

Compulsory Treatment of Anorexia Nervosa

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Abstract: Compulsory treatment in anorexia is a controversial subject brought to the fore of public awareness with each new case reported in the media. The attitudes towards involuntary hospitalization for anorexia swing like a pendulum from recognizing the necessity for compulsory treatment in life-threatening situations to advocating the patient's rights for autonomy over his/her body and thus the right to refuse treatment. In view of the fact that the existing legislation in Israel (Law of Patient's Rights, 1996; Law of Guardianship 1962; and the Law for the Treatment of the Mentally Ill, 1991) does not provide an adequate solution to emergency situations in which anorexia is life threatening, the authors suggest that the Law for the Treatment of the Mentally Ill (1996), which enables compulsory treatment, can be interpreted to include life-endangering conditions.

Introduction

The increasing number of adults referred to treatment for anorexia in the past two decades is evidence that anorexia is no longer an illness exclusive to the younger population. Specialized eating disorders units have been opened in response to the request for treatment settings aside from those in the traditional psychiatric framework. The presentation of Anorexia Nervosa can be full or part syndromal, restrictive, bulimic, mixed-Eating Disorder Not Otherwise Specified (1).

Anorexia is one of the few medical conditions in which there is no community of interests and goals between the patient and the caregiver. The classic anorectic refuses to recognize the presence of an illness and implicitly the necessity for a curative intervention. Anorectic patients often oppose change and if they do adhere to a recommended treatment program it is generally under protest. The problem is especially difficult for severe anorexia patients whose lives are threatened by the seriousness of the illness.

From a medico-legal perspective it is not the incidence of severe anorexia, but its characteristics and consequences, which distinguish it from other DSM-IV(TR) eating disorders. Experienced by up to one per cent of young women (2), anorexia nervosa differs precisely because it is such a serious, life-threat-

ening condition (3). This feature tests the ethical limits of medicine, the State and the law in deciding whether to coerce patients into treatment (4).

It is possible that death rates could be reduced by early diagnosis and by long-term specialist care (5).

Anorexia is not an incurable disease and treatment has been proven effective in most cases (6). As such, should compulsory treatment be imposed upon a life endangered patient who still chooses to exercise free will and refuse treatment (7)? Some therapists believe that involuntary treatment is not an option, since quite often even involuntary treatment does not lead to recovery. Patients who are compulsorily hospitalized tend to be readmitted, sometimes in a more critical condition. Coercion may undermine the patient's trust in the caregivers, and particularly in the therapeutic relationship. However, others endorse this decision, in extreme cases, for lack of any other option, in order to save patients' lives. Moderates contend that compulsory treatment should be invoked only by the courts.

The legal standpoint varies in different countries. In Israel a number of laws deal with this issue (8-10).

This paper will focus on the question of involuntary hospitalization of anorectic patients and the related clinical, ethical and legal implications.

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Emergence of the Illness and Choice of Treatment Setting

Anorexia does not have a high prevalence in the general population (estimated prevalence: 0.3% to 3.7%) (11, 12). Outcome studies show that about 20% remain chronically ill despite treatment (13). The reported mortality rates is as high as 6% per decade (14), and 16% in a 21-year follow-up or 20% in the long term (15).

A patient who exhibits a reasonable degree of motivation and compliance can be treated in a community-based outpatient clinic by a multidisciplinary team. Treatment goals include nutritional rehabilitation and correction of psychological, behavioral and social deficits (16).

However, when the proposed treatment proves ineffective, hospitalization is required. Inpatient treatment can be carried out in one of the following settings:

1. an internal medicine department within a general hospital;
2. a specialized department for eating disorders;
3. an open psychiatric ward in either a general hospital or a psychiatric institution;
4. a closed psychiatric ward.

Incidence of Involuntary Hospitalization

Experience in two departments (adolescents and adults) at Sheba Medical Center over a 14-year period (1987-2001) has shown that among a sample of at least 700 patients with eating disorders, at most 2% (12-15 female patients) required involuntary transfer to a closed psychiatric ward due to life threatening conditions combined with refusal of treatment.

In the last decade there were only 57 compulsory hospitalizations for eating disorders in all of Israel; that is about 6 cases per year, as compared to 5,054 compulsory psychiatric hospitalizations during the year 2002, out of a total of 48,265 psychiatric hospitalizations (17; Ministry of Health, Personal communication, 2003). The number of compulsory hospitalizations prompted by anorexia might have been higher since in some cases the alleged reason for involuntary hospitalization was not recorded as

anorexia, but as its comorbid disorder (severe depression with risk of suicide or psychosis), which unquestionably warranted involuntary psychiatric admission

Difficulties Involved in Treatment of Resistant Inpatients

In open psychiatric wards or in special eating disorders units where admission is voluntary, a treatment-reluctant patient is quite difficult to handle. The opposition to recovery is revealed by thwarting the demands and breaching the rules and boundaries of the treatment program. This pattern of behavior somewhat reflects the anorectic patient's ambivalence and illusion of having maintained a measure of self-esteem, autonomy and freedom of choice.

Internal medicine departments are not equipped to provide adequate supervision for the anorectic patient. Even a momentary lapse of supervision is sufficient for the patient to induce vomiting or dispose of his/her food. In addition, the total milieu therapy necessary for optimal psychiatric care is lacking.

In a closed psychiatric ward there is less room for free expression of ambivalence. However, hospitalizing an anorexia patient together with severely psychotic patients is certainly not advisable.

The Legal Viewpoint

Israeli courts, in accord with the Law for the Treatment of the Mentally Ill (8), uphold the view that in a legal sense, the only mental condition warranting involuntary commitment is a psychotic disorder. Since anorexia is not considered a psychotic illness, involuntary hospitalization of anorectic patients cannot be enforced unless an undisputable comorbid psychotic state is present (sections 6, 9-17 of the law) (18). The legal dispute regarding this issue is reflected by inconsistent court rulings.

In one case (19), the court ruled for the release of an anorectic patient from involuntary hospitalization, stating that "due to the lack of mental illness, despite the life-threatening risk, compulsory hospitalization cannot be justified." In a different case, however (20), the court dismissed an anorectic patient's appeal against involuntary hospitalization and ruled that the patient must be compulsorily admitted

since the patient would not survive unless forcefully fed.

In the lack of a general consensus, court decisions are often disputed by legal counsel (21).

The Law of Patient's Rights (9) allows physicians to treat patients in life threatening situations even without the patient's consent. Hospitalization in situations of medical emergency, such as urgent treatment for a patient suffering from hypokalemia, is apparently intended for short-term or one-time only admissions. However, the law cannot impose its authority on a patient who refuses treatment. This law enables treatment without consent in emergency situations, but cannot be implemented in the case of a patient who actively refuses treatment, and is therefore not appropriate for long-term compulsory treatment. The third option is in accordance with the law for legal competence and guardianship (10) that enables the court to appoint a guardian (22-24), since the main deficit in most anorectic patients lies in a severely impaired capacity to make competent decisions regarding their need for treatment and nutrition. The role of the guardian is to make decisions regarding these issues.

The court usually appoints a family member, most often a parent, to act as a guardian. This solution has some drawbacks, such as the difficulty of a parent to be directly involved and bear responsibility (and guilt?) vis-à-vis pungent treatment measures such as forced-feeding and restraints. It is difficult for the parent to deal with the patient's anger and blame for coercing compulsory treatment. The patient may threaten to abandon the parent, or may threaten suicide, which makes the role of guardianship even more difficult.

Discussion

Anorexia nervosa is one of the few medical conditions in which the interests of the patient and caregiver may not coincide. The anorectic wants more than anything to remain thin and to continue to lose weight. Therapeutic efforts are fiercely rejected. In anorexia the dangerous patient refuses nourishment, but does not usually express suicidal intent, and thus it is necessary to focus on actual behavior and actions (25-27).

Anorexia nervosa has been shown to be a classic

case where the tension between preservation of liberty of the patient and the imperative to treat a severe illness becomes quite acute (28).

In most cases of anorexia nervosa, a well-structured therapeutic program, administered by a multidisciplinary staff experienced in treating eating disorders, is adequate. Within such a treatment setting, it can be determined if and when it is necessary to move from outpatient to inpatient care, and from an open to a closed ward.

The ongoing conflict of the anorectic surrounding control results from a fear of loss of control over life in general, and over his/her body in particular. Defeating the caregiver becomes an attractive challenge in itself. On the caregiver's side, there are also counter-transference dangers, such as paternalism or professional activism which might induce overpowering strategies beyond those which are strictly necessary (29).

Persuasion of the patient of the gravity of their medically compromised status is often a forlorn prospect. While clear they may not wish to die, many such patients lack the "insight" to grasp the imminence of the threat to their survival.

In extremis (refusal of treatment by a severely medically compromised patient), there is no choice other than compulsory hospitalization to save this patient's life. Experience teaches that only a minority of cases requires compulsory hospitalization.

In most cases treatment modalities are provided with the patient's consent. The objection of some caregivers and the general public to compulsory hospitalization comes from the misconception that anorectic patients in their refusal of care (30) are exercising legitimate free choice.

Involuntary hospitalization does not necessarily involve compulsory treatment and certainly does not by definition imply forced feeding. Psychotherapy and other treatments that require basic cooperation cannot be forced. Some authors (31) argue that weight gain achieved through forced hospitalization will not be maintained in the long run, and without the possibility for intense psychotherapy there will be no change. It should be emphasized that compulsory treatment does not always harm the client-therapist relationship, and sometimes it even testifies to the worry and concern of the therapist (32) and, in

retrospect, the patient is occasionally grateful for the intervention (33).

Compulsory hospitalization probably reduces the short-term, but not the long-term risk, since a closed ward is not the appropriate setting for rehabilitation of anorexia patients.

Involuntary hospitalization might ultimately become a revolving door: involuntary hospitalization in a closed ward, forced feeding, weight restoration, discharge, followed by subsequent relapses entailing repetition of the entire process.

Patients requiring repeated hospitalizations are quite often readmitted with more severe physical parameters (weight, cardiac and metabolic status) than at previous admissions and, thus, across time their overall condition continues to deteriorate. However, this outcome might reflect more on the chronicity of the disease rather than on the modality of treatment.

Although involuntary hospitalization of anorectic patients is infrequently invoked, it is our responsibility as mental health professionals to assure that the process of hospitalization, when it needs to be implemented by coercion, should be accessible and available and not become, with each new case, an exhausting battle evolving from ethical and legal disputes.

According to the courts, presently, the law in Israel does not provide a good solution for the forced treatment of anorexia patients. In our opinion, appointment of a guardian is not an appropriate solution.

The guardian is called to make decisions with regard to a dependent who is declared unfit. The parent or guardian finds it difficult to deal with a family member who opposes treatment, demands to be discharged, and blames the guardian for taking away his freedom. Since the guardian relies on the professional medical opinion, why shouldn't the authority rest with the physician? Aside from nourishment, the anorectic patient maintains decision-making capacity in all other life domains. Tan et al. (34) reported that in competence assessments, anorectic patients scored "normal."

It is not loss of a capacity to think logically, but it is basing one's thinking on thoughts which are themselves pathological.

Reference to the law regarding anorexia patients varies throughout the world. The European Council

on Eating Disorders discussed the subject of involuntary hospitalization as early as 1989 (35) and issued a statement that compulsory hospitalization of patients diagnosed with anorexia nervosa was more for the benefit of the therapist than for the patient. In 1995, they concluded that involuntary hospitalization of patients with eating disorders was not essential. However, when the European Council conducted a vote among the attendees of the conference, the majority was indeed in favor of involuntary hospitalization: There is a difference of opinion between the treating physicians and the basic declared view.

In the United States, Appelbaum and Rumpf (27) claim that emphasis should be placed on the patient's actions rather than their intentions alone. While patients diagnosed with anorexia nervosa do not always declare their suicidal intentions, it is contended that their behavior reflects an attempt at self-destruction that justifies a diagnosis of a mental disorder requiring involuntary hospitalization.

The present lack of a solution in some countries may lead to a change in the current law, as in Australia. "At a hearing concerning a 19-year-old severely ill patient with anorexia nervosa, in New South Wales the Mental Health Tribunal decided that she was a mentally ill person, and hence did fall under the Act even though anorexia nervosa as such was not considered a mental illness. This brings the State in line with legislation in the UK, and other states of Australia" (36).

The relationship between anorexia and depression may lead to a solution in legal terms. In anorexia, the desire for death may be associated with depression and may fluctuate over time and with the course of the illness (37). It can be claimed that severe anorexia is similar to major depression with suicidal tendencies.

Severe anorectic patients distort reality and engage in overvalued ideas of being able to master the laws of nature and starve endlessly, without risking death. They foster omnipotent belief of control. These thoughts lead to self-starvation and threaten life in a way not essentially different from any other dangerous thought disorder that lawfully warrants a hospitalization order. In major depression with suicidal tendencies, the law (8) enables compulsory hospitalization, though there is no psychotic state *per se*.

Conclusion

This paper focused on the clinical and ethical debate concerning involuntary hospitalization of treatment-resistant anorexia patients. The authors regard this option not so much as an ultimate remedy to a chronic illness, but rather as a last resort life-saving measure. The physician is committed to heal and save lives and the law and its interpretations should assist, with all of the necessary checks and balances.

This issue can be summarized with Beumont and Carney's viewpoint (28) "It is when we come to recognize the challenges in defining a psychiatric illness like anorexia nervosa for the purposes of deciding whether involuntary treatment laws can be invoked that we begin to appreciate the high stakes at this intersection between law and psychiatry."

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