

# Reception and monitoring of patients diagnosed with eating disorders: a case study at the Family Health Unity Bandeiras, in Anápolis-GO

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### ABSTRACT

Eating disorders are psychosocial problems increasingly present in the current scenario, marked by a progressive advance of globalization, which accompanies a discourse aimed at the standardization of bodies. What is preached is that the physical form determines the image that the subject assumes before society, especially women. As a result, many who do not conform to these pre-established standards end up

developing psychological dysfunctions that interfere with the way they see their own bodies. Thus, health professionals assume the responsibility to support women diagnosed with this type of problem from their arrival at health units until referral to specialist professionals. Starting from the analytical descriptive method, the present work seeks to investigate how this monitoring happens through the analysis of a case observed in the Family Health Unit Bandeiras, in Anápolis-GO, starting with a brief description of the unit's functioning and starting for a specific discussion about the case studied and about the importance of adequate professional monitoring.

**Keywords:** Eating disorders, Professional support, Family Health Unity Bandeiras.

## 1 INTRODUCTION

Eating disorders (EDs) are behavioral syndromes fundamentally represented by two main entities: Anorexia Nervosa (AN) and Bulimia Nervosa (BN). The main symptoms of EDs are excessive fear of weight gain, preoccupation with the aesthetics of the body, decreased food intake, and, in the case of BN, inducing vomiting soon after eating. In addition, some cases present the use of laxatives and diuretics (FAVA and PERES, 2011).

AN presents certain specific behavioral pictures, such as refusal to maintain body weight even in cases of underweight, body image disorder, and irregular menstrual cycles. BN, on the other hand, shows recurrent binge eating, accompanied by vomiting to compensate for the weight gained while eating. The diagnosis of bulimia depends on the behaviors occurring at least twice a week for a minimum period of three months (APA, 2003). Those diagnosed with BN also have difficulty dealing with their own emotions (ROSA and SANTOS, 2011).

Eating disorders are considered serious pathologies, and 5% of cases lead to death, due to late diagnosis and treatment (SCHMIDT and MATA, 2008). These disorders have multifactorial origin, since they can originate from biopsychosocial and historical-cultural issues (ANDRADE e SANTOS, 2009; ROSEN, 2010). Usually the first symptoms appear in childhood or adolescence, being primarily divided into two basic groups: the disorders that occur in childhood, marked by changes in the child's relationship with food (which are not necessarily related to dissatisfactions with the body, but that affect child

development), and the disorders that occur in adolescence and, more rarely, in adulthood; it is at this stage that AN and BN, also known as binge eating disorders, come into the picture.

These diseases lead to progressive weight loss or difficulty in gaining muscle mass, and are precursors to other malnutrition-related diseases. In the case of childhood disorders, the vast majority begin before the age of six (APPOLINÁRIO and CLAUDINO, 2000) and are not related to general medical conditions. Thus, the main objective of treatment is to ensure the nutritional improvement of the patient, through steps such as the evaluation of parents or guardians and the analysis of psychosocial factors.

The onset of anorexia is marked by progressive dietary restrictions and fattening foods, such as pasta and carbohydrates in general. As the years go by, the patients begin to show discomfort with their body weight, developing a fear of gaining weight. The fear of weight gain characterizes the disease and aids in its diagnosis among other illnesses (secondary anorexia or other clinical and psychiatric illnesses). The diagnosed women start to live exclusively in function of the desire to lose weight, supported by the frequent and unregulated practice of physical exercises.

On the other hand, BN is very rare before the age of 12. Its etiology shows biopsychosocial factors, and its main symptom is binge eating. At the beginning of the disease, the behaviors may be accompanied by hunger, sadness, anxiety, frustration, boredom, and loneliness (the latter appear as the condition worsens). In addition, guilt, shame, and the need for self-punishment are also manifested. People diagnosed by bulimia ingest in an amount of calories ranging between 2,000 and 5,000 calories, inducing vomiting in 90% of the cases.

The present paper brings a case analysis of a 31-year-old patient diagnosed with an eating disorder who sought help at the Bandeiras Family Health Unit.

## **2 METHODS**

This research was developed based on the analytical method of description from the gathering of information obtained through work experience in a Family Health Strategy (FHS) in Anápolis-GO. Along with the observations, readings of authors who propose to work on the theme were gathered. After systematizing the data, we began writing the article, which will be better grounded later in the Course Conclusion Paper.

## **3 RESULTS AND DISCUSSIONS**

The work was developed in the Bandeiras Family Health Unit, located at Rua Marcel Roriz de Paiva, n. 689, Vila Jaiara, Anápolis-GO. The unit has a service structure divided into three areas, as shown in the table below:

Table 01- Areas and daily attendance capacity at the Family Health Unit Bandeiras

Areas	Service Capacity
10	4.377
11	3.756
12	3.804

Source: Own (2020)

Each area has a professional team made up of a doctor, 7 or 8 community workers, 1 nurse, 1 nursing technician, 1 dentist, and 1 dental assistant,

The patient I.M.L.S., whose case was the object of investigation for this work, is 31 years old and has a history of menstrual delay that has lasted 5 years. Laboratory and imaging exams were performed and did not show any pelvic alteration that would indicate an organic cause for the menstrual delay.

When asked about stress, the patient mentioned having eating disorders. She said she sees herself as very obese, so she goes on restrictive diets and vomits in an attempt to lose weight. She reports that she has had these episodes since she was 17 years old, spends the whole day without eating, and when she does eat (at night), she stimulates vomiting.

The patient mentions dissatisfaction with her body and great difficulty in losing weight, even though she presents a clinical picture of malnutrition. Nevertheless, she has difficulties in completing tasks and maintaining physical exercises, in addition to having nightmares and crying easily. She denies having thoughts of self-extinction, loss of libido, hallucinations, or hearing voices. She claims that she has tried to see a nutritionist, but without success. She says she needs help and that no one in her family is aware of her problem.

After consultation, clinical evaluation and analysis of tests, the patient was diagnosed with an eating disorder. The patient was referred to psychiatry, psychotherapy, and nutritionist, in addition to receiving guidance on the importance of physical activity. The use of selective serotonin reuptake inhibitors was initiated, which brought the patient a partial clinical improvement. We continue to follow up with the patient while waiting for consultations with nutritionists and psychiatrists.

What draws attention is the lack of family support in a process that has lasted fourteen (14) years. It is true that the way of seeing the family in the context of fighting eating disorders has been undergoing changes over the years. Many researches seek to verify possible associations between anorexia and bulimia symptoms and family dynamics (LANE, 2002). These studies are permeated with criticism such as, for example, the lack of a consistent empirical support that allows us to affirm the predisposing character of the family dynamics in relation to the appearance of the first symptoms (since we cannot induce that the disorders are necessarily a consequence of family relationships or even of the reorganization of the domestic eating behavior).

It is worth noting, however, that the view of the family order as a risk factor for the onset of symptoms of anorexia and bulimia collaborate to the construction of a "pathologizing" discourse (SOUZA and SANTOS, 2010) that often ends up contributing for fathers and mothers to feel guilty for their children's

situation (DODGE, EISLER and DARE, 1995). However, this discourse may fall into the risk of generating a false idea of irreversibility of the situation and hinder the cure of the disease. With this, research has turned its attention to the relationship between professionals and patients.

It is important to take into account that, throughout the treatment against eating disorders, the patient may present behaviors of resistance to the processes, which generates in the professionals responsible wear out, stress and leads them to develop certain defense instruments, such as the breakdown of the professional-patient relationship, the distancing and the absence of empathic and understanding postures. Thus, professionals who deal with ATs relate their patients to scenarios of emotional lack of control, aggressive behavior, distortion of body image and neediness (GRANDO and ROLIM, 2006 *apud* RAMOS and PEDRÃO, 2013).

Given this scenario and emphasizing the importance of strengthening the bonds between patients and health professionals, it is necessary to establish health policies that encourage practices that have as a priority to ensure that the user is well received and that there is a good relationship between them and their doctors/nurses.

For Campos and Amaral (2007), the bond that is formed between health professionals and patients brings immense contributions to the outcome of the treatment and favors the participation and commitment of the user in the process, since his citizenship and autonomy as an integral and decisive being in the treatment are stimulated. In the specific case of the patient in question, her initiative in seeking help and her family's lack of knowledge about the situation show better possibilities of connection between her and those responsible for her treatment, thus offering ample opportunities for cure.

Silva Júnior and Mascarenhas (2004) classify the patient-health professional relationship in three dimensions: affectivity, therapeutic dimension, and continuity. For the authors, affectivity is configured as the dominant character of the liking that the professional has for his work and the interest for the patient as a unique and individual being. With this, the therapeutic face also emerges, characterized by the involvement of the health professional and the patient with the results expected in the treatment. Finally, continuity is related to the responsibility that the professional assumes and exercises toward the patient's health. It is up to this professional to assume the paths and orientations that the user must follow to solve his health problem; this task cannot be transferred to other bureaucracies or decision-making instances (MERHY et. al, 1997).

The refusal of patients with AN and BN in treatment makes relationships with health professionals difficult (CAMPBELL and AUSILIO, 2012). Thus, it is important that doctors, nurses, and all those involved in the process are prepared to conduct it in the best possible way, prioritizing an approach based on dialogue, friendship, and a human look at the problems that the person is facing and how this affects their quality of life. With this in mind, the Unified Health System has been developing strategies that guarantee the quality of the welcoming and offer support so that the therapeutic team knows how to deal with attacks on self-esteem and relative worsening of the clinical picture (CHANDLER, 1998).

Ramos and Pedrão (2013, p. 114) point out that another factor that can damage this bond between professionals and users is "the technical rationality implicit in the training, added to the patient's resistance to treatment. This rationality offers risks because it eliminates from therapy subjective elements that are essential and devitalizes communication between professionals and patients (MONTEIRO and FIGUEIREDO, 2009). Professional skills in cases of eating disorder treatment must be added to understanding, empathy, comprehension and interest in the patient's story. Listening and counseling are integral and indispensable parts in the search for a cure, especially in cases like the young woman in question, who does not have family support in this fight.

Ramos and Pedrão (2013, p. 115) further highlight that:

Although the empathic and understanding postures are necessary to the relationship, the wear and tear and stress caused by the patient's resistance to treatment generate defense mechanisms in the professionals, such as fragmentation of the professional-patient relationship, depersonalization, categorization and denial of the importance of the individual, distancing and denial of feelings. Thus, professionals who assist patients with AD adhere to a discourse about patients anchored in representations of lack of control, body image distortion, destructive and manipulative behavior, neediness, low frustration threshold, and need for attention.

Thus, we come to the discussion point about the competence and skill of doctors and nurses. For Campos and Amaral (2007 *apud* RAMOS e PEDRÃO, 2013, p. 117), the core of professional competence and responsibility is understood by a "set of knowledge and ethical responsibilities specific to each professional and field of professional competence and responsibility as the knowledge and responsibilities common or confluent to several professionals or specialties of the team". Thus, to enhance the results of the work performed by these professionals, it is important to delimit the core of each professional's action and promote the integration of specific modalities and complementary knowledge in clinical practice. In other words, it is considered the need to develop a team work, where each one, within their own field and respecting their responsibilities, contributes to the quality of the service provided. This brings to light the benefits of interdisciplinary work, where each professional offers his/her maximum potential.

The biomedical conception that some health professionals present gives the approaches a character that limits the articulation of knowledge and the overcoming of breaks in the team, which helps in the development of more effective methods to achieve the proposed objectives (SILVA JÚNIOR and MASCARENHAS, 2004). With this, the need to invest in a medical and therapeutic training that instructs and leads to a broad view of health is highlighted, leading to the idea that it is important to master not only biological and pharmaceutical techniques, but also, and fundamentally, the understanding of the psychological, emotional and affective conduction of the patient throughout the treatment.

#### **4 CONCLUDING REMARKS**

Throughout this experience report, we seek to analyze how the reception of patients diagnosed with eating disorders that arrive at health clinics and units happens, based on a case treated at the Bandeiras

Family Health Unit in Anápolis (GO). Anorexia Nervosa (AN) and Bulimia Nervosa (BN) are disorders that, in their great majority, appear in childhood and adolescence, and may manifest as first symptoms the desire for weight loss and some negative feelings, which culminate in body depreciation, loss of nutrients due to lack of food, and development of other diseases. We saw that the professional welcoming is essential to the quality of treatment, being indispensable a human accompaniment and empathy for the processes experienced by the user. For the continuity of these studies, we suggest a deeper analysis on how the professional training of doctors and nurses works with issues related to the psychological support of women diagnosed with this type of disorder.

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