Eating Disorders and Coercion

In chiaroscuro outline, on a high mountain plateau at sunset, as in a Bergman film, the three major ethical principles march entrained along the landscape: autonomy first, followed by beneficence, and then nonmalfeasance. The serious study of how these ethical principles apply to eating disorders, especially anorexia nervosa, has been woefully neglected. Jurisdictions in the United States and elsewhere differ sharply on whether anorexia nervosa—or any eating disorder—qualifies for judicially sustained legal commitment to hospital or whether separate petition for use of medications is required, if use of medications is allowed at all.

There is little conflict on the need for life-saving commitment to hospital in other areas of serious psychiatric disorder, such as major depressive disorder with clear suicidal intent and means, with or without psychosis. Similarly, a patient suffering from schizophrenia with command hallucinations to harm others may be required to be admitted to hospital for safety and treatment, whether or not the individual perceives the process to be coercive.

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Why are eating disorders, especially anorexia nervosa, viewed differently and through a more conflicted lens? There may be several reasons. First, there is no consensus on the core psychopathology of eating disorders, and hence our understanding of the disorder's etiology is problematic. Differing beliefs about the nature of a disorder lead to different views regarding the legitimacy of the use of coercion, whether formally applied or informally perceived. Second, many outdated assumptions and frank mistruths exist about eating disorders, especially anorexia nervosa, including beliefs that these disorders are voluntary in nature and thus can be self-improved, that mandated treatment is futile, that chronicity is inevitable, and that eating disorders are indistinguishable from "normative cultural distress" about weight.

Leaving aside dogmatic conclusions about the etiology of eating disorders, the following statements about these disorders are generally accepted as factual:

1. Anorexia nervosa has the highest premature mortality of any major psychiatric disorder, estimated to be as high as 19% without treatment. It clearly can be a deadly disorder. Bulimia nervosa can be equally deadly when associated with hypokalemia or suicidality.
2. Eating disorders are multifactorial, and much remains unknown about the process by which widespread, culturally sanctioned, usually ineffective dieting transitions to a deadly disorder. The situation resembles that of a person boarding a canoe headed for Niagara Falls on a journey that begins voluntarily but ineluctably transforms into a nonvoluntary propulsion toward the Falls, with the person at times not recognizing that the upcoming Falls even exist.
3. Eating disorders are spectrum disorders, and clinicians' assumptions about the need for involuntary treatment may depend on whether their experience has been with mild or severe cases of this not uncommon disorder (its prevalence is the same as that of schizophrenia and childhood diabetes).

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4. The core psychopathology of eating disorders is not, as has been intermittently proposed, a psychosis, obsessive-compulsive disorder, or a forme fruste of affective disorder, but rather overvalued beliefs. Overvalued beliefs are probably the most neglected category of psychopathology in the instruction provided in U.S. psychiatric residency programs, despite the fact that they were appreciated in detail by Kraepelin and Meyer and other great psychopathologists. They are pragmatically defined as widely held sociocultural values or beliefs that are given ruling passion with risky, even deadly, behavioral consequences in a minority of the population, usually during the years of identify formation, the teens and early twenties. McHugh (1) has noted that the core of terrorism resulting in homicide (not suicide) bombing results from overvalued beliefs.

The overvalued belief at the core of eating disorders is summarily described as the overvaluation of the benefits of and need for weight loss or shape change, leading to dieting behavior, augmented with binge-purge behavior in some cases of anorexia nervosa and in 80% of cases of bulimia nervosa, and with severe overexercise in many cases. Bulimia nervosa may be viewed as an attempt at anorexia nervosa in individuals who do not have the extreme perseverance that allows the overriding of the hunger-induced drive to eat. This view suggests a core shared psychopathology for all eating disorders, and in the persuasive view of some, a transdiagnostic approach to treatment. The specific psychopathological motifs that form the two sides of the same psychopathological coin in eating disorders are a morbid fear of fatness vying in intensity with a relentless pursuit of thinness. As an indication of how seriously these core misbeliefs are taken, the avoidance of calories takes precedence over receiving the Host in the Mass in many Catholic patients with anorexia nervosa who take their religion seriously but take their fear of fatness and pursuit of thinness more seriously. This is not a touch of "cultural insanity" but a potentially deadly illness.

If a patient's clinical condition meets common legal criteria for petition for involuntary admission to hospital and treatment, there is no reason the category of eating disorders should be excluded from consideration for life-saving treatment. The common criteria for involuntary care are that a patient has a psychiatric disorder; the disorder presents a substantial possibility of deadly outcome by direct action or inaction by the patient; and the patient does not recognize the need for treatment even though the illness is life threatening.

Involuntary care can be compassionate care. Although accounts remain sparse in the literature, several recent publications have reported that anorexia nervosa patients who are treated involuntarily do as well in acute treatment as "voluntary" patients. In sum, after treatment, they offer a grudging or overt "thank you" rather than wishing "a plague on you" (2, 3).

The article by Guarda et al. in this issue contributes substantially to supporting the practice of using perceived coercion or frank pressure to be admitted in order to treat severely ill eating disorder patients. The study illustrates how short-term beneficence trumps autonomy in selected situations and how quickly autonomy is restored with treatment. Within several weeks of the start of treatment, the ego-syntonic nature of the eating disorder diminishes, yielding to the patient's recognition of the need for treatment and autonomous support of treatment. By following changes over time in patients' willingness to endorse the need for treatment, several goals are accomplished at once: the need for treatment that is perceived as coercive is validated by the seriousness of the eating disorder; the beneficent use of perceived coercion does not endure long as a perception but changes to a gradually strengthening therapeutic alliance with the treatment team; and autonomy returns as leader of the train of principles on the mountain plateau.

The ethical principle of nonmalfeasance, the third in the train of principles, is widely abused in diagnosis and treatment (not to mention health care funding) of eating disor-

der patients, but a detailed discussion of this misuse must be deferred to another time. In the meantime, the report by Guarda et al. on perceptions of coercion and need for treatment in eating disorders is a welcome contribution to the field, and one that may help sway jurisdictions that currently do not view the use of coercion or involuntary treatment with eating disorder patients as necessary and validated. Still, as the authors note, long-term follow-up after mandated or "coerced" treatment is needed to assess long-term outcomes. The one published study using indirect methods of following the long-term outcome of involuntarily treated anorexia nervosa patients (4) suggests less favorable outcomes for those receiving mandated treatment, but not as any direct negative consequence of the acute involuntary treatment itself.

Eating disorders, especially anorexia nervosa, raise significant ethical challenges and dilemmas regarding even the diagnostic terms and criteria commonly used, treatment methods, length of stay, health care funding, and feasibility of preventive intervention. These ethical challenges are not beyond study, however, and research is urgently need to elucidate them.

References

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