given the patients significant influence on time and course of hospitalisation [18]. On the other hand, nursing personnel is significantly responsible for executing the contract, especially as far as the consumption of meals is concerned, which is connected with the phenomenon of transference and countertransference experienced by patients and nurses. These issues are discussed in a team and individually during the process of therapy. The author is aware of transference and countertransference in a therapy whereas working systemically she uses such therapeutic methods as: reformulation, circular questions, reflective questions and the analysis of genogram [19].

QUESTIONS ABOUT FACTORS VIOLATING THE DIGNITY OF PATIENTS DIAGNOSED WITH BN IN THE PROCESS OF THERAPY

The questions that arise are mainly connected with the description of the symptoms. May detailed questioning the patient about the amount and extent of binge eating, except for the information essential to diagnose, violate the feeling of dignity? May expecting the patient to describe

precisely and with details what she eats during the bulimic symptom (while behaviours connected with bulimia are very often humiliating for the patient) be the violation of the patient's dignity? Does logging the symptoms, their frequency and extent strengthen the sense of dignity or may it be the strengthening of the fight and failures which the patient had experienced before taking up the treatment? Does concentration on the symptoms reinforce focusing on negative experiences and bans used by patients instead of concentrating on resources and positive goals? [14].

Is not concentration on the symptoms in therapy of patients with BN paradoxically the former attitude of the patient based on constant thinking about eating? Is not a therapeutic attitude towards the fight with the symptoms duplication of the former way of dealing with the illness used by a patient before taking up the treatment?

According to the concept of Margaret Gröne patients functioning in a vicious circle expect from a therapist among others to fight together with them against bulimia and at the same time accept a patient the way she is. Patients also assume that they will be able to accept themselves only when they get rid of bulimia and only after having accepted themselves will be able to get rid of bulimia. Many patients report that focusing in a therapy on symptoms is not only unpleasant to them and sometimes even humiliating but also stops the process of therapy as such [11].

Next questions arise. Do the recommendations used in therapy to make patients with BN resign completely from eating carbohydrates speed up recovery and reinforce the sense of independence and freedom or do they reinforce attempts to cut down on food restrictively and often irrationally? Does confirming the patients that bulimia is an addiction and requires a therapy modelled on treating alcoholics where different food is excluded help in recovery and regaining the sense of dignity? The posed questions stem from the previous experience of the author in work with patients with BN and a lot of information from them that concerns using the aforementioned therapeutic expectations towards them. Patients diagnosed with BN very often eat irrationally, avoid eating meals during the day, do not eat in the company of other people, do not have breakfast, also periodically exclude different products. Such behaviours, as it was mentioned earlier, can be one of the trigger factors which stem from the long-lasting hunger. It stems from the therapeutic experience of the author that what seems to be beneficial in the process of therapy is not so much concentrating on binge eating but paying attention to patients eating rationally and regularly.

QUESTIONS ABOUT THE CONSEQUENCES OF IDENTIFYING BN WITH AN ADDICTION

This question concerns identifying ED with an addiction, which is very often observed in practice. The symptoms of AN are described as „an addiction to not eating" and the symptoms of BN as „an addiction to eating". It is stated in studies that while eating, especially food that contains sugar, secretion of dopamine takes place in the similar brain areas when taking drugs. However, according to the author of the article, it is not favourable to treat AN and BN in a simplified way as an addiction. Moreover, many types of pleasures that are felt, such as music, beauty, sex or physical activity are connected with the release of dopamine similar to the reaction to a high fat meal. However, these reactions are described as a sense of pleasure and not an addiction and their formation may be connected with different mechanisms [20]. The author has omitted a detailed physiological and neurophysiological analysis of the processes of eating and addiction because it exceeds her competencies. Nevertheless, from a therapeutic perspective a question arises if, especially in bulimia, identifying the symptoms with an addiction may influence prognostic consequences connected with the conviction about chronic course of BN among others.

The view that bulimia is an addiction is quite popular among patients and persons conducting a therapy. A therapeutic consequence of such a conviction is treating patients with BN as addicts and using therapeutic interactions molded on methods of treatment of alcoholic anonymous. It very often amounts to making the ill give up particular food, such as sweets or bread among others. In the author's opinion the essential dif-

ference are the goals of therapies used in case of bulimia and an addiction. The goal of treating addictions is to give up taking harmful substances or stop self-destructive behaviours. On the other hand, one of the goals of the therapy of BN is regaining full control over eating and correcting eating behaviours, without the exclusion of particular products. As it stems from the interviews during the process of therapy, the majority of patients admit that treating bulimia as an addiction is subjectively "beneficial" and "comfortable" for them because the very fact of thinking about oneself as an addicted person may exempt them from responsibility for behaviour conducive to the symptoms, such as neglecting regular meals or other ways of functioning that are the factors supporting bulimia [21].

Moreover, in currently effective ICD-10 and DSM-IV classifications eating disorders and addictions are classified in separate categories [22, 23, 24].

CONCLUSIONS

It is difficult to answer unambiguously the aforementioned questions without the results of detailed studies. However, one can try to answer them hypothetically.

A hypothesis may be put forward that patients with ED experience deficiency of dignity. The adopted hypothesis implies the next ones, described below.

The symptoms of AN and BN very often make the patients feel externally controlled and limited as well as face criticism and lack of understanding. On the other hand, they subjectively experience the feeling of guilt, shame, failure and excessive control or alienation.

Interpersonal experiences and felt emotions may disturb the sense of subjectivity, disturb the ability to self-control, objective self-assessment and self-acceptance as well as the ability to analyse achievements and failures. Within the scope of freedom, they violate the freedom of choice in both the intellectual and emotional spheres, as well as behaviours. On the other hand, in the context of broadly understood violence [9], the symptoms of AN and BN are often connected with physical abuse (external restrictions) and mental abuse (criticism, humiliation) as well as overcoming oneself (overcoming one's own weaknesses, forcing oneself to symptoms or the fight with symptoms). Thus, the patients can be both the object and subject of abuse.

In the process of psychotherapy with patients diagnosed with AN and BN, the meaning of narration cannot be overestimated. Narration performs here a particular function because patients very often use self-labelling. It seems that not paying attention to the language patients use to talk about themselves and their illness, and what is more, using by a therapist labelling expressions such as: "anorexic" or "bulimic" may be a reinforcement of attitudes disturbing the sources of dignity: the sense of subjectivity, self-control and freedom.

ED, because of their specificity, may hamper, limit or make it impossible to experience dignity:

- Within the scope of personal dignity – they disturb the feeling of self-esteem and subjectivity
- Within the scope of active attitude – they disturb the ability to self-control and objective self-assessment, self-acceptance as well as the ability to analyze achievements and failures,
- Within the scope of freedom, they violate the freedom of choice in mental and emotional spheres as well as in behaviours.

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