



## Involuntary admission: The case of anorexia nervosa



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### ABSTRACT

Involuntary treatment of psychiatric disorders has always been controversial; this is especially true for eating disorders. Patients with anorexia nervosa of life threatening severity frequently refuse psychiatric hospitalization. Ambivalence toward treatment is characteristic of eating disorders and patients are often admitted to inpatient programs under pressure from family and doctors. In this article, we report research on the positive or negative impact of involuntary admission in the treatment of eating disorders, its application and effectiveness as well as the adverse consequences of coercive treatment in eating disorders.

A literature review was done. From a total of 134 publications which were retrieved from the literature search, 50 studies were directly relevant to the scope of this review and fulfilled all inclusion criteria.

There are trends and arguments for both sides; for and against involuntary treatment in anorexia nervosa. The scientific literature so far is inconclusive, although in the short term, involuntary hospitalization has benefits. This review has also shown that involuntary hospitalization can have adverse long-term consequences for the patient–therapist allegiance.

We conclude that in some cases, involuntary treatment can save lives of young patients with anorexia nervosa; however, in other cases, it can break the psychotherapeutic relationship and make the patient abandon treatment. It is the clinician who has to decide for whom and when to approve involuntary treatment or not.

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## 1. Introduction

### 1.1. Background and aim

Anorexia nervosa (AN) is a serious psychiatric disorder characterized by body image distortion, an intense fear of weight gain, and self-induced weight loss leading to physical and mental abnormalities. Despite the profound effects of AN on the patient's physical, emotional, and social well-being, many sufferers refuse treatment, even stating they would rather die than gain weight. Because AN is an ego-syntonic disorder, meaning the patient feels the "disorder" is a part of her and does not want it to go away, it is a uniquely treatment resistant condition (Guarda, 2008). In this way, issues of consent and capacity arise in the treatment of patients suffering from AN (Bryden, Steinegger, & Jarvis, 2010).

Involuntary treatment of any psychiatric disorder has always been controversial, especially for eating disorders. Patients with an eating disorder of life threatening severity frequently refuse hospitalization. Ambivalence toward treatment is characteristic of eating disorders, and patients are often admitted to inpatient programs under pressure from clinicians, family, friends, educators, or employers (Guarda et al., 2007).

The aim of this review is to report the positive or negative impact of involuntary admission in the treatment of anorexia nervosa, its application and effectiveness as well as the adverse consequences of coercive treatment in eating disorders.

### 1.2. Legal issues

Since the 50s, developments in Mental Health care and the activities of human rights movements changed the focus from a prescriptive type of treatment and control to one that takes into consideration the views and respects the human rights of mentally ill people. Consequently, individuals suffering from a psychiatric disorder are currently regarded as vulnerable individuals, requiring protection as well as access to treatment programmes that provide humane care and a substantial degree of choice and respect for autonomy (Harding, 2000). As the previous procedures leading to compulsory treatment have been considered to be jeopardising the rights of mentally ill people (International Commission of Jurists, 1992) and to constitute a fundamental infringement of their civil liberties (McIvor, 1998), the legal framework for involuntary admission and treatment has been reformed in many countries around the world (Brahams, 1997; Dressing & Salize, 2004; Dyer, 1993; Grubb, 1994; Harding, 2000; Stromberg & Stone, 1983; Surgenor, 2003; Swanson et al., 2000; Wachenfeld, 1992).

International organizations have published official documents outlining the safeguards that need to be implemented in compulsory admission legislation and practice in order to protect patient's

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individual rights. In particular, the Steering Committee on Bioethics (CDBI) produced in February 2000 a white paper on the protection of human rights and dignity of people suffering from mental disorders. In 2003, the World Health Organisation also published a mental health policy and service guidance package. These documents attempt to balance three, often conflicting interests: first, the basic human rights of the person who suffers from mental illness, secondly, his/her need for adequate treatment and finally the right of the public for safety (World Health Organization, 2003). To achieve this, they offer broad suggestions and attempt to describe “good and politically correct practice”.

Furthermore, a dimension frequently not considered stems from the United Nations (UN) Convention on the Rights of Persons with Disability (2006) where in article 12 referring to “equal recognition before the law” paragraph 4 mentions “respect of rights, will and preferences” that if applicable to individuals with eating disorders adds to the pressure to justify involuntary treatment (U.N. Office of Legal Affairs, 2006). One could argue that this UN Declaration not only adds to the argument for better justification of involuntary treatment but also since eating disorder is considered to be a chronic condition and chronic mental disorders approach the concept of disability, adds weight to the arguments against involuntary treatment.

Mental capacity is a multidimensional construct that is a central determinant of an individual's ability to make autonomous decisions. Its assessment has become increasingly important with the move away from the paternalistic role of healthcare professionals towards a greater emphasis on an individual's own treatment decisions. The American Psychiatric Association has developed a model statute which uses a mental capacity test (Stromberg & Stone, 1983). In other national jurisdictions the assessment of mental capacity and mental health legislation have developed along different lines in order to accommodate the needs of specific groups of patients (Okai et al., 2007).

All WHO countries have mental health legislation in place. At the time of the WHO report (2008), from a total of 42 countries, 20 (47%) have adopted new mental health legislation or updated their legislation since 2005. Most countries' mental health legislation is relatively new. Almost seventy per cent of the countries have dedicated mental health legislation, and 31% have provisions about mental health as part of general health legislation (World Health Organisation, 2008).

In this article, we have reviewed the relevant scientific literature on the use of involuntary admission for anorexia nervosa and present their findings.

## 2. Methods

A total of 134 publications were retrieved from the Scopus literature search using the following keywords: “anorexia nervosa” or “eating disorder” and “force” or “coercion” or “involuntary” “sedation” or “restraint” or “de-escalation” or “detain” or “compulsory” in the medical subject area. References from the reviews identified during the first search were also studied and relevant articles identified were included. The titles and abstracts of the studies retrieved were read and publications not related to the topic of the review were excluded. The full texts of the remaining 58 publications were read separately by the authors to decide on suitability for inclusion. Overall, we included from the initial literature search 21 articles and the remaining 29 were selected from the references included in the reviews identified during the first search.

Specifically, the inclusion criteria for this review were as follows: studies which contained primary data related to treatment and treatment outcome of anorexia nervosa in association with coercion in patient populations with eating disorders. Studies which used quantitative research strategy were also included as were studies which used valid measures (interviews or questionnaires) to establish diagnosis of eating disorders and related concepts. All studies were published in peer-reviewed journals. Since the research reviewed was often research

on a small number of patients, we decided to include studies with series of cases regardless of the number of subjects. The articles reviewed were a mixture of theoretical, case studies, small sample studies, and reviews. Excluded were the following: studies published earlier than 1990, studies referred to other eating disorders except anorexia nervosa, and studies which employed exclusively qualitative data and individual personal accounts of the experience of involuntary admission and treatment. The review was limited to publications in English, failing to report on findings presented in another language.

## 3. Results

### 3.1. Treatment issues—arguments for involuntary hospitalization in anorexia nervosa

Mental health legislation and involuntary admission has been used in some instances in order to treat individuals with eating disorders. Involuntary admission has been used mainly for severe restrictive anorexia that at the time of admission was deemed to be life threatening. According to the “Stone model,” in order to consider involuntary admission and treatment, the physician should establish the existence of the following 4 preconditions: (1) that he/she can be given a reliable psychiatric diagnosis, (2) that the patient is experiencing “serious discomfort,” (3) that there is available effective treatment, and (4) that the patient is unable to decide and accept the treatment offered. Overall though, in the presence of mental illness, the disorder threatens the life of the patient because of self-harm or neglect of vital care caused by the disorder, the patient refuses to accept the treatment. The criterion of dangerousness to others is not applicable in the case of eating disorders.

This approach in the management of eating disorders is controversial to say the least and gives rise to strong feelings not only among the individuals suffering from this disorder but also to the individuals that belong to the multidisciplinary team that treats individuals with eating disorders (Melamed, Mester, Margolin, & Kalian, 2003). From the above-mentioned general criteria for involuntary commitment, the “refusal” criterion is difficult to apply in eating disorders. Although psychiatrists recognize that acutely psychotic individuals cannot accept treatment because they “lack insight,” this is difficult to apply in eating disorders (1994).

There seems although to be scientific basis for the argument for involuntary admission in some cases. According to research, some patients have impaired judgment and behavior and reduced capacity to fend for themselves (Tan & Hope, 2006; Tan, Hope, & Stewart, 2003; Tan, Hope, Stewart, & Fitzpatrick, 2003; Watson, Bowers, & Andersen, 2000) (Appelbaum & Rumpf, 1998). These cases overall concern patients whose life is threatened because of extreme weight loss. It is established that severe acute or chronic malnutrition regardless of the cause can lead to structural and functional changes in the central nervous system (CNS) (Hatch et al., 2011; Hay & Sachdev, 2011) (Brooks et al., 2011; Kerem & Katzman, 2003). Furthermore, according to Kaye (2008), neurobiological research has demonstrated unilateral blood flow reduction in the area of frontal lobe in the majority of patients with severe malnutrition with an early central damage of the ocular function and the complex visual memory as well as retrograde information processing. The same researcher has shown that severe malnutrition disrupts the serotonin and dopamine systems, especially in the limbic system. This can result in emotional dysregulation. Neurobiological studies have also shown memory and information processing deficits (Kaye, 2008).

In a previous retrospective comparative study by Carney, Crim, Wakefield, Tait, and Touyz (2006), two groups of anorexic patients were studied: one was treated involuntarily ( $n = 27$ ) and the other voluntarily ( $n = 96$ ). The involuntary treated group had lower BMI at admission and more previous admissions. Involuntary admission was associated with treatment in a locked ward and tube feeding; however,

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