

Introduction

[Eating disorders are]...*really like a great, mythological artichoke... a single flower, green and purple, where each leaf hides another, each layer covers another layer, jealously hidden. Whoever knows how to take off the outside leaves will discover unimaginable things, in a difficult voyage in time and space...*¹

Eating disorders are a complex condition: they have many sides and, like artichokes, are made up of layers. You have to have the patience to look beyond, to proceed step by step to find the core of a problem, to find ‘the person within’.² Eating disorders are puzzling in many ways. They are puzzling because they are a *self-imposed* disease. People with eating disorders are normally young and bright. They do not complain about their eating habits and they either hide them or defend them, or both, sometimes in the face of advanced emaciation. However, as well as being *wanted*, eating disorders are clearly self-destructive and potentially lethal. The risks for health are great, and mortality (up to 20 per cent) is one of the highest among psychiatric disorders. Even when emaciation is not advanced, disordered eating threatens a person’s life in ways that are not always apparent: the effects on the heart, for example, are particularly worrisome, especially as they may be undetectable. Moreover, abnormal eating contributes to the probability of the person spiralling down into a condition of unhappiness and loneliness, and one of the main causes of death in people with eating disorders is suicide.

Eating disorders have been the subject of extensive research in clinical psychology, sociology, and psychiatry. The disorder raises many different questions. This book will concentrate on the ethics of the care and treatment of the person with eating disorders. It will not deal with epistemological issues on the nature of mental illness. It will be clear throughout the book that this is irrelevant to the ethics of care and treatment of the eating-disordered person (in particular, see Chapters 2 and 3). Moreover, I will

¹ Carlo Levi, *Le mille patrie* (Rome: Donzelli, 2000).

² This expression was used by Hilde Bruch in the title of her *Eating Disorders: Obesity, Anorexia Nervosa and the Person Within* (London: Routledge and Kegan Paul, 1974).

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not compare eating disorders to other forms of food refusal—medieval ascetic saints, for example, or hunger strikers. Other researchers have provided extensive studies on the matter, and it would be superfluous to repeat the results of these studies. Another aspect that will be marginal to this study is the impact of gender socialization in the development and treatment of eating disorders. We will discuss the family and society of the eating-disordered person, but there is much important work by feminist philosophers that will not be discussed in this book, as I do not wish to consider eating disorders from a feminist perspective or as a ‘women’s’ issue and as thorough discussion of this topic would require a separate study and would direct us into areas of investigation that are not strictly pertinent to this book. The Bibliography at the end of the volume provides references for those who are interested in the subject.

Chapter 1 provides a description of the condition. It explores aetiology, incidence, and prevalence, and reports the risks for health that are caused by abnormal nutrition. I will focus on anorexia and bulimia nervosa, which are generally regarded as the main eating disorders, and mainly on anorexia nervosa. Diagnostic manuals identify borderline types and subtypes of eating disorders, which I will not analyse. I will focus only on the two major syndromes, and mainly on anorexia nervosa, because I am concerned with the phenomenon that seems to underlie all eating disorders that are psychological in nature,—namely, *the desire to be thin*. Rather than providing a clinical exploration of the various forms of eating disorders, I will try to answer a general question: why do people want to be thin? I will focus on attempts to control eating, rather than on the result of eating anomalies in terms of body weight or shape. In other words, I shall try to understand why people are preoccupied with body weight, and why they try to control their eating habits: whether they will become emaciated, keep normal weight, or become overweight is secondary. Whether people vomit as a way of purging themselves or only diet is also secondary. I will consider bulimia as one form in which the fight for thinness and lightness may take shape.

Anyone who is involved with a person with an eating disorder and who cares for her³ will be troubled by an ethical dilemma: should one respect the person’s self-destructive behaviour, should one try to persuade the person to modify it, or, if there seems to be no alternative, should one force the person not to perform self-destructive acts?

³ For easiness, given that the majority of sufferers are women, I shall use the female pronouns she/her. However, it should be remembered that eating disorders also affect the male population. See H. G. Pope Jr, J. I. Hudson, D. Yurgelun-Todd, and M. S. Hudson, ‘Prevalence of Anorexia Nervosa and Bulimia in Three Student Populations’, *International Journal of Eating Disorder*, 3 (1984), 33–51; and the Eating Disorders Association reports at edauk.com, section ‘Men’s Issues’. See also Section 1.3 below.

These questions raise an issue of principle: is there an entitlement to intervene against people's wishes, in order to protect their welfare?

1. *Autonomy v. Paternalism*

Chapter 2 explores the value of autonomy as compared with the value of people's welfare and articulates a theory of ethically justifiable paternalism. It will be explained in what circumstances non-consensual interventions may be ethically acceptable.

I shall propose a theory of 'weak paternalism' according to which, at least *prima facie*, it may be legitimate to restrict freedom of action and choice only when the actions and choices that are impeded are non-autonomous in some important way (for example, when they are based on inaccurate information or on false beliefs). If a person is making autonomous actions and choices, these actions and choices, however harmful for the person herself, should be respected, at least *prima facie*. In principle, a person should be entitled to refuse other people's advice, and even to refuse life-saving treatment, provided that the choice is significantly autonomous.

I will apply this theory to the case of eating disorders, and I will analyse eating-disordered behaviour to determine whether it may be considered autonomous and whether, therefore, it should be respected (Chapter 12). It should be noticed that the theory articulated here is *prima facie* (other things being equal, this is what carers and health-care professionals should do). This theory applies *prima facie* to everyone, whatever their illness, and therefore is not specific to people with eating disorders. However, after we have analysed eating disorders, we shall notice that this theory loses a significant part of its normative strength. There are two reasons for this: first, it is extremely difficult (for a number of reasons that will be discussed in Chapter 12) to determine whether eating-disordered behaviour is significantly autonomous. Consequently, it is extremely difficult to answer the question as to whether that behaviour should be respected or not. Secondly, there are circumstances that are particular to anorexia nervosa in which, even if we could determine with certainty that some actions and choices are fully autonomous, it is not clear that these actions and choices should always be respected, or that the appeal to the principle of respect for autonomy would be enough to guarantee that the autonomous choice should be respected. I am here referring in particular to the choice of refusing life-saving treatment—and thus, to the choice of letting the patient die from starvation.

It has been suggested that in some cases refusal of life-saving treatment by anorexic patients may be autonomous. Based on the theory of weak paternalism, an autonomous refusal of life-saving treatment should be respected.

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If we could determine that a patient with anorexia is autonomously refusing life-saving treatment, in theory we should respect that choice. However, the anorexic patient is normally a young woman, who is otherwise physically fit, and who could become healthy again, if she just accepted that she should eat. This simple awareness sets the whole situation in a peculiar light: the fact that the anorexic *may decide to eat* and *to go back to normal* (as many anorexics do) creates a situation in which it may be extremely difficult for carers and health-care professionals *to let the patient go*. The case of eating disorders thus imposes enormous psychological distress on the significant others (normally relatives and carers). The death of a young woman who *just refuses to eat* may be an intolerable event for the significant others, possibly more intolerable than other deaths. This is not only understandable but also ethically important.

Whereas *prima facie* the autonomous choice to refuse life-saving treatment should be respected, the peculiarities of anorexia lead us to widen the scope of the analysis also to include carers in the choice of how to deal with the patient. This is not to say that ‘the relatives should decide’; rather, this is to say that *some weight* should be given to the particularities of the case and that it is possible that the normative strength of the principle of respect for autonomy, in some instances, is *weakened*.

An appeal to the principle of respect for patients’ autonomy may be insufficient to allow the anorexic patient to starve herself to death. Not that this would necessarily be *wrong*. However, this would be, or could be, *psychologically unbearable*. It seems to me, and I will show this in Chapter 13, that, if we decided to respect the anorexic’s choice to die, while we had the power to feed her and thus keep her alive, we would not do so only for the sake of respect for people’s autonomy. It is more likely that we would also do so *because we are profoundly sorry for the person*, because we understand that all this is intolerable for her, *because we feel compassion for her*. I will argue that the principle of respect for autonomy loses part of its normative strength in the case of anorexia, and that the choice to respect the person’s decision to die will be based on *our compassion*, or at least some sort of ‘mixture’ of respect for autonomy and compassion.

I should clarify one point. The autonomy of the psychiatric patient has historically been trumped, and this book shows that very often the reasons for which this has happened are untenable. This book will argue that people with a psychiatric diagnosis should be treated in the same way as people with other diseases. If, as I have just argued, in some cases there may be reason not to accept straightaway the anorexic’s decision to die, even if that decision was autonomous, this is *not* because the patient has a mental illness, or because, since the patient has a mental illness, she should be treated differently.

2. *The Value of Autonomy in Psychiatric Health Care*

The value of autonomy is universally recognized in philosophy, ethics, law, medical ethics, and international protocols. The idea that autonomy is valuable and ought to be respected and protected is one of the pillars of democratic societies. The principle of respect for autonomy is to be found in the health-care law of most societies: people are normally entitled to consent to or refuse medical treatment for any reason, so far as they understand what they are refusing and the consequences of their refusal, even if they will die as a result of their choice. It is generally accepted that autonomy should be given priority over people's welfare.

However, many people believe that the principle of respect for autonomy should be suspended in psychiatry. People with mental illnesses are often thought to be deficient in autonomy in important ways. It is believed that mental illness compromises people's autonomy, at least in important areas of their life. Therefore, for example in the UK, a special statute regulates assessment and treatment of people with mental illness (the Mental Health Act 1983). The statute provides that people with mental illnesses or mental disorders who are hospitalized under the Mental Health Act 1983 shall not be required to give consent for treatment of their mental disorder. The rationale for this is that people with a mental illness are believed to lack autonomy when it comes to decisions relating to their mental health.

Because of the belief that mental illness 'may compromise people's autonomy', it is often accepted that people with mental conditions be treated paternalistically.

Empirical evidence seems to suggest that such a belief is false. Most people with mental disorders are able to make important decisions, including decisions about their health and mental health. And people with eating disorders are typically capable of running their life in any sense that may be considered relevant to autonomy: they are generally intelligent, skilled people, and often successful in school and professional life. So, in what sense may mental illness 'compromise' people's autonomy? What does this statement mean exactly?

Chapter 3 shows that the claim that mental illness compromises autonomy is meaningless. This statement is *tautological*.

This does not mean that people with mental illness *must necessarily be autonomous*, or that people with eating disorders *are and must be considered* autonomous. Indeed, it is questionable whether eating-disordered behaviour is autonomous. The point that I make in Chapter 3 is that, in most cases, it is mistaken to claim that *mental illness compromises people's autonomy*.

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This has an important ethical implication: the fact that the person has been diagnosed as having a mental disorder does not provide us with a justification to act paternalistically. Clinical diagnosis has no ethical relevance. In other words, we cannot claim that we are justified in forcing people to accept treatment, or in restricting people's freedom of action and choice, on the basis of the fact that they have been diagnosed as having a mental illness.

People, whether they suffer from a mental or a physical illness, or from no illness at all, should be free to act and choose as they wish—so far as they do not harm others—if their actions and choices are autonomous to a relevant extent. Thus, if people with a mental illness prove capable of making decisions about their mental health, or about any other matter that is relevant to them, the protection of their own good is not a valid reason to deny them the exercise of autonomy.

People *with a mental illness* who are capable of making a decision (whether or not related to their illness) should be respected for the same reason that people *without a mental illness* who are capable of making a decision should be respected. And people *without a mental illness* who are going to harm themselves while acting non-autonomously (out of ignorance, or false beliefs, or because they are under the effect of some drug, for example) should be protected in the same way and for the same reasons that people *with a mental illness* who are going to harm themselves while acting non-autonomously should be protected.

This idea is very far from commonly accepted views, common practice, and legislation. The law entitles health-care professionals to section people with mental illnesses for assessment and treatment of their mental condition, and their competence to decide upon their mental health is not assessed. People with eating disorders are subjected to the same legislation. Chapter 11 analyses the law regulating assessment and treatment of people with mental disorders; it discusses issues of competence and consent. Chapter 11 focuses on cases specifically concerning people with eating disorders and discusses the resolutions taken in courts. Legal provisions are critically analysed.

The conclusion is that there is no ethical justification for the different treatment that the law reserves for people who have received a psychiatric diagnosis. Some may object that surely 'some' diagnoses justify different treatment. In this book I will argue that of course different diagnoses justify different treatment, in the sense that a diagnosis of cancer justifies chemotherapy whereas a diagnosis of diabetes justifies insulin. However, the *coercion* (*this* type of different treatment!) is not justified by the diagnosis. What may justify coercion is the fact that the patient is incapable of acting or choosing autonomously on a particular occasion. Lack of autonomy is sometimes (or maybe often) associated to a psychiatric diagnosis, but this is not always the case, because people with a psychiatric diagnosis may be

autonomous to make numerous choices. In any case, it is not the type of diagnosis that justifies coercion: it is the lack of autonomy. By providing that people with a psychiatric diagnosis may be coerced in ways in which people without a psychiatric diagnosis cannot, legislation violates not only one of the requirements of ethics, *consistency*, but also a fundamental human right, that is, *equality*. It is universally understood that individuals should be treated as equal, unless an ethically valid reason justifies difference in treatment. The diagnosis of mental disorder—including eating disorders—is not an ethically valid reason to *enforce* treatment.

Although it is easy to agree in principle with the argument that we ought to respect people's autonomy, despite an ongoing mental disorder, it is hard to accept that we should respect the behaviour of people with eating disorders. There is something far too irrational in eating-disordered behaviour and it is hard to believe this is what a person genuinely wants: such an irrational behaviour cannot be autonomous. One tends to believe that there must be 'something wrong with the person': it is 'impossible' for someone to sacrifice her health and even her life for the sake of 'thinness'. She 'must be driven' by some irrational force: there must be some 'irrational fear', some 'obsession', or some 'perceptual disorder'. Or maybe some 'addiction' that 'compels' the person to act in that particular way. Or some endocrine disorder or some genetic factor that explains why the person behaves in this way.

The entire behaviour of the eating-disordered person is so puzzling that people need to make sense of it. The behaviour of the sufferer throws people around her into a state of utmost psychological and emotional confusion: sympathy and worry mixed with horror, on the one hand; on the other, frustration and anger. The person is perceived as stubborn and untrustworthy, as a manipulator who has no genuine illness and who imposes her suffering both on herself and on others for unknown reasons, maybe just for power—as a demonstration of her iron will.

For most of us eating-disordered behaviour seems completely impossible to understand. Carers and health-care professionals are thrown into the same whirlpool of emotional distress. Their best attempts to help clash with the person's unwillingness to cooperate. The person may seek help but then mislead everybody over and over again. Her attitude is likely to cause irritation or deep frustration. It is possible that at some point both those who care for her and professional health-carers will just be tempted to contrast the 'iron will' of the sufferer with authority: one had better save a life than give up to the caprices of a stubborn and unreasonable (most often) *girl*.

Such an attitude may be understandable, but is it right?

Inability to understand people's behaviour has a direct impact on ethics. Because of the apparent impenetrability of the condition, because of the

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contradictory feelings that it generates in carers and professionals, and because of the power game that is likely to be created between carers and the sufferer, it becomes extremely difficult to determine whether any coercive intervention is appropriate or justifiable. If we believe that this person ‘in one way or another’ has to be fed, for example, to what extent is our judgement determined by our irritation and frustration? Or, for example, if we suggest that such behaviour is too irrational and is not what the person really wants, or that the person behaves in this way because she is ill, therefore we need to protect her, to what extent are such judgements determined by our incompetence to understand what is going on with the person?

If we do not know why the person behaves in a certain way, it seems impossible to determine what we should do, or whether it would be right to act paternalistically. The ethics of care and treatment of the eating-disordered person therefore relies on better understanding of the disorder.

3. Understanding Eating Disorders

Eating disorders are commonly considered as complex, multidimensional diseases. They are thought to be affected mainly by genetic, neurophysiological, psychological (the personality of the subject), familial, and social factors (including cultural and moral elements). These factors are all thought to play a role in the genesis and maintenance of the disorders. They constitute a network of biological and psychological connections, and I will try to provide a comprehensive and accessible account of these. Moreover, I will add further aspects that I believe should also be taken into consideration, in addition to the genetic, psychological, sociological, and other aspects.

Chapter 4 analyses the genetics and neuro-physiology of eating disorders, Chapters 5–6 explore the personality of the subject, the rationale of her behaviour, and the values underpinning eating anomalies. These chapters focus in particular on the value of lightness. Chapters 7 and 9 explore the family of the eating-disordered person; Chapters 8 and 10 are a study of the society in which the disorder is found. Finally, Chapter 12 explores the system of beliefs informing eating-disordered behaviour, to assess whether eating-disordered behaviour is autonomous.

The main conclusion of this analysis is that eating disorders should be understood from a moral perspective. Eating disorders signify a person’s belonging and adherence to a determined moral context. The disorder is the consistent expression of values that have ancient roots in Western culture and that have been incorporated into ordinary morality. Eating anomalies are not the *symptom of an underlying mental disorder*, as is often argued. They are the symptoms of ordinary morality, which is just being *taken*

seriously—or more seriously than usual. The logic of anorexia and bulimia nervosa is not a *dysfunctional* logic: it is a *moral* logic. This is not to say that eating-disordered behaviour, since it is dictated by moral beliefs, is autonomous and should be respected. Nor is it to say that the person is fully conscious of the values that guide her behaviour. On the contrary, the person may be not completely aware of the meaning of her behaviour and may also not be fully autonomous, as we shall discuss in Chapter 12. However, eating-disordered behaviour may be understood if it is seen from the point of view of the moral values that may direct it. The analysis of morality *makes sense* of apparently irrational behaviour.

This result has important implications for the moral philosopher, and for anyone who looks at the eating-disordered person from the standpoint of ethics ('what is it good or right to do in these cases?'). No one will have a definite answer. Many ethically consistent arguments may be produced, but none will be fully satisfying. An honest look through eating anomalies in some way represents a challenge to the very moral concepts of 'goodness' and 'rightness'. If the logic that underlies eating disorders is a moral logic, then understanding and unmasking that logic has, as a consequence, the *loss of ethics*. Someone who follows this book on its journey towards the heart of eating disorders, with the aim of finding out what it is ethical to do in these cases, is left in the same position as the cook who takes off all the leaves of the artichoke in the search for the artichoke.

The question 'What is it ethical to do?' will appear to be, in an important way, the *wrong question*. The real issue is *why* people want what they want, why they want it so much, why they are ready to sacrifice their health and even their life in order to get it. From this point of view, ethics collapses into psychology. The ethicist who gets to this point has to accept that there may be no definite answer to the ethics of paternalism towards people with eating disorders and that in an important sense searching for 'what is the right or good thing to do' is just missing the point and reinforcing the logic that gives rise to eating anomalies.

It may be objected that sometimes carers and doctors still have to make decisions as to how to deal with an eating-disordered person. This becomes particularly evident when we are faced with the most difficult decision of whether or not we should save a person's life by forcibly feeding her. Ethics cannot be sidelined entirely.

Chapter 13 will discuss the case of coercive therapy for people with anorexia nervosa; it will explore the arguments for and against force-feeding. We shall see that the arguments both for and against force-feeding have some strength. Once more, a definite answer to questions about the ethics of care and treatment of the eating-disordered person cannot be provided. However, some general principles may be applied to individual cases. As

I have anticipated above, the principle that should guide carers is respect for the person's autonomy. However, the psychological distress of carers should also be given some weight in the decision as to how to deal with the dying anorexic. When the circumstances and peculiarities of the case are taken into consideration, we shall notice that the principle of respect for people's autonomy loses part of its normative strength. The decision eventually to accept the patient's choice to refuse food and to die as a consequence will be based not only on the principle of respect for autonomy but also, importantly, on compassion for the patient's intolerable life.

I draw conclusions in the final chapter. Wittgenstein said that anyone who understands his book the *Tractatus Logicus Philosophicus* must *throw it away*. 'He must, so to speak, throw away the ladder after he has climbed up it'.⁴ In some way, something similar will happen to this book, once it has been read and understood. The perspective from which eating disorders are normally observed needs to be surpassed. If eating disorders have been understood, then one should no longer be interested in eating disorders, eating, fasting, autonomy, or competence. What one will want to discuss is not eating disorders but our ordinary moral values, our shared moral notions, such as moral perfection and moral integrity, and our moral categories. The perspective from which the investigation of this book started also needs to be surpassed. We started our investigation puzzled by ethical dilemmas, and we asked what we should do with eating-disordered people: should we respect their choices or protect their welfare? What is good or right to do? But the same ethical categories through which we looked at the disorder are to be questioned. It is our very concepts of 'good' and 'right' that are to be questioned. Their value needs to be discussed, and their possibly lethal consequences need to be openly addressed.

The analysis of eating disorders and of the ethics of treatment of eating-disordered people touches our very moral values and beliefs. The main argument of this book is that, if we really want to understand eating disorders, and to understand *what it is right to do* with eating-disordered people, we have to forget about how people eat and look at *what they believe*, and more generally at *what we all believe—at our morality*. This book shows extensively that eating-disordered behaviour is the consistent implementation of moral values that the person (the sufferer) *takes seriously*. This claim does not mean that people with eating disorders 'act morally' with their eating-disordered habits; or that eating anomalies are 'right' types of behaviour; or that a person who develops eating disorders will do something morally worthwhile. This claim means that eating-disordered behaviour

⁴ Ludwig Wittgenstein, *Tractatus Logico-Philosophicus*, trans. D. F. Pears and B. F. McGuinness (London: Routledge and Kegan Paul, 1961), 6.54.

can be understood if one considers a determined moral background. Eating disorders are an expression of some moral beliefs. In this sense, it is morality that is at the heart of eating disorders, and is therefore morality that we need to understand and discuss: our very concepts of ‘goodness’ and ‘rightness’—those concepts from which we started our investigation. At the end of our search, so to speak, the part of the artichoke we are left with will be the stem.

