Anorexia Nervosa through the Lens of Primary Health Care Practitioners in the Kyrgyz Republic

Нервная анорексия в представлении врачей первичной медицинской помощи Кыргызской Республики

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Original research

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ABSTRACT

BACKGROUND: Anorexia nervosa was investigated in a large number of studies. Several of the studies in our review highlighted how important it is to factor in the opinion of health care practitioners if we want to improve the quality of the medical care provided to patients with anorexia nervosa. Additionally, the dominance of studies focused on anorexia nervosa within the Western culture raised the need for cultural diversity in such research.

AIM: The present study endeavored to explore how primary healthcare practitioners in Bishkek, Kyrgyz Republic, perceive anorexia nervosa and people who suffer from it.

METHODS: The study used the qualitative approach of Interpretative Phenomenological Analysis. Six semi-structured interviews with six primary health care practitioners from Bishkek were conducted.

RESULTS: The analysis of the collected data pointed towards four themes: (1) Anorexia nervosa as a reaction to distressing events in the form of loss of appetite; (2) Attributing blame for developing anorexia nervosa by a patient to family members; (3) Local versus Western socio-cultural standards in the development of anorexia nervosa and seeking treatment; and (4) Denial of mental health disorders by patients.

CONCLUSION: The discussion of the interpreted results led us to the conclusion that the perceptions of the health care providers in Bishkek represent the common prism through which anorexia nervosa is viewed in the larger population, which is constructed out of information received from the physical and virtual environments.

АННОТАЦИЯ

ВВЕДЕНИЕ: Нервная анорексия исследована достаточно подробно. Многочисленные исследования указывают на то, что для повышения качества медицинской помощи пациентам с нервной анорексией, важно понимать, как воспринимают болезнь врачи. Отмечается необходимость культурного разнообразия в исследованиях.

ЦЕЛЬ: Цель данной работы — изучить, как врачи первичного звена здравоохранения в городе Бишкек (Кыргызская Республика), воспринимают людей, страдающих нервной анорексией, и само расстройство.

МЕТОДЫ: Один из качественных методов — интерпретативный феноменологический анализ — был использован при работе с шестью интервью, взятыми у врачей первичной медицинской помощи различных центров семейной медицины города Бишкек.

РЕЗУЛЬТАТЫ: Анализ полученных данных выявил четыре темы: (1) Нервная анорексия как реакция на тревожные события в виде потери аппетита; (2) Приписывание вины за развитие нервной анорексии у пациента членам семьи; (3) Местные и западные социокультурные стандарты в развитии нервной анорексии и обращении за медицинской помощью; (4) Отрицание пациентами наличия у них психического расстройства.

ЗАКЛЮЧЕНИЕ: Представления врачей первичного звена отражают общее понимание нервной анорексии жителями города Бишкек, сконструированное из мозаичной социокультуральной информационной среды.

Keywords: *anorexia nervosa; primary healthcare; interpretative phenomenological analysis; Kyrgyz Republic*
Ключевые слова: *нервная анорексия; первичная медико-санитарная помощь; интерпретативный феноменологический анализ; Кыргызская Республика*

INTRODUCTION

Eating disorders (EDs), particularly anorexia nervosa (AN), represent a serious threat to public health [1–4], constituting on average a prevalence of around 1% as reported mainly by westernized countries [5], with 20–40% of new cases starting during adolescence and accompanied by significant lethality [6, 7]. They affect both males and females, irrespective of age [8]. Recent studies suggest that the health care system needs to prioritize the prevention of EDs, as more than half of the people diagnosed with EDs receive no or improper treatment [9].

Treatment of such disorders as AN is complicated by the high incidence of cases of relapse, the comorbidity with other mental disorders, along with shifts from one subtype to another, and the denialism that often accompanies AN [1, 10, 11]. The complications related to the treatment of AN also have much to do with limited knowledge among medical practitioners, who often constitute the first line of specialists patients encounter. The poor training of primary healthcare (PHC) providers on the topic of EDs leads to a poor record of identification of symptoms during clinical assessments [12, 13]. Along with that, key barriers to seeking treatment include stigmatizing beliefs and attitudes among health care practitioners [14]. The authors of the study emphasized the importance of confronting such perceptions and beliefs amongst medical workers in order to curb them. In other words, circumscribing and addressing perceptions and attitudes among healthcare workers regarding AN and developing more efficient evidence-based clinical guidelines regarding the subject matter is crucial if we want to improve the medical care that is available to persons with AN [4, 14, 15].

Early research into EDs and AN has mainly focused on the female population of Western countries, where the concepts of EDs and AN first appeared [16]. Recent research in the field of EDs has shifted the focus from Western to other countries. Thus, such research has highlighted the importance of exploring the impact of socio-cultural factors on views about EDs as a way to better manage them in the context of, for example, the Asian culture [17].

The present study

Lack of research in the area of AN in the Kyrgyz Republic is in contrast with the current rising number of studies in this area in other non-western countries [16–18]. This feeds the belief that AN is present in the Kyrgyz Republic but does not receive enough attention. Taking into account the recommendations on the importance of investigating the perceptions of healthcare practitioners in order to improve the quality of medical care [14, 15, 19], this study aimed to investigate how Kyrgyz PHC practitioners perceive AN and people suffering from it. The supporting rationale for choosing PHC practitioners for our sampling was the assumption that such practitioners are supposed to be accessible to the majority of the local population, according to the current structure of the health care system [20]. People with AN can seek treatment from PHC practitioners, who may be the first line of defense

in the health care infrastructure posture and, therefore, exercise considerable influence in the process of seeking and receiving medical care.

The scarcity of research related to attitudes toward AN in the Kyrgyz Republic and Central Asia in general leaves Russia as the main proxy source of literature in terms of how EDs are confronted on the closest thing to the territory of the Kyrgyz Republic. For example, one study contributed to research into cultural differences in terms of AN by investigating the dichotomous thinking about EDs in the context of cultural differences between Japanese and Russian female samples and provided an interesting angle on cultural specifics in Russia, where the political and economic upheavals of the Perestroika era prompted a need for stability and led to rigid thinking [18]. Another study conducted in Russia [21] provided insight into virtual culture as a socio-cultural phenomenon involved in the development of AN.

Along with the limited research into EDs and AN in Central Asia, representative samples of the majority of studies in European countries and America might not be reflective of the situation of patients in Central Asia and the issues related to the perception of AN in their countries. The classification of EDs within The Diagnostic and Statistical Manual of Mental Disorders [22] does not include a contextual understanding in terms of diverse cultures, which may lead to underdiagnoses [16]. Therefore, it becomes imperative to explore how healthcare practitioners view AN and perceive patients with AN in the Kyrgyz Republic.

METHODS

Study design

This study employed a qualitative approach and followed the methodology of Interpretative Phenomenological Analysis (IPA). The reason for choosing this approach was to explore a particular phenomenon from the point of view of the participants through in-depth, semi-structured interviews [23]. Therefore, IPA was chosen as the tool for investigating the perceptions of PHC practitioners who participated in this study. Additionally, the theory of social constructionism was employed in order to discuss and draw conclusions on the results of the study.

Setting

The interviews were conducted at Centers for Family Medicine (CFM), which are part of the primary healthcare system in Bishkek, Kyrgyz Republic [20]. The participants chose those settings because they proved convenient for them and allowed them to meet with the researcher at their place of work. Each of the participants was interviewed separately face-to-face with a researcher in auditoriums made available for the purpose. Two of the participants (Aliya and Tynara) were interviewed at CFM No. 8, three of the participants (Aikyz, Burul and Gulnaz) were interviewed at CFM No. 2, and one (Tonya) was interviewed at CFM No. 3. The interviews were audio-recorded upon consent.

Participants

Six participants aged 28–65, all females and staff at community health centers in Bishkek, Kyrgyz Republic, were recruited. Five of the participants were primary care physicians, while one was a clinical advisor (Tynara). All participants were Kyrgyz by ethnicity, Kyrgyz- and Russian-speaking, and resided in the urban communities of Bishkek. All the participants were graduates of local medical schools and completed internships in city hospitals.

Procedure

The participants were contacted directly at their place of work, and they were recruited by means of snowball sampling. The participants were informed on the matter of the study and the terms of participation, which included ethical considerations. Those who agreed to participate signed written informed consent forms. Interviews lasted from one hour to one hour and a half and took place at the participant's place of work. All of the interviews were audio-recorded and transcribed upon consent. Interviews were conducted by the lead author, in person, in the Russian language. The interviewer was a young woman aged 31 at the time of the interviews. She is of Kyrgyz ethnicity and grew up in an urban environment in Bishkek.

The study was structured around the following two research questions: *"How do Primary Healthcare Practitioners in the Kyrgyz Republic perceive AN and people who have it? What public, cultural, and traditional background do they draw from when discussing patients with AN?"* (Box 1).

Transcription and translation

The interviews were conducted in the Russian language, since the language was spoken by the participants and the researcher. They were transcribed verbatim and translated into English by the researcher. Only the researcher who

Box 1. The semi-structured interview guide used for the study (only key questions)

- What do you know about eating disorders?
- Do you know how they differ from each other?
- What do you know about anorexia nervosa?
- Why do you think people develop it?
- How do you feel about people who have anorexia nervosa?
- Have you had patients with anorexia nervosa?
- How did you feel about that experience? What was your choice of treatment?
- What would you think/feel about/suggest to a person who has anorexia nervosa?

conducted the interviews had access to documents and data collected from the participants.

Ethical approval

The study was approved by the Institutional Review Board, American University of Central Asia (Approval Letter No. 2022031600000255).

Data analysis

The IPA approach employed in this study is widely used in psychological research [24]. The process of exploration was guided by the phenomenology, idiographic approach, and hermeneutics, in accordance with IPA guidelines [24]. The interpretation of the data depended on the existing set of knowledge the researchers held, which is known as fore-conception [25]. In order to avoid fusing with a single perspective, researchers explored the phenomenon of AN from multiple perspectives, which is known as a hermeneutic circle [26].

According to the IPA guidelines [23], the study was conducted upon collection of data by means of semi-structured interviews. The interview protocol was based on information gleaned from previous research in the related field [14, 15, 19]. The steps for data analysis included verbatim transcription, careful reading and re-reading of the interviews by the research team, identification of emerging themes, classification of the themes, and their refining. All the steps were conducted in accordance with the IPA guidelines [23]. The results were discussed in the frame of social constructionism theory.

RESULTS

Four superordinate themes were uncovered: (1) AN is perceived by physicians as a reaction to distressing events in the form of loss of appetite, (2) attribution of blame for developing AN by a patient to family members, (3) local versus western socio-cultural standards in the development of AN and the search for treatment, and (4) denial of mental health issues by AN patient.

(1) AN is perceived by physicians as less of a psychological condition and more of a reaction to distressing events in the form of loss of appetite

Although some participants saw AN as a psychological disorder that manifests itself in the form of restrictive eating behavior, they generally described AN patients as female adolescents who want to lose weight and push things to the extreme due to a distorted perception of their bodies:

"When you start talking to a patient, not interrogating, but talking, they say that they want to be thinner. At the same time, she weighs 40 kilograms, and keeps on trying to lose weight. That's when we start to sound the alarm."
Aliya, 50 years old

Most of the descriptions of AN provided by the participants assumed a goal of weight loss from patients as a result of overreaction to psychological distress: for example, Gulnaz highlighted how she and her colleagues could relate to patients with AN based on personal experience of losing appetite and weight at times of emotional distress or burnout. She stressed that she related to the experience of patients with AN, because she was personally experiencing the struggles of losing appetite while going through the hardships of being a medical worker during the COVID-19 pandemic. She provided the example of her experiencing the disorder, discribing it as a brief episode of changes in eating behavior due to her chaotic work schedule, which led to her feeling worn out, as she mistakenly assumed that AN was nervous exhaustion to emotional distress:

"I had it myself. During the pandemic. During the first wave all the doctors got sick, and I was left alone. There were some pediatric physicians, they were helping me. But during that time my phone was ringing constantly. I did not even have time to eat properly. I had little kids, and a husband. They were helping me, of course, but I was so exhausted."
Gulnaz, 31 years old

By providing the example described above, Gulnaz compares herself with AN patients, implying that people who end up developing the condition are predisposed to the disorder organically, unlike her. She views the disorder as a result of an exaggerated reaction to stress:

"Some people have a stable nervous system, for example, right? Some people have a labile one. Some are labile, they cry like that, they immediately react to something like this."
Gulnaz, 31 years old

The distinction between people who can overcome stressful situations and people who may suffer from the consequences of experiencing excessive emotional distress due to the specifics of their nervous system is seen across the interviews (Aliya, Burul, Gulnaz, Tynara). For example, Burul describes people who tend to react excessively to distressing events as "anxious" peoples:

"It becomes clear when a person has some kind of stress, like exams or something. Ultrasound screening is normal; gastroscopy is also ok. It's usually anxious people."
Burul, 28 years old

Aliya sees the risk population for AN as adolescents, as the developmental features of the nervous system characteristic of their ages makes them vulnerable to stress:

"And teenagers, they are flexible, they have hormonal imbalance. During this period, they are flexible, vulnerable and sensitive. They are vulnerable to it during these times."
Aliya, 50 years old

Our participants perceive emotional distress and hormonal disbalance as interrelated conditions that lead to maladaptive behavior, such as weight loss. This assumption is incorporated in the common understanding of the development of the disorder among several participants (Aikyz, Burul, Gulnaz, and Tynara).

Another participant, Gulnaz, highlighted the importance of the longevity of the stressor; so it can be assumed that people have to experience negative emotions for a considerable period of time for the negative changes in the nervous system to appear. However, her usage of the word "apparently" points to her doubt about her knowledge on the nature of AN:

"Nervous exhaustion develops when a person is under stress for a long time (thinks). Or under some kind of pressure. They start losing their resources, and they are on the brink of a breakdown. This is called nervous exhaustion, apparently, nervous anorexia."
Gulnaz, 31 years old

The prolonged distressing event as the reason for experiencing physiological consequences can also be lethal, according to Tynara. She links AN to nervous exhaustion caused by the disruptions in the nervous system due to stress, as well:

"Even if you eat well, you will lose weight, as it is nervous exhaustion. The whole body starting from the very nail, it's all the nervous system it is being regulated by. If a person is always in a stressful state, of course, nervous exhaustion will develop, nervous exhaustion. A person can even die from it."
Tynara, 65 years old

Since the consequences of experiencing distress lead to a loss of weight, it is not identified as a disorder by the participants, until it becomes noticeably severe. Burul, for example, described a patient who demonstrated apathy towards her, which led her to link the loss of weight to adverse life events; however, to her, the patient was not overly underweight to consider it a disorder:

"I had a patient recently. Not that skinny, it was not anorexia yet. She comes in, and it becomes clear by the way she talks. They speak so quietly, in sunglasses, they do not look at you. In a low mood. And then you start asking them, and it appears that they had some kind of stress, exams or something. She asked me whether stress could be the reason. Of course, it can. I asked her about her problems. She said that she could not keep up with her studies. She failed her exam."
Burul, 28 years old

Oftentimes, the participants directly linked cases of AN to psychological and interpersonal stressors:

"His mom made the call, as we make house calls to provide our services. And he was just lying there. She said that it's been two months. He didn't stand up, he didn't complain, didn't eat. She said that something happened at his job. Something personal. He didn't fit in with colleagues."
Tonya, 46 years old

(2) Participants attributed the blame for developing AN symptoms to family members

While some respondents (Aliya and Tynara) empathized with the relatives and family of AN patients, as they carry the burden of the care providers, at the same time many (Aliya, Aikyz, Burul, Gulnaz, Tonya) saw relatives, in particular mothers, as those responsible for the development of the disorder in female adolescents. The participant Gulnaz thought that "anorexia in women does not develop due to work, it's all due to family issues" and that "someone made them suffer at home". Such attitudes may have to do with the local cultural context and gender bias. Tynara assumed that "something might be not ok at home" and that "someone is aggressive at home". A female adolescent, according to Tynara, lost a lot of weight due to emotional abuse at home. She shared that her step-mother "always screams" and "constantly criticizes" her.

Mental health issues, as seen by the participants, arise when children lose their autonomy due to parental pressure. In cases of AN, mothers are seen as controlling and demanding. Since mothers are often the prime caregivers and actively participate in their daughters' problems and treatment, they are often perceived as key figures and the source of stress for the daughters. The mothers are described as the ones who can set overly ambitious goals for their daughters, since they "didn't reach them themselves" (Aliya). Thus, daughters internalize those goals from their mothers, in the opinion of the doctors, which leads to perfectionism in their effort to reach those goals:

"I do not know what they push for, what kind of leverage they have. I think every parent needs an individual approach. For each parent and each patient. For example, [parents say] you should attend dance classes, and this is their level [of expectation], right? Why does she have to go there? To dance classes? Why would her parents want her to dance? What do they want from this girl? Why do they want that from the girl?"
Aliya, 50 years old

One participant (Aikyz) described the scenes she observed during her practice, where mothers shout at their daughters: "You do not eat anything!", "You did it to yourself!" This imagery and tone for Aikyz indicate the blaming and criticizing behavior of the mothers, who confuse care with blaming and probably dosing and so push their daughters to develop EDs symptoms.

Tonya linked the development of the disorder in a male patient who passed away to the pressure he experienced from his mother. He had to be a provider for the family, according to his mother. Tonya stressed the gender-based pressure in the family, primarily from the mother:

"She made him go to work because: "You're a man!" She created some kind of a bar for him: "You have to provide for us already". And maybe something broke within him. When I saw him, he was already in bed."
Tonya, 46 years old

In general, all participants emphasized the role of a stressful situation at home in the development of AN symptoms, especially in female adolescents. They shared interpretations of the home environment as aggressive and hostile, or neglectful. Burul stated that "parents must pay attention to girls", but that they "*do not* have enough time" and "do not understand each other". They *do not* reward their girls by saying "well done" or "you are beautiful". Looking for the causes of the condition in adolescent patients but lacking a full understanding of the disorder, the participants saw the development of the disorder as a result of not feeling accepted enough by parents:

"Girls start to, like, especially when parents do not pay enough attention to a child, and they start to want to be like someone else… Parents do not say to them that they are good, beautiful. I think that they have associations like that, like, beauty is everything, thin waist (thinks). And they start to diet. Based on the opinions of those surrounding them, they start to react already…'So, they will love me, if I become thin, I will be beautiful' (impersonates)."
Burul, 28 years old

In conclusion, the participants considered the negative environment at home, in particular the relationship with mothers, to be the key underpinning of distress, especially in young or adolescent patients, and as the cause behind the development of EDs symptoms. Such a perception, as a whole, suggests that there is a tendency among the participants to look for an external cause for patients' behavior and find a convenient reason to attribute the blame to. On the other hand, such a perspective contradicts the view of AN patients as people with a heightened response to common stressors.

(3) Physicians contrast local to western socio-cultural standards in the development of AN and willingness to seek treatment

Some participants (Aliya, Aikyz, Burul, Gulnaz) based their views about AN suffered by patients in the Kyrgyz Republic on the discourse about body type ideals pushed by the media on adolescents, engendering a threat that pushes young people to put an outsized importance on their bodies:

"They live in terms of those TV shows, Hollywood and there, I do not know all of those actresses, right? They have amazing bodies, right? And they think that all of this is, I do not know, happiness. Being beautiful means having it all."
Burul, 28 years old

Burul links the onset of AN symptoms to stressful life events, and somewhat refuses to consider it as a special psychological condition, dismissing such an approach as enabled by the media. She maintains that in "real life" people lose weight when they face adverse life events and can not handle the ensuing distress, as opposed to what is depicted in the media. The implication is that the media exaggerates the issue to the point of making it appear more severe than it is in real life:

"We saw patients like that on TV. They come to us, but they are not as scary, of course. The scary ones are only on the screen. I had a patient who lost a lot of weight, but not too much, not skin and bones. It's only in the movies, skin and bones. In real life they are skinny, but not like in the movies. They have some weight; it is just starting to become noticeable."
Burul, 28 years old

Aikyz is another participant who separates between AN portrayed in the media and that in real life. Her understanding of the disorder is rooted in beauty standards:

"The first thing that comes to mind, is (thinks) the models. They need to look thin, so they lose weight to the point that it becomes scary."
Aykiz, 33 years old

The participants (Aliya, Aikyz, Burul, Gulnaz) attributed the cause to the influence of the global media, which promotes beauty ideals based on Western culture. For Aliya, the promotion of norms of physical appearance through the access to the media young people enjoy leads to the burden of comforming to the globally celebrated beauty ideals:

"The idea of a perfect body shape is promoted via the Internet. Those who are involved in the virtual culture of Westernized beauty standards appear under pressure to look a certain way."
Aliya, 50 years old

Those who feel pressured to follow those beauty standards, according to Burul, seek external validation because of a lack of self-esteem. She mentioned low self-esteem as a reason for falling under the influence of the virtual environment. The process of achieving this goal involves major sacrifices; "the rush":

"For the most part, I think the reason is the pursuit of beauty, the rush, right? And low self-esteem."
Burul, 28 years old

The local culture in the Kyrgyz Republic has opposite norms, according to the participants (Aikyz, Burul, Gulnaz), in terms of the physical appearance of a person, especially a female. Traditionally, females are seen as the ones responsible for procreation. They have to maintain a properly functioning reproductive system, which requires a bigger body shape:

"Our mentality does not demand it. Our people love the chubby ones, so that they could give birth to normal, healthy kids."
Gulnaz, 31 years old

As the local beauty standards deviate from global ones, people who look noticeably underweight may even become targets of bullying. Aikyz feels relieved that she did not get bullied for being thin during her high school days, unlike one of her classmates:

"I had a girl in my class, she was very skinny. Well, I used to be skinny too, but I was not called names. Because, maybe, I was shorter than her, it was not that noticeable. She was very tall. And every time during classes they called her 'anorexic'."
Aikyz, 33 years old

Tynara described how the treatment of her sister was postponed because of a need to organize the traditional annual commemoration "Ash" for her deceased husband.

She was afraid of being shamed by relatives if she failed to follow the tradition. She was extremely underweight by the time of her treatment. Tynara tried to hospitalize her, but the traditions were too hard to stand against:

"I said: 'Come here' [to Bishkek], but she said: 'My husband is dead, I have to organize Ash'. It is usually like that among us, Kyrgyz people. Relatives would say: 'Oh, she went off to Bishkek', they would get offended."
Tynara, 65 years old

While most of the participants (Aliya, Aikyz, Burul, Gulnaz) talked about the burden of following the socially accepted norms for females in the form of external appearance, Tonya provided insight into local gender stereotypes as relates to the male population. She stated that males are pressured to hide their emotions, which leads to such reactions to emotional distress as a loss of appetite:

"Girls overcome it faster. They overcome it somehow, they socialize more maybe. And boys close down, it is more difficult for them. He has this [belief] that he is a man, that he has to do it, to provide for his girlfriend, mother, sister."
Tonya, 46 years old

Overall, socio-cultural specifics are perceived as the influencing factors in the development of conditions seen as AN by the participants, as they see how significant the environment, whether virtual or physical, can be in terms of impact on mental health and worldview in general.

(4) Denial of mental health issues

The participants (Aliya, Aikyz, Tynara, Gulnaz, Tonya, Burul) described such patients as being unaware of the psychological roots of their physiological concerns. Thus, Tonya sees the cases of denial as unresolvable, as she does not know how to provide care in such situations. Since she assumes that AN develops in young adults because their nervous system is "not yet developed", she describes them as "impulsive, with barriers" (Tonya). Those barriers do not let them admit to themselves that they need the help of a mental health specialist.

"At the same time, he will deny everything, thinking he is healthy and cheerful, that he is doing everything right, and that he does not need help from a physician. He just came to do some tests. For example, a blood test, because he feels a little bit tired. That's all. We can't say anything directly, and questions alluding to a mental health issue will be rebuffed by him."
Tonya, 46 years old

Such patients come to seek help for their physiological concerns, rather than psychological help. Burul chalks such a situation up to a lack of self-awareness or escapism. The denial may morph into a refusal of treatment, when patients admit it to themselves but hide from that awareness due to the shame associated with being called "crazy" (Burul):

"But they come for other reasons, of course, they feel nauseous, for example or they have stomach ache. I think they, I do not know, maybe realize it, but they do not want to see. Maybe they do realize it."
Burul, 28 years old

As Aliya is the only one who confidently described the disorder as a result of a patient's goal-oriented restrictive eating behavior with values linked to perfectionism due to societal pressure, she sees denial in adolescents as an explanatory outcome. They are doing what they think they have to do; therefore, there is nothing they are doing wrong:

"Because if a girl does not reconsider her thinking, nothing will help, medication will not help. I tried just to talk to her, but the girl said: 'I want it this way'."
Aliya, 50 years old

For Aikyz, seeking treatment is impossible without the acknowledgement of having a disorder. Only people with self-reflection can seek help for themselves. However, common situations include cases of denial, where people would not admit to themselves that they have a problem. Along with denial, patients try to avoid stigmatization, as they do not want to be perceived as "psychos" (Aikyz):

"She [a psychotherapist at CFM] told me that if he [patient] has the capacity to self-criticize, it is possible [to treat him]. And if he refuses, there is nothing we can do."
Aikyz, 33 years old

All the participants suggested an empathetic approach towards patients in denial. For example, Gulnaz sees

young people as the ones at risk of developing AN, as well as those who may resist treatment due to their rebellious temperament. She highlights the fact that the resistance may occur in the case where they feel "judged", which is why they require a subtle approach:

"We have to talk to them gently. Young people behave this way nowadays. If you start arguing with them, they will have a reverse reaction. Without judgment. We have to find a common language for everyone."
Gulnaz, 31 years old

Interestingly, although in the majority of cases the participants (Gulnaz, Burul, Tynara, Tonya) had difficulty seeing the symptoms of AN as a psychological disorder proper, connecting it to life stressors and the underlying psychological conditions, they expressed an often vague but passionate need for mental health practitioners to participate in the process of diagnosis and treatment:

"I want the number of them [psychotherapists] to increase. We need them a lot. The salaries need to go up, I do not know how it will be done, but the attention of the young trainees must be brought to it, so that they would study to become psychotherapists. It would be great, yes."
Gulnaz, 31 years old

As mentioned in the citation above, the need for the support of specialists in mental health seems rather vague and expressed only in the number of psychiatric interns. Here and in other interviews (Aikyz, Burul, Gulnaz, Tonya, Tynara), the respondents did not describe using any current resources related to mental health in their work with AN patients. It seems that the participants positioned themselves outside of the system of psychological support:

"I refer to her [psychiatrist] only if a patient needs it. She is a psychiatrist, so she treats mainly those with severe disorders. Like schizophrenia, intellectual retardation, or very severe disorders. So, if a person has light insomnia, or, I do not know."
Gulnaz, 31 years old

From the above citation, understanding of what kind of a mental health specialist is needed and for which cases is vague. It seems that only severe cases require referrals to psychiatrists. In cases where a patient experiences seemingly mild distress symptoms, referrals to mental health specialists are not discussed by the participants.

DISCUSSION

The PHC practitioners in this study perceive AN patients as people who have lost appetite as a result of emotional distress which is influenced by their external environment, where family members play a significant role. On a larger scale, they attribute the development of AN to socio-cultural pressures in the global and local contexts, discussing discourses available in the media. AN patients, according to the participants, are in denial of the fact that there are underlying psychological reasons behind their physiological concerns. However, our interviews lacked references to working with mental health care professionals and encouraging patients to seek psychological support or treatment.

It was crucial for us to let the participants steer the dialogue towards them, as was suggested in the IPA guidelines [27]. Therefore, the participants freely moved away from the topic of AN into discussing other psychological causes of weight loss, framing it into the discourse related to AN. Hopping from talking about intentional loss of weight to losing weight due to stress may be identified as confusion between these two phenomena or folding of one into another. Either way, both confusion and folding are linked to a lack of knowledge about AN. Overall, AN patients are perceived by the participants as those who lose weight as a result of stress, mainly. AN is a primarily psychological condition which leads to physiological consequences, according to them. This explanation is similar to the description of AN within previous diagnostic criteria, where EDs were described as psychophysiological gastrointestinal reactions, where negative emotions lead to physiological gastrointestinal symptomatology [28]. The majority of PHC physicians see AN as a consequence, or one of the symptoms of experiencing emotional distress, rather than a separate disorder. Discussions of the influence of the media on the desire to lose weight due to beauty standards proved distant from real life cases. The participants were hesitant to answer the question about the symptomatology of AN and mainly referred to the disorder as "nervous exhaustion". It can be concluded that they are unaware of the current clinical symptomatology of AN, as was highlighted by previous studies [15, 28]. However, one of the participants demonstrated knowledge of AN symptomatology related

to body image concerns. After all, lack of knowledge among PHC practitioners in Bishkek may not be widespread.

The physical appearance and behavior of an average AN patient was constructed from the words "skinny", "pale", "passive", "apathetic", pointing to the depiction of a person in psychological distress. The imagery of an abstract AN patient is built from the media representation of AN, along with the clinical practice of the participants. Not all of the participants viewed an AN patient as an adolescent female, with some of them describing cases of AN in males, adults, and elderly people. However, the participants who did not attribute AN to a particular age or gender viewed it as a case of nervous exhaustion. So, it cannot be stated definitively that AN is not gender- or age-specific from the point of view of the participants.

The role of family members was highlighted by all of participants, with the focus on the mother-daughter relationship. The existing literature also focuses on the role of primary caregivers within EDs and AN [29–31]. The controlling and pressuring nature of parenting leads the participants to perceive parents of AN patients as responsible for the development of the disorder in their children. However, the controlling style of parenting is what makes seeking help possible for unwilling patients. So, responsibilities and blame end up in a circle. Previous research [30] explored family dynamics, as it plays a significant role at every stage of AN, and focused on maternal caregivers making sense of their daughters' experiences of having the disorder. Thus, mentioning the role of maternal caregivers within AN is important, which was covered by the participants of this study.

The participants linked body image concerns to the global media, which spreads the ideas of a socially accepted physical appearance. However, there is a point of intersection where the global social standards meet the local social environment. Local body type ideals differ from westernized ones. This is linked to the role females fulfill in the local society, where they are responsible for reproduction, which is thought to require a thicker body shape to be performed safely. The authors of a previous study on the subject [16] mentioned that their participants held up thicker body type preferences in terms of Asian culture. Thus, there is often a gap between the dominant Westernized view of body shape and local ones. The result of present-studies regarding geographical differences in the socio-cultural factors influencing perceptions of physical appearance [32] and the global spread of information through virtual communities is consistent with previous research in the field [18, 21].

Development of AN was also linked to low self-esteem and refusal to accept one's body. The refusal to accept oneself pushes a person to seek validation from others. Previous studies have also suggested that low self-esteem leads to the development of disordered eating [1, 33].

AN patients are reluctant to accept treatment for the psychological causes of their condition. Our participants see AN patients as those who are unaware of, do not want to be aware of, or deny the psychological causes of their physiological concerns. Their thinking can be described as rigid. This can be an illustration of a case of dichotomous thinking in terms of disordered eating described in a study on the subject matter [18]. According to our participants, the perfect body shape is a value for patients who intentionally lose weight. Consistently, recovery is understood as targeting these values and reformulating them. This is in line with the preventative program described in previous research [9].

Denial of mental health issues by patients makes physicians feel helpless. According to our participants, treatment can be effective in the case of early mental health interventions, but it is often postponed until it is too late to reverse the process. This perspective is similar to that of Nordic healthcare specialists, who held negative expectations towards the outcome of AN treatment [14]. Denial and resistance to treatment was also discussed in previous studies [34–36].

The overall perceptions of local PHC practitioners as relates to AN and people with AN can be fitted in the frames of the social constructionism theory. According to it, meaning creation and categorization emerge concurrently during interactions between people [37]. The perception constructs through language, the cultural and historical context, as well as through sets of meanings [37]. AN has been discussed in other research efforts [38] in the framework of the social construction of psychopathology, which is a collectively constructed set of understandings of suffering grafted to a particular, constantly changing social context [38]. Therefore, the social construct of AN among local healthcare specialists in the Kyrgyz Republic is shaped by the local context and represents locally held socio-cultural perceptions of psychopathology.

Implications for future research and practice

This study is a step in further research that attempts to explore manifestations of AN in the Kyrgyz Republic;

the experiences of PHC practitioners and socio-cultural factors in the framework of AN. There is a potential for this study to be applied in healthcare practice targeted at the improvement of quality in medical care for AN in the form of providing information for the development of training programs for medical workers and reducing stigmatization.

Strengths and limitations

This study has tried to advance research on the topic of AN in the context of diverse cultures, as it reflects the socio-cultural factors influencing perceptions regarding AN and can be applied in medical practice.

However, there are limitations to the study, which are related to the subjectivity of interpretations. It must be brought to attention that the results hereby are predominantly influenced by the researchers' perspectives.

CONCLUSION

The PHC practitioners in the study construct a perception of AN and patients with AN using consideration drawn from the global and local contexts. Most of the topics discussed by the participants are present in the extant literature, making the views expressed by Kyrgyz PHC practitioners reflective of common understanding of AN by means of information emanating from local and virtual social media sources.

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