Compulsory Treatment in Anorexia Nervosa: The Case of Israel

Yael Latzer[1,2,*] and Adit Zohar-Beja[3]

[1]*Faculty of Social Welfare and Health Sciences, University of Haifa, Haifa, Israel*

[2]*Eating Disorders Clinic, Psychiatric Division, Rambam Medical Center, Haifa, Israel*

[3]*Eating Disorders Department, Sheba Medical Center, Tel Hashomer, Israel*

Abstract: Anorexia Nervosa (AN) is a serious mental illness associated with high morbidity and mortality rates. Nevertheless, patients with AN are prone to refusing treatment despite life-threatening complications, requiring at times compulsory intervention. Involuntary treatment of eating disorders (EDs) through legal commitment is a controversial issue. In such cases, patient autonomy may conflict with protection of his or her best interest. In many industrialized countries, it is impossible to legally mandate treatment of patients with severe and even life threatening AN. In the last decade the ethical and legal concerns about compulsory treatment in Israel have been on the rise. According to the current law in Israel, it is illegal, with a few exceptions, to enforce treatment against the patient's will.

The aim of this paper is to review the existing literature about the legal and ethical dilemmas associated with compulsory treatment in AN and the effectiveness of its treatment outcomes. Research findings included in this review address both perspectives of the debate and discuss the patient's competence to make this decision. Additionally, this paper focuses on the legal process in Israel in the last decade, illustrating the dilemmas in two case studies. This review raises important questions and clinical implications that must be addressed in further research.

Keywords: Anorexia Nervosa, compulsory treatment, Israel, ethics, legal coercion.

INTRODUCTION

AN is a serious mental illness characterized by a failure to maintain a minimal normal weight, a fear of gaining weight or becoming fat, and a preoccupation with body shape or weight. AN is estimated to affect 0.5%-1% of females during their lifetime and approximately one tenth as many males [1]. AN is associated with higher morbidity and mortality rates than any other psychiatric disorder [2, 3]. Severe and enduring AN results in the death of between 4-20% of patients [4, 5].

In addition, patients with severe AN have significant medical and psychiatric co-morbid diagnoses [6, 7], as well as high levels of dysfunction [8]. Patients with severe AN must be medically stable before they can engage in meaningful psychiatric and/or psychological therapy. However, they often refuse treatment despite life-threatening complications [9]. Involuntary treatment of eating disorders (EDs) by means of legal commitment is a controversial issue. In such cases; a conflict arises between protecting the patients' autonomy and their best interests. Despite the importance of this dilemma, research on compulsory treatment is limited. Furthermore, the few studies that have examined the mental competency of patients with AN showed mixed results [10, 11]. Comparing compulsory to voluntary treatment revealed that hospitalization was longer and co-morbidity at admission was more severe among those who received compulsory treatment. Discharge results in compulsory and voluntary treatments were similar, yet the long-term effectiveness of compulsory treatment is not yet clear [12-15].

In Israel, the only article written on this topic describes the legal aspects of compulsory treatment. The authors indicated that legal agents are now more open to authorize involuntary hospitalization. Thus, therapists should be prepared to create new compulsory treatment approaches for severe cases of AN [16]. The aim of the current paper is to describe the legal and ethical dilemmas regarding compulsory treatment of AN, particularly in Israel. Additionally, we aim to review studies that explore the effectiveness outcomes of compulsory treatment in AN. Two case studies are presented to illustrate this dilemma in light of the legal process in Israel in the last decade.

To identify the relevant articles on this topic, we conducted a literature search using the online databases PubMed, Web of Science, and PsycInfo. The literature search was conducted independently by two investigators and then compared. Key search terms included: "Anorexia Nervosa", "Compulsory treatment", "Involuntary hospitalization", "Competence", "Mental health law", and "Israel". Publications were then cross-referenced and published review articles were examined for additional relevant studies to ensure

*Address correspondence to this author at the Faculty of Social Welfare & Health Sciences, University of Haifa, Mount Carmel, Haifa, 31905, Israel; Tel: +972-54-736673; E-mail: latzery@gmail.com

E-ISSN: 2310-8231/14

that any further articles missed by the database and journal searches were also identified and included in the review. We included empirical articles, as well as case reports and commentaries, using the aforementioned search terms.

THE CHALLENGE OF TREATMENT IN ANOREXIA NERVOSA

Since the 1980's, researchers and clinicians have made efforts to understand the complexity of AN but finding effective treatment strategies remains a challenge. Many individuals with severe AN are reluctant to engage in treatment, both medical and psychological [17], and may require enhancement of motivation, persuasion or coercion. Patients may appear to be compliant, while secretly conspiring against treatment [17]. Refusal of treatment in severe cases raises many difficulties, mainly the ethical and medical dilemmas of involuntary treatment.

INVOLUNTARY TREATMENT FOR PATIENTS WITH ANOREXIA NERVOSA

Involuntary treatment in psychiatric disorders, and especially in EDs, is a controversial issue, with inconsistent views rising from ethical and legal considerations. One perspective warns of negative effects encountered when involuntary treatment is imposed upon a patient with AN [12, 18, 19]. Conversely, there is clinical evidence which indicates the gravity of nonintervention in this disorder, which may lead to chronic morbidity and high mortality [2, 3, 20].

Healthcare professionals have a moral and legal obligation to save a patient's life. This creates difficult situations in which patients, their families and health professionals are engaged in struggles surrounding treatment options [9]. However, the refusal may not be total in the case of AN, as patients may accept psychotherapy or family therapy, but refuse other components of treatment, such as increasing food intake, reducing physical activity and inducing weight gain [14].

The reasons for treatment refusal among patients with AN include fear of loss of personal identity and control, feeling that the choice of relinquishing the eating disorder is not an autonomous one, needing to be coerced before feeling able to comply, and feeling that loss of life might be less important in comparison to feeling in control of the illness [9].

Poor insight into the illness is a well-recognized phenomenon in patients with AN [21, 22]. Furthermore, their impaired cognition, perception, judgment, and behavior makes it very difficult for them to make the appropriate decisions necessary to meet their nutritional and psychological needs [23]. The concept of clinical understanding is highly controversial. The legal aspects of severe AN are often complicated by the conflict between the medical necessity of treating the illness and the patients' knowledge of their right to refuse care. The essence of the conflict is a clash between the paternalistic approach of a responsible society and the autonomous rights of the individual. Therapists are faced with an ethical quandary between their obligation to protect life and to respect their patients' autonomy. The issue at stake is whether AN may be legally conceptualized to represent a condition similar to that of a psychotic illness, or if it should be regarded as a separate entity. That is, should treatment refusal be perceived as part of impaired thoughts, perception and judgment, or as part of clear judgment and wish, regardless of how disturbed the wish is. This dilemma must account for the patient's competence and right to refuse treatment [16, 24].

THE COMPETENCE TO REFUSE TREATMENT IN ANOREXIA NERVOSA

Factors relevant when considering patient competence, particularly in psychiatric illness, may encompass a range of elements that are not included in standard legal definitions of capacity, such as appreciation of information as applying to the self and the influence of mental illness [25]. However, at present time such elements are poorly defined. The MacArthur Competence Assessment Tool-Treatment (MacCAT-T) is a clinical tool used to assess a patient's capacity to make treatment decisions. It is a semi-structured interview process that involves aspects of informed consent and assessing patients' abilities to make decisions based on the information provided to them. The MacCAT bases this assessment by focusing on patients' capacities in four areas: understanding information and recommended treatment relevant to their condition, reasoning about potential risks and benefits of their choices, appreciating the nature of their situation and consequences of their choices, and expressing a choice [25]. Tan *et al*. (2003) used sociological qualitative analysis to explore the beliefs and values relevant to competence to refuse treatment in female patients with AN. Although they assessed a small number of participants, they demonstrated that there is a wide range of difficulties with competence to

refuse treatment. The participant's results on the MacCAT-T were comparable to a healthy control group [10]. The authors suggested that the standard concept of capacity to consent to treatment, as a construct of reasoning and understanding as assessed by the MacCAT-T, may not be relevant to the difficulties that patients with AN experience in their decision making. Rather, a question about their desire to die appears to be relevant. The question is whether treatment refusal reflects a conscious or unconscious wish to die or a denial of the possibility of death. It may also reflect the conflict between their wish to live and their perception that the treatment offered renders no meaningful change in the intolerability of their life [26]. These interpretations may play a crucial role in treatment refusal, yet are not related to the diagnosis of major depression, as one might think, nor detected by the MacCAT-T as indicating impairment of capacity.

The importance of AN to the patient's sense of personal identity can also lead to reluctance to receive treatment. But if AN is a mental illness, similar to psychotic disorders, then such a reluctance may impair the competence to refuse treatment. This raises the question of how changes in personal values and sense of identity should be assessed with regard to competence [11]. The considerable ambivalence of many AN patients about their treatment may intensify the uncertainty of the care team regarding which action would best respect the person's autonomy [11].

The current legal criteria for capacity, applied by the MacCAT-T test, fails to capture difficulties relevant to the competence to refuse treatment in AN. In order to respect patients' rights whilst protecting their best interests, the analysis and assessment of competence in AN needs further grounding in empirical research, capturing the real dilemmas that patients and their families face [27-29].

Another interpretation of the patient's treatment refusal may reflect their impairment in the development of coping strategies for managing real-life struggles, which may relate to the development of the illness in the first place. This deficit could account for the inability of some patients with AN to make decisions within the context of future perspectives, and their preference to favor choices that yield high immediate gains despite higher future losses [27]. This preference is evident from their impaired performance on tasks modeling real-life decision-making processes. For example, during the acute phase of illness, patients with AN are impaired on the Iowa Gambling Task (IGT) [27, 30, 31], a measure of decision-making propensities [32]. Their poor performance on this neuropsychological test does not appear to be related to illness severity, thus suggesting the lack of association between nutritional status, severity of symptoms and cognitive impairment [33]. In contrast, in a recent study using cognitive tests, it was found that greater cognitive impairment is associated with malnutrition [34].

When hungry, patients with AN choose to avoid consuming calories in order to obtain an immediate reward, by gaining a false sense of control over their life and by the immediate relief of food-related phobic anxiety. This is done at the cost of ignoring the long-term negative consequences of their choices (i.e. the progressive and severe decline in their physical and mental condition). Altogether, these patients seem unable to correctly orient their eating behavior [31]. The pathological eating actions of AN patients could be the expression of their inability to modulate reward and punishment in a long-term perspective, thus leading to deficits in planning real-life strategies. Cavedini and colleagues (2006) confirmed the presence of decision-making impairment in patients with AN. They claimed that decision-making impairments appear stable over time and do not depend on physical and clinical modifications after treatment. This finding suggests that impaired decision-making is an inherent trait of AN or a consequence of prolonged malnutrition that may not be modifiable with the correction of malnutrition or following treatment [27].

In contrast, Liao *et al*. (2009) has found that IGT scores improve with weight gain and Guillaume *et al*. (2010) suggest the likelihood of normal decision-making abilities in euthymic and non-medicated patients with EDs. Thus, further studies on decision-making in patients with AN are required to achieve a more definite conclusion with respect to the decision-making abilities of patients with AN [35].

COMPULSORY TREATMENT - THE PERSPECTIVES OF PATIENTS AND TREATMENT PROVIDERS

When considering the need for formal compulsory treatment, the patients' point of view must be included in the equation. One study found that patients with AN experience 'perceived coercion' i.e. the perception that they are being coerced into treatment, regardless of whether or not formal coercive mechanisms are actually used. Some of these patients have changed their views in hindsight about the 'coercion' they had felt [36]. The complexity of the issue is specifically

demonstrated in an in-depth study on the views of currently ill and recovered patients about their experiences of coercion and compulsory treatment [37]. The study revealed that patients with AN reported considerable experience of compulsion and restriction of choice despite a relative lack of the use of formal compulsory treatment. Moreover, regardless of their views about the use of compulsion in AN in general, all participants agreed that it is right to impose treatment in order to save life. What mattered most to the participants was not whether or not they were compelled to have treatment, but the nature of their relationships with their parents and treatment providers [38].

Indeed, compulsion may be experienced as care within a trusting relationship [37]. Providing a different perspective, Draper (2000) stated that even though it is hard to watch someone young die when they can be saved, we must listen carefully to their refusal of therapy, as it may relate to a wish to get a different treatment that suits their needs better. The first step is to accept that at least some sufferers of AN may be competent to refuse therapy, even if it is only a minority of the patients. We need to consider whether their reasons for refusal reflect the burden that living with AN and therapy have become. While feeding may be life-saving, it does nothing for the underlying condition and may even worsen it. According to Draper (2000), respecting the autonomy of a patient is not simply about letting that patient make decisions. Rather, it is accepting that the patient is responsible for the consequences of his or her decisions [39].

In line with these results, a recent study examined the literacy of psychiatrists with respect to EDs. Psychiatrists were asked about their attitudes towards the use of the Mental Health Act (MHA) in the treatment of AN. The Mental Health Act allows health care providers to use coercion in treatment of severe cases of AN. In a set of different questions, results indicated that 86.1% of psychiatrists felt it is 'appropriate that the Mental Health Act enables compulsory re-feeding of patients with AN'. Only 1.8% believed that 'the MHA should not be used to enforce admission to hospital for patients with AN' [40]. This suggests that psychiatrists are mostly willing to hospitalize involuntarily those with severe AN. Furthermore, 5.2% of the respondents believed that 'the MHA should not be used when patients clearly believe that the advantages of AN outweigh the disadvantages'. Approximately 30% believed that 'the MHA should be used more frequently to protect the health and safety of patients with AN'. It is important to emphasize that significant differences in attitude were found between senior and junior psychiatrists. More senior than junior psychiatrists believed that MHA should not be used to force admission to hospitals [40].

In another study, Carney *et al*. (2007) suggest that in AN, legal coercion into treatment is associated with three main indicators: the patient's past therapeutic history (number of previous admissions), the complexity of their condition (the number of other psychiatric co-morbidities), and their current health risk (measured either by body mass index (BMI) or the risk of re-feeding syndrome), including the refusal to be treated.

THE EFFECTIVENESS OF COMPULSORY TREATMENT

A limited number of controlled trials explored compulsory treatment for AN and its outcomes. Griffiths *et al*. (1997) investigated compulsory treatment under guardianship legislation for 15 patients with AN, in comparison to voluntary patients. They found that the guardianship sample was comprised of a more severely ill group than the voluntary patients. However, the two groups were similar in their BMI on admission and discharge [41]. Serfaty *et al*. (1998) considered the legal implications, psychotherapeutic management, and follow-up of 11 severely ill patients with AN. These patients were treated in a Professorial Medical and Psychiatric unit that combined psychiatrists, physicians, medical and psychiatric senior nurses and dieticians, and clinical psychologists. They were admitted under compulsion according to Section 3 of the Mental Health Act. Patients were in life threatening physical condition and refused any treatment. Their findings suggested that if the intervention was pursued in a structured and caring manner, compulsory treatment and/or nasogastric tube feeding might not adversely affect the therapeutic relationship [15]. Ramsay *et al*. (1999) reported that involuntary commitment of patients with AN led to satisfactory short-term treatment results, but it was associated with long-term morbidity. The mortality rate at a mean follow-up period of 5.7 years was 12.7% for the detained patients as compared to 2.6% for the voluntary patients. However, the authors suggested that the increase in long-term mortality in the former group might have been associated with a greater severity of the AN and/or with selection factors, potentially increasing the likelihood of a more severe illness because of potential underlying childhood physical and sexual abuse and self-harm [14]. In another study, Watson *et al*. (2000) examined nearly

400 patients with AN admitted voluntarily and involuntarily to an inpatient treatment program over 7 years. In this study, the two groups were similar in age, gender ratio, and marital status, but those hospitalized involuntarily had longer illness duration and significantly more previous hospitalizations. On admission, these patients had lower weight and required significantly longer hospitalization to attain their required weight. However there were no between-group differences in the severity of the AN and in the rate of weight restoration. A similar rate of weight restoration was also found in another study comparing voluntary and involuntary hospitalization of patients with AN [42]. This study suggested that despite the involuntary initiation of treatment, the short-term response of legally committed patients was just as good as that of patients admitted for voluntary treatment. Furthermore, the majority of the involuntary patients later affirmed the necessity of their treatment. Lastly, a study comparing the characteristics and 12-month post-discharge outcomes of adolescents with AN treated under parental consent or detained under the Mental Health Act (MHA) found that detained patients had an earlier age of illness onset and more previous hospitalizations. On admission, the involuntary patients had poorer psychosocial functioning and higher rates of comorbid depression and suicidal behavior. Still, there were no differences between the two groups at discharge in the rates of improvement in the physical and psychosocial condition. Furthermore, there was no evidence of higher mortality in the detained group at discharge nor 12 months after discharge [12].

THE ETHICAL AND LEGAL DILEMMAS WORLD-WIDE

Compulsory treatment for AN is a debated topic worldwide, generating insightful dilemmas. The law in European countries tends to view involuntary hospitalization of patients with AN as more beneficial for the therapist than for the patient. In 1995, The European Council on EDs concluded that involuntary hospitalization of patients with EDs is not essential, though the majority of the attendees were in favor of it [16,43]. In the United States, Appelbaum & Rumpf (1998) have claimed that in the case of AN, emphasis should be placed on the patients' actions rather than on their intentions. While these patients do not always declare their suicidal intentions, their behavior reflects an attempt at self-destruction that justifies a diagnosis of a mental disorder requiring involuntary hospitalization. In other countries, the concept of "grave disability" is used to emphasize the patient's impaired capacity for judgment [16]. In recent years, there has been a growing understanding that while patients diagnosed with AN may be able to make valid judgments and function “normally” (i.e. regarding matters such as employment and education), they are often unable to make rational decisions regarding their body weight, diet behavior, and acceptance of medical care. The question of whether to invoke or not invoke compulsory treatment for patients with AN, whose primary focus is on body and weight, may lead to a life-threatening situation [16].

THE ISRAELI LAW REGARDING COMPULSORY TREATMENT

It is not possible to involuntarily hospitalize a patient diagnosed with AN under the Israel Mental Health Law. In 2001, only six out of 3600 cases of compulsory hospitalization involved patients with EDs (Ministry of Health, 2002) [44]. In Israel, three conditions allow compulsory hospitalization in adult psychiatric patients. However, the first two do not apply for patients with AN. Firstly, in the Israeli Mental Health Law (1991), AN is termed a Mental Disorder as opposed to a Mental Illness. This is because it is not associated with psychosis, for which the law authorizes compulsory hospitalization in the case of patients with a psychotic disorder who are at risk to themselves or others. Under these circumstances, regional psychiatrists have the authority to initiate involuntary hospitalization. After a period of two weeks, a mental health commission has the power to extend the hospitalization [16]. Second, the Law for the Protection of Patients' Rights (1995) authorizes compulsory emergency treatment in life-threatening situations (not only psychiatric illnesses), when three doctors support issuing the order for involuntary care. However, this law does not address prolonged treatment of patients diagnosed with AN [16]. There is an option, through an appeal to the court, to appoint a legal guardian (only for the patient’s body) who can determine the need for compulsory hospitalization for a short but fixed period of time. In most of the cases, the appointed guardian is a member of the immediate family [16]. A recent verdict of the district court in Tel Aviv, Israel, on October 14, 2012, set a precedent for such cases. The judge ruled for the first time that AN is indeed a mental disorder and thus should be included under the Israeli Mental Health Law (1991). This law authorizes compulsory treatment in cases of patients who are at risk to themselves and lack insight into their life threatening physical condition. In the case of AN, a patient’s judgment with respect to her life threatening condition is completely distorted.

Under these circumstances, regional psychiatrists have the authority to initiate involuntary hospitalization [45].

CASE STUDIES

The Following Case Studies are Presented to Highlight the Dilemmas of Compulsory Treatment. The *Names have been Changed to Maintain Confidentiality of the Patients

Case A

Sharon*is a 27-year-old single woman, born and raised in Israel, and living by herself. She has completed 12 years of schooling with full matriculation (similar to SAT). Sharon began advanced academic studies but was forced to stop due to her very poor physical condition. Sharon was diagnosed with AN binge-purge subtype at age 11. She had 8 previous hospitalizations in an Israeli inpatient unit in a general hospital designed for the treatment of adult patients with EDs. Some of these hospitalizations were voluntary, whereas others were obligatory under court order. Generally, Sharon did not cooperate with her treatment and discharged herself against medical recommendations, whenever this was possible, not reaching a healthy minimal body weight. At home, she lost weight rapidly, reaching severely low weights that required repeated re-hospitalizations. Her psychiatrist referred her to the following hospitalization when her BMI reached the level of 10.3 kg/m^2. Despite her condition, Sharon refused treatment and/or nasogastric feeding and threatened to discharge herself. Her family appealed to the court and asked to be appointed as the legal guardians of their daughter, to which the court agreed. While in hospital care, Sharon's physical condition gradually improved. However, after removing the nasogastric feeding tube and progressing to independent eating, her condition rapidly deteriorated once again. Therefore, it was decided to return Sharon to tube feeding. She adamantly refused to be re-fed and threatened to commit suicide, leaving no other option but to be hospitalized in a psychiatric department more suitable for her mental condition. Sharon did not cooperate with treatment in this department and discharged herself several days later. Although she was hospitalized under court order, and her physical condition was life threatening, the hospital was not allowed legally to enforce the continuation of in patient treatment.

This case raises ethical issues regarding the responsibility and legal and moral rights of therapists and society at large about whether to act for one's right to live or for one's right to decide on his or her life's outcome, when the individual is not considered to suffer from a mental illness according to legal definitions. Furthermore, it highlights the dilemma of the mental health law whether patients with AN have or do not have an accurate judgment of the medically-related meaning of their weight, and hence the competence to understand the severity of their medical condition and to make proper decisions.

Case B

Karen* is a 20-year-old single young woman, born and raised in Israel, and living with her parents. She completed 12 years of schooling with full matriculation. Karen was recruited into the Israeli army, but was released after only 4 months of service because of extremely low BMI (13.5 kg/^{2}). Karen was diagnosed with AN restrictive subtype at age 14 and had no history of previous hospitalizations. She was referred to an inpatient ED treatment unit in a general hospital in Israel but refused treatment. She was admitted only after her parents were appointed by the court as her legal guardians. During the beginning of her hospitalization, Karen cooperated passively; from time to time she asked to be released and threatened to leave the hospital. Her physical condition gradually improved, but she refused to take part in family therapy and behaved very aggressively toward her parents. Later on, her resistant behavior decreased, and she agreed to join the family therapy process. Her attitude towards her therapists gradually changed, and she became fully cooperative. Karen was discharged at a healthy body weight and with a good physical and emotional status. During her hospitalization, Karen casually expressed a desire, which strengthened over time, to live a meaningful life, to study and improve her social life, and to slowly give up the need for her AN. After discharge, Karen decided to continue therapy, and joined a residential program for EDs. Karen completed 2 years of rehabilitation at a residential treatment program, continued weekly psychotherapy, and kept a stable healthy body weight. She was able to have good relationships with her family and friends, maintained a steady job, and eventually achieved full recovery. This case shows how enforced treatment can save a life, prevent the revolving door syndrome of chronic AN, and help the patient live a reasonable and productive life.

DISCUSSION

Anorexia Nervosa is a serious mental illness with a growing lifetime prevalence in recent decades in many

Western countries [20]. This serious mental disorder often leads to fatality as a result of self-imposed malnutrition and reduction of weight, and because of elevated rates of suicide [46].

Treatment refusal, along with non-compliance and resistance to treatment by patients with AN, is a common feature of the disorder [20]. Refusal of treatment, where life is in immediate danger, creates a complicated dilemma regarding the appropriateness of imposing treatment against the patient's declared will. This situation raises serious ethical, medical, and forensic predicaments as to whether to impose compulsory treatment or not where clinically required. Furthermore, it is questionable whether compulsory treatment is appropriate for AN. These dilemmas lead to the examination of parallel issues, i.e., whether there is sufficient mental competence to refuse treatment or there is a clear wish to terminate life. Ideally, treatment of AN should be conducted in the context of the patients being responsible partners in therapy. Still the need for compulsory treatment cannot be avoided in some cases. These situations present with great difficulties for treatment providers. It has been argued that after compulsory treatment, a constructive therapeutic alliance and relationship cannot evolve because of the inherent break in the therapeutic alliance associated with involuntary treatment. However, one may be confronted with moribund patients who are in an absolute denial yet require lifesaving intervention.

Modern Law

In accordance with the legal context in which compulsory treatment is mandated, legal issues and policies that are currently in place must be considered. For example, in 1997, the Mental Health Act Commission of the United Kingdom [14] issued a Mental Health Act (MHA) stating that, in certain situations, severely ill patients with AN whose health is greatly jeopardized by food refusal may be subject to inpatient detention. Additionally, there are cases in which the Guardianship Act has been applied to institutionalize the patient for compulsory treatment. These cases require appointment of a guardian, either a private person who is often a family member or a Public Guardian to initiate treatment [14]. Israel allows compulsory treatment in adult patients with AN under three conditions: in the case of psychosis, in accordance to the 1995 Law of Protection of Patients' Rights which supports compulsory emergency treatment in life-threatening situations, and in the case of an appeal to appoint a legal guardian. This strategy is the one most commonly used for the compulsory treatment of patients with AN. However, patients can discharge themselves from treatment at any time without legal action to stop them once their condition is not at risk. Thus, the patient can deteriorate and regress back to a life-threatening condition. Accordingly, the need to establish a new bill for severe, life-threatening AN is highly necessary for the patient's protection.

There are two opposing views when dealing with compulsory interventions in patients with AN: one group claims that these patients lack insight and competence, whereas others posit that patients have clarity and freely chose not to live rather than living with their disease. Bachar and colleagues (2002) differentiate between the attraction to and repulsion of life, and the attraction to and repulsion of death, and view them as independent factors in the perceptions of life and death among patients with EDs. They have found that patients with AN are characterized as having a rejection of life rather than with contemplation of death or an attraction to death [26]. These attitudes to life and death should be considered and incorporated within the context of the patient's competence in making decisions regarding their physical and mental health. Taking into account these considerations and factors reviewed earlier, there seem to be two major opposing views with regard to compulsory treatment.

The Case for Compulsory Treatment

Patients with AN have no specific wish to die. Rather, they suffer from a feeling that it is an intolerable difficulty to live with their disease [26]. The symptoms of AN, representing the circumstances potentially predisposing to the illness serve, ironically, as a source of life in a sea of misery, and provide meaning to an otherwise meaningless life [48]. Denial is a large psychological component of an ED. According to a self-psychology perspective, patients with AN would rather deny their need for help with their illness in order to avoid feeling the pain associated with facing their unmet childhood needs for self-object .[48]

As clinicians with the knowledge of this pain, is it not our duty to help the patient without waiting for their plea, not allowing them to act on their pain in an irreversible manner before we listen to their unspoken plea? Furthermore, is it not our ethical commitment as treatment providers to save lives, while at the same time improve patients' quality of life, which according to

the patients' views might coincide in the case of AN? Another aspect to consider in the case for compulsory treatment is whether a patient plagued with AN may have a cognitive distortion [49], potentially interfering with his or her decision-making capabilities, primarily in the case of severe malnutrition [34]. Another argument for compulsory treatment is that eventually, primarily within trusting relationships, patients may understand and support the need for their own involuntary treatment [37]. Finally, the question of society's responsibility for the individual must be considered. Individualistic ways of thinking derived from Westernized cultural lifestyles and values may leave the individual with AN alone in his or her distress. A society characterized by alienation, lack of caring, and pressures to succeed and to reach 'perfection' may unintentionally promote the vulnerable individual's wish to escape the pressure by death. Additionally, the mortality rate in Anorexia Nervosa related to both the medical complications and to the high suicide rate, even if patients are adequately treated, is the highest of all mental disorders. The risk of mortality might likely be even greater if patients would be allowed to refuse treatment even if their medical and mental conditions are severely deteriorated

The Case Against Compulsory Treatment

Despite the reservations in allowing patients with possibly limited insight, cognitive functioning, and competence to decide upon a treatment course for themselves, there are several arguments in support of this position. In an individualized oriented society, there is a law regarding human freedom and free choice in life. In such a society, it is an important human right that it is an individual's choice to live or die, even if this is hard to accept or understand. This freedom of choice does not distinguish between those who truly want to die and those who simply do not want to continue living while experiencing their current, unbearable condition. Additionally, compulsory treatment may cause harm to patients simply by its being against their will [despite some studies showing the contrary as described in the study]. In some cases, if the patient is not ready to participate, they may react to the re-feeding process by engaging in suicidal behavior. Another argument against compulsory treatment is that the need to save a life may be more for the sake of the treatment team than for the patient's sake. It is impossible to save every patient. Therefore, this view posits that treatment providers should listen carefully to a patient's refusal. Furthermore, as no treatment has proved yet its total efficacy in the case of AN, it might be problematic to carry it out against the patient's will. A more holistic approach asserts that, as a society, we must learn to tolerate variance and accept that illness might not be always described only in black and white terms. The case against compulsory treatment posits that the long-term efficacy of compulsory treatment has not been yet thoroughly studied [18]. However, the argument for compulsory treatment due to lack of competence is also not definitive, as the results are contradictory. Further research is necessary to better understand both the long term efficacy of compulsory vs. voluntary treatment and the role of malnutrition in the decision making process.

CONCLUSIONS

Anorexia Nervosa is a debilitating disorder that often requires intense treatment if it is not treated in its early stages. Not surprisingly, the more chronic the illness, the more complicated the treatment. There is no clear consensus about which treatment or intervention should be used in severe and enduring cases. The issue of compulsory treatment becomes exceptionally problematic in these conditions. There is a significant conflict between invoking compulsory treatment for patients at that stage and allowing them to exercise their legal autonomy to refuse treatment. No adequate resolution to this predicament has been established yet in the legal realm. Until that happens, therapists should make a concerted effort to help patients with severe and enduring AN try to make a responsible decision about receiving treatment. However, if the patient continues to refuse treatment, it is the therapist's ethical responsibility to take the necessary legal steps, despite understanding the roots of the patient's refusal, to allow treatment that will in the long run not only save the patient's life but improve its quality. Israel is not different from other countries in demonstrating the complex and exhaustible challenges that families, treatment providers, the legal system and society at large face when faced with patients who often do not want or actively refuse to accept the treatment offered to them.

REFERENCES

[1] Hoek HW, van Hoeken D. Review of the prevalence and incidence of eating disorders. Int J Eat Disord 2003; 34: 383-96. http://dx.doi.org/10.1002/eat.10222

[2] Harbottle EJ, Birmingham CL, Sayani F. Anorexia nervosa: a survival analysis. Eat Weight Disord 2008; 13: e32-4.

[3] Steinhausen HC. The outcome of anorexia nervosa in the 20th century. Am J Psychiatry 2002; 159: 1284-93. http://dx.doi.org/10.1176/appi.ajp.159.8.1284

[4] Korndorfer SR, Lucas AR, Suman VJ, Crowson CS, Krahn LE, Melton LJ,3rd. Long-term survival of patients with anorexia nervosa: a population-based study in Rochester, Minn. Mayo Clin Proc 2003; 78: 278-84. http://dx.doi.org/10.4065/78.3.278

[5] Sullivan PF. Mortality in anorexia nervosa. Am J Psychiatry 1995; 152: 1073-4.

[6] Birmingham LC, Treasure J. Medical management of Eating Disorders. Second Edition ed. United States of America, New York: Cambridge University Press; 2010.

[7] Zaider TI, Johnson JG, Cockell SJ. Psychiatric comorbidity associated with eating disorder symptomatology among adolescents in the community. Int J Eat Disord 2000; 28: 58-67. http://dx.doi.org/10.1002/(SICI)1098-108X(200007)28:1<58::AID-EAT7>3.0.CO;2-V

[8] Strober M. The cronically ill patients with AN. In: Grilo M, Mitchell J, editors. In the treatment of eating disorders: a clinical handbook NY: Guilford press; 2009. p. 225-237.

[9] Tan JO, Hope T, Stewart A, Fitzpatrick R. Control and compulsory treatment in anorexia nervosa: the views of patients and parents. Int J Law Psychiatry 2003; 26(6): 627-645. http://dx.doi.org/10.1016/j.ijlp.2003.09.009

[10] Grisso T, Appelbaum PS, Hill-Fotouhi C. The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions. Psychiatr Serv 1997; 48: 1415-9.

[11] Tan J, Hope T, Stewart A. Competence to refuse treatment in anorexia nervosa. Int J Law Psychiatry 2003; 26: 697-707. http://dx.doi.org/10.1016/j.ijlp.2003.09.010

[12] Ayton A, Keen C, Lask B. Pros and cons of using the Mental Health Act for severe eating disorders in adolescents. Eur Eat Disord Rev 2009; 17: 14-23. http://dx.doi.org/10.1002/erv.887

[13] Watson TL, Bowers WA, Andersen AE. Involuntary treatment of eating disorders. Am J Psychiatry 2000; 157: 1806-10. http://dx.doi.org/10.1176/appi.ajp.157.11.1806

[14] Ramsay R, Ward A, Treasure J, Russell GF. Compulsory treatment in anorexia nervosa. Short-term benefits and long-term mortality. Br J Psychiatry 1999; 175: 147-53. http://dx.doi.org/10.1192/bjp.175.2.147

[15] Serfaty M, McCluskey S. Compulsory treatment of anorexia nervosa and the moribund patient. European Eating Disorders Rev 1998; 6: 27-37. http://dx.doi.org/10.1002/(SICI)1099-0968(199803)6:1<27::AID-ERV192>3.0.CO;2-5

[16] Melamed Y, Mester R, Margolin J, Kalian M. Involuntary treatment of anorexia nervosa. Int J Law Psychiatry 2003 c; 26: 617-26. http://dx.doi.org/10.1016/j.ijlp.2003.09.006

[17] Goldner E. Treatment refusal in anorexia nervosa. Int J Eat Disord 1989; 8: 297-306. http://dx.doi.org/10.1002/1098-108X(198905)8:3<297::AID-EAT2260080305>3.0.CO;2-H

[18] Carney T, Crim D, Wakefield A, Tait D, Touyz S. Reflections on coercion in the treatment of severe anorexia nervosa. Isr J Psychiatry Relat Sci 2006; 43: 159-65.

[19] Hay PJ, Touyz S, Sud R. Treatment for severe and enduring anorexia nervosa: a review. Aust N Z J Psychiatry 2012; 46: 1136-44. http://dx.doi.org/10.1177/0004867412450469

[20] Hoek HW. Incidence, prevalence and mortality of anorexia nervosa and other eating disorders. Curr Opin Psychiatry 2006; 19: 389. http://dx.doi.org/10.1097/01.yco.0000228759.95237.78

[21] American Psychiatric Association editor. Diagnostic and statistical manual of mental disorders, 4th ed. Text revised DSM-IV-TR. Washington, DC: APA; 2000.

[22] Vitousek K, Watson S, Wilson GT. Enhancing motivation for change in treatment-resistant eating disorders. Clin Psychol Rev 1998; 18: 391-420. http://dx.doi.org/10.1016/S0272-7358(98)00012-9

[23] Appelbaum PS, Rumpf T. Civil commitment of the anorexic patient. Gen Hosp Psychiatry 1998; 20: 225-30. http://dx.doi.org/10.1016/S0163-8343(98)00027-9

[24] Vialettes B, Samuelian-Massat C, Valero R, Beliard S. The refusal of treatment in anorexia nervosa, an ethical conflict with three characters: "the girl, the family and the medical profession". Discussion in a French legislative context. Diabetes Metab 2006; 32: 306-11. http://dx.doi.org/10.1016/S1262-3636(07)70284-7

[25] Grisso T, Appelbaum PS. Assessing competence to consent to treatment: A guide for physicians and other health professionals. Oxford, UK: Oxford University Press, USA; 1998. p. 173-200.

[26] Bachar E, Latzer Y, Canetti L, Gur E, Berry EM, Bonne O. Rejection of life in anorexic and bulimic patients. Int J Eat Disord 2002; 31: 43-8. http://dx.doi.org/10.1002/eat.10003

[27] Cavedini P, Bassi T, Ubbiali A, *et al*. Neuropsychological investigation of decision-making in anorexia nervosa. Psychiatry Res 2004; 127: 259-66. http://dx.doi.org/10.1016/j.psychres.2004.03.012

[28] Tchanturia K, Liao PC, Uher R, Lawrence N, Treasure J, Campbell IC. An investigation of decision making in anorexia nervosa using the Iowa Gambling Task and skin conductance measurements. J Int Neuropsychol Soc 2007; 13: 635-41. http://dx.doi.org/10.1017/S1355617707070798

[29] Gillberg IC, Rastam M, Wentz E, Gillberg C. Cognitive and executive functions in anorexia nervosa ten years after onset of eating disorder. J Clin Exp Neuropsychol 2007; 29: 170-8. http://dx.doi.org/10.1080/13803390600584632

[30] Liao PC, Uher R, Lawrence N, *et al*. An examination of decision making in bulimia nervosa. Journal of clinical and experimental neuropsychology 2009; 31: 455-61. http://dx.doi.org/10.1080/13803390802251378

[31] Cavedini P, Zorzi C, Bassi T, *et al*. Decision-making functioning as a predictor of treatment outcome in anorexia nervosa. Psychiatry Res 2006; 145: 179-87. http://dx.doi.org/10.1016/j.psychres.2004.12.014

[32] Bechara A, Tranel D, Damasio H. Characterization of the decision-making deficit of patients with ventromedial prefrontal cortex lesions. Brain 2000; 123: 2189-202. http://dx.doi.org/10.1093/brain/123.11.2189

[33] Lauer CJ, Gorzewski B, Gerlinghoff M, Backmund H, Zihl J. Neuropsychological assessments before and after treatment in patients with anorexia nervosa and bulimia nervosa. J Psychiatr Res 1999; 33: 129-38. http://dx.doi.org/10.1016/S0022-3956(98)00020-X

[34] Harrison A, Sullivan S, Tchanturia K, Treasure J. Emotional functioning in eating disorders: attentional bias, emotion recognition and emotion regulation. Psychol Med 2010; 40: 1887-97. http://dx.doi.org/10.1017/S0033291710000036

[35] Guillaume S, Sang CN, Jaussent I, *et al*. Is decision making really impaired in eating disorders? Neuropsychology 2010; 24: 808-12. http://dx.doi.org/10.1037/a0019806

[36] Guarda AS. Treatment of anorexia nervosa: insights and obstacles. Physiol Behav 2008; 94: 113-20. http://dx.doi.org/10.1016/j.physbeh.2007.11.020

[37] Tan JO, Stewart A, Fitzpatrick R, Hope T. Attitudes of patients with anorexia nervosa to compulsory treatment and coercion. Int J Law Psychiatry 2010; 33: 13-9. http://dx.doi.org/10.1016/j.ijlp.2009.10.003

[38] Shahar M, Latzer Y, Buchbinder E. Recovery from Anorexia Nervosa: the patient's perspective. In: Stein D, Latzer Y, editors. *Treatment and recovery of Eating Disorders*. New-York: NY: Nova science publishers; 2012. p. 171-186.

[39] Draper H. Anorexia nervosa and respecting a refusal of life-prolonging therapy: a limited justification. Bioethics 2000; 14: 120-33. http://dx.doi.org/10.1111/1467-8519.00185

[40] Jones WR, Saeidi S, Morgan JF. Knowledge and attitudes of psychiatrists towards eating disorders. Eur Eat Disord Rev 2013; 21: 84-8. http://dx.doi.org/10.1002/erv.2155

[41] Griffiths RA, Beumont PJV, Russell J, Touyz SW, Moore G. The use of guardianship legislation for anorexia nervosa: a report of 15 cases. Australasian Psychiatry 1997; 31: 525-31. http://dx.doi.org/10.3109/00048679709065074

[42] Brunner R, Parzer P, Resch F. Involuntary hospitalization of patients with anorexia nervosa: clinical issues and empirical findings. Fortschr Neurol Psychiatr 2005; 73: 9-15. http://dx.doi.org/10.1055/s-2004-830078

[43] Russell GF. Involuntary treatment in anorexia nervosa. Psychiatr Clin North Am 2001; 24: 337-49. http://dx.doi.org/10.1016/S0193-953X(05)70229-X

[44] Ministry of Health. Mental health in Israel: Statistical annual 2002. 2002.

[45] Tel Aviv District Court. Anonymous v The Tel Aviv Mental Health Commission. 2012(Case Number 37847-09-12).

[46] Pompili M, Mancinelli I, Girardi P, Ruberto A, Tatarelli R. Suicide in anorexia nervosa: a meta-analysis. Int J Eat Disord 2004; 36: 99-103. http://dx.doi.org/10.1002/eat.20011

[47] Latzer Y, Hochdorf Z. Dying to be thin: attachment to death in anorexia nervosa. ScientificWorld J 2005; 5: 820-7. http://dx.doi.org/10.1100/tsw.2005.95

[48] Bachar E. The contributions of self psychology to the treatment of anorexia and bulimia. Am J Psychother 1998; 52: 147-65.

[49] Arbel R, Koren D, Klein E, Latzer Y. The neurocognitive basis of insight into illness in anorexia nervosa: a pilot metacognitive study. Psychiatry Res 2013; 209: 604-10. http://dx.doi.org/10.1016/j.psychres.2013.01.009

Received on 03-04-2014 Accepted on 05-05-2014 Published on 22-09-2014

DOI: http://dx.doi.org/10.12970/2310-8231.2014.02.02.6