INVITED REVIEW

Ethical Dilemmas in Treating Clients with Eating Disorders: A Review and Application of an Integrative Ethical Decision-making Model

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Abstract

Ethical dilemmas frequently arise in the treatment of clients with eating disorders, and clinicians regularly encounter an array of ethical challenges related to whether or not overt and covert coercive tactics should be implemented. In this paper, the authors provide an overview of perplexing ethical questions relevant to medical, nutritional and psychological treatment of clients with eating disorders including imposed treatment, enforced feeding, the duty to protect minors and adults, the determination of competence and capacity among medically comprised clients, and the effectiveness of coercive treatment for clients with eating disorders. The processes of ethical decision-making in terms of ethical principles, professional codes of conduct, the existing empirical literature and the use of a decision-making framework are explored. Taking a collaborative and client-sensitive approach, the authors outline and apply an integrative ethical decision-making model to facilitate clinicians' decision-making process.

Keywords

eating disorders; ethical dilemmas; decison-making models

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Introduction

Ethical dilemmas pervade many aspects of treating clients with eating disorders, and clinicians aspiring to make ethical treatment decisions find their task fraught with difficulty. Given the complexity of these ethical decisions, no hard and fast rules for resolving the ethical conflicts exist. Rather, decision making is often guided by clinical judgment and determined on a case by case basis using best practice recommendations (American Psychiatric Association, 2006) and consultation among professionals to strike a balance between respecting the client's right to personal autonomy while providing optimal treatment to preserve the client's life and health (Goldner, Birmingham, & Smye, 1997; Russell, 1995). No single decision always prevails across the complex array of clinical cases. In this review paper we explicitly address the wider issues of overt and covert coercive tactics often employed in the treatment of clients with eating disorders and provide an overview of perplexing ethical questions relevant to medical, nutritional and psychological treatment of clients with eating disorders.

Key ethical dilemmas

Ethical issues surrounding the use of coercion in treatment are explored in relation to the following questions: (1) Should mental and allied health

professionals be allowed to usurp the client's autonomy and force either hospitalization or coerce feeding?; (2) When is there a duty to protect the client and how does the resolution of these issues vary when the client is a minor versus an adult?; (3) What do mental and allied health professionals need to know about how to determine competence and capacity among clients with eating disorders and in particular the client who is medically compromised by starvation?; (4) To what extent do mental and allied health professionals have the right to employ other coercive tactics (e.g. implementing bed rest, restricting exercise, monitoring food intake and bathroom use, limiting visitors and a variety of other privileges) with clients in treatment for an eating disorder?; and finally (5) Is coerced treatment effective in treating clients with eating disorders?

Ethical dilemmas encompass a range of strongly coercive strategies such as involuntary commitment as well as smaller scale impositions related to the terms of treatment for clients who may have consented overall to treatment or are reluctantly engaging in treatment at the behest of loved ones and professionals. In fact, even 'voluntary' clients can experience coercion and not every 'involuntary' client necessarily experiences each aspect of their treatment as coercive. Indeed, the line between coercion and excessive social influence and pressure can become blurry. For example, in the MacArthur study of coercion among psychiatric inpatients, 40% of 'voluntary' patients reported that they expected to be committed involuntarily if they refused voluntary admission (Pescosolido, Boyer, & Lubell, 1999). Consequently, coercion is often defined as the individual's perception or sense that her freedom has been violated (female pronouns will be used throughout for clarity). It can occur in both formal and informal forms, and involves legal and/or physical deprivation of an individual's liberty or the implied threat of such a punishment if compliance is not forthcoming (Szasz, 1997). There are many examples of coercive treatment strategies and restrictive disciplinary practices that are employed in the treatment of clients with eating disorders and these are illustrated in Table 1. To distinguish formal legal compulsion from lesser coercive tactics to increase treatment compliance, formal legal compulsion consists of involuntary admission under mental health laws or the appointment of a third party as a guardian to make treatment decisions for the incapacitated client (Carney, Tait, Richardson, & Touyz, 2008).

Table 1 Coercive and restrictive treatment strategies and disciplinary practices

Involuntary hospitalization
Guardianship orders
Naso-gastric tube feeding
Enforced nutritional replacements (liquid supplements in lieu of solid food)
Supplementary feeding (additional snacks, meal add-ons, or nocturnal tube feeding)
Unwanted pharmacotherapy (including drugs with side effects of weight gain)
Surveillance at meals and in bathroom
Bed rest and/or movement restriction
Exercise restriction
Restrictions of visits and activities contingent upon progress and compliance
Removal of contraband items (i.e. diet soda, outside food, diet pills)
Redirections for inappropriate meal-time conversation
Redirections for rituals with food
Behavioural contracts
Measuring of food and calories consumed
Other coercive or restrictive interactions with staff

This review will present a collaborative process of making ethical decisions when faced with the complex issues of imposed treatment, enforced feeding, use of coercive behavioural strategies and management of treatment resistance in light of existing theoretical and empirical literature in this area. The use of both formal and informal coercion, among other ethical dilemmas, will first be reviewed in relation to relevant ethical principles and subsequently in relation to an integrative, collaborative and culturally sensitive model for ethical decision making (Garcia, Cartwright, Winston, & Borzuchowska, 2003). An integrated ethical model is presented to aid professionals in navigating the extensive ethical dilemmas which can arise either infrequently and/or daily for professionals treating clients with eating disorders.

Ethical principles

Discerning the best course of action for both rare (i.e. involuntary commitment) and more frequent ethical dilemmas (i.e. deciding when is it appropriate to restrict personal freedoms such as going to the bathroom unattended) requires a closer examination of key ethical principles of autonomy, beneficence, non-malificence, justice, and the duty to protect. A brief overview of these ethical principles will frame the larger discussion of relevant ethical dilemmas for this population.

Autonomy

The concept of autonomy involves liberty, the responsibility for personal behaviour, freedom of action and freedom of choice. The principle of autonomy grants the right to make informed choices about treatment without coercion or undue influence. An important aspect of autonomy includes respecting others' autonomous decisions despite believing that another's choice is mistaken, wrong or harmful. However, autonomous decisions are contingent upon one's ability to use rational deliberation and whether or not one is competent to make a particular choice (Kitchener, 1984).

Beneficence

The concept of beneficence entails doing good for others by contributing to and promoting overall human health and welfare (Beauchamp & Childress, 2000). This concept requires professionals to work within areas of competence and assumes that clients will benefit from seeking effective psychological services. Doing good for clients and promoting growth can however conflict with avoiding harm. In instances where the potential for both benefit and harm exist, Beauchamp and Childress (2000) direct readers to find the maximum balance of benefit over harm.

Justice

Related to beneficence, the principle of justice can broadly be defined as striving for fairness. Ethical practices and decision-making strive for fairness and justice. Issues of justice include ensuring equal access to psychological services, respect for human rights, client dignity, and limiting unreasonable and unfair treatment (Rosenman, 1998). Just treatment for clients with eating disorders involves using the least restrictive intervention to ensure client safety and promote good treatment outcomes (Fedyszyn & Sullivan, 2007).

Non-malificence

Related to justice and beneficence, the concept of non-malificence comes from the Hippocratic Oath to 'above all do no harm'. This includes 'not inflicting intentional harm nor engaging in actions which risk potential harm to others' (Kitchener, 1984, p. 47). In essence, the principle of non-malificence forbids actions that will harm or reasonably bring about harm to clients.

Duty to protect

The duty to protect refers to the clinicians' responsibility to protect clients' (or an identified third party's) welfare when a clinician knows that a client poses an imminent risk of danger towards him or herself or an identified third party. According to some professionals' interpretation, the ethical guidelines and code require clinicians to take action when a client's eating disordered behaviours have progressed to the point of life endangerment regardless of the client's expressed wishes (Griffiths & Russell, 1998; Werth, Wright, Archambault, & Bardash, 2003). Self-destructive clients at risk for significant self-harm generate concerns of paternalistic treatment (Rathner, 1998). Paternalism, or interfering with a client's personal liberty, presumes that the professional's opinion and actions are justified and in the client's best interest. Paternalism and the duty to protect lie at the heart of involuntary commitment and coercive acts in treatment. This intersection of autonomy and beneficence in paternalistic acts (such as the duty to protect an individual who is incompetent to make decisions regarding treatment) privileges beneficence at the expense of sacrificing autonomy.

Concerns with a purely principle ethics approach

The negotiating and balancing of conflicting ethical principles explicated by Beauchamp and Childress (2000) has been criticized by Cottone and Claus (2000) as failing to adequately address decision-making processes in depth. The danger of this approach emanates from professionals' personal privileging of one of the aforementioned ethical principles over the others and ultimately steering the outcome of ethical decision-making in lieu of reaching consensus upon which principle should prevail. As a whole we recognize the inherent subjectivity involved in weighing individual ethical principles within the context of a particular case. As such, we advocate for the explicit disclosure of professionals' personal values and advise professionals to make the rationale and steps involved in their decision-making *transparent* to clients. We present an ethical decision-making model that strives to make the process a truly collaborative and interpretive transaction.

We recognize that just as an Ethics Code (e.g. American Psychological Association, 2002) cannot provide absolute answers, ethical decision making models do not ensure ethical decisions. Instead the models provide professionals with a rubric to thoughtfully and thoroughly derive ethically appropriate resolutions for circumstances which are relatively far from straightforward. By explaining the reasoning that underlies the clinician's treatment recommendation and inviting the client and other identified key stakeholders to participate in this decision process, a plan of action can be determined in the event that the client's life becomes jeopardized by her eating disorder and her capacity to make health care decisions becomes diminished. Furthermore, the identification of new circumstances which would warrant a re-visitation of the decision should also be articulated (Manley, Smye, & Srikameswaran, 2001). Through the dynamic process of interacting with other professionals in consultation and deliberating the options with the individuals impacted by the decision, the group can arrive at a satisfactory decision.

Adopting an integrative, collaborative and culturally sensitive ethical decision-making model

Upon reviewing the ethical decision-making model literature we sought a model with emphases on relational, contextual, and cultural features. The transcultural integrative model (Garcia et al., 2003) resonated with us due to its core focus on Tarvydas' (1998) integrative model (which incorporates elements of both principle and virtue ethics) as well as the additional components of cultural factors. For this population, family, gender role and the eating disordered cultures are particularly relevant. This model also incorporates aspects from both Cottone's (2001) social constructivist and Davis' (1997) collaborative models. We subscribe to this particular model because it incorporates Cottone's theory-driven social constructivist model which purports that ethical decision-making results from interpersonal exchanges and agreement upon what is fact. Cottone's (2001) model rightly places the decision-making process within an interpersonal, social context involving the processes of *negotiating* (i.e. the ensuing discussion when a disagreement on an issue exists among individuals), *consensualizing* (i.e. the process of agreeing and coordinating disparate viewpoints), and *arbitrating* (i.e. the process of seeking arbitration if agreement continues to be elusive). This interactive, process oriented model seemed particularly well suited to the resolution of conflicting viewpoints often found in working with clients with severe eating disorders.

Because of the many systems involved in treating clients with severe eating disorders we sought a model that would attend to and specifically incorporate the multi-system perspectives of those involved in decision-making process (i.e. family system, treatment team members from a variety of disciplines and potentially the legal system). The ethical dilemmas which arise in treating clients with eating disorders are complex enough, but the issues 'become even more complex when working with persons who have different worldviews' (Garcia et al., 2003, p. 269). As such the transcultural model includes the virtue of tolerance, which integrates the notion of honoring and 'accepting diverse worldviews, perspectives, and philosophies' (Welfel, 2002 as cited in Garcia et al., 2003). Tolerating and valuing disparate viewpoints such as how one lives a good life are prioritized in a multi- or transcultural framework. The contribution of Davis' (1997) collaborative and relational model advocates for inclusion and cooperation among the various stakeholders, and argues that attendance to multiple perspectives is inherently better than a model focused on any single perspective. In brief, the interactive nature of examining and resolving an ethical quandary in unison with the eating disordered client and other impacted individuals (i.e. spouses, parents, and other family members) requires 'self-awareness, the ability for critical thinking, the willingness to take personal responsibility, the openness to alternative choices, and the ability to monitor and implement feedback subsequent to ethical decisions' (Cottone & Claus, 2000, p. 281). Further explication of this integrative model will be discussed in light of the ethical dilemmas presented below.

An overview of ethical dilemmas and decision-making processes in treating clients with eating disorders

By their very nature ethical dilemmas in treating clients with eating disorders are fraught with ambiguity and

complexity because there are no clear-cut best decisions. In fact, different ethically excellent decisions may be reached depending on the circumstances and context of each situation. Our stance can generally be described as client-sensitive. Following Tjeltveit's (2006) reasoning, we subscribe to the belief that acting beneficently includes respecting individual choice and autonomy whenever possible when it comes to clients' ideas about living the good life.

At the heart of the dilemma clinicians are torn between conflicting ethical principles and the competing demands of their clients and their clients' concerned loved ones. In terms of conflicting ethical principles, clinicians are bound by their duty to protect the health and welfare of clients when clinicians know that their clients are in imminent danger of dying or in serious, irreversible medical danger. On the other hand clinicians are obligated to respect clients' autonomy, their wishes regarding treatment, and to use the least restrictive interventions possible (Bentovim, 2000; Fedyszyn & Sullivan, 2007; Macdonald, 2002). Just because a proposed treatment stands to benefit an eating disordered client is not a sufficient reason to impose treatment. This benefit must be weighed in relation to short and long-term outcome and the individual's autonomous right to self-determination through the utilization of an ethical-decision making model.

The value of a relational perspective

Taking a relational perspective, ethical decision-making involves strengthening the therapeutic alliance through building a collaborative partnership as opposed to becoming adversarial. Joining and working together with clients while simultaneously prioritizing client safety is one important strategy. Goldner et al. (1997) strive for a balance between respecting the clients' rights and offering optimal treatment. These authors (1997) suggest engaging the client in a sincere discussion around the reasons for the refusal of or resistance to treatment, providing explanations for the recommended treatment, and being willing to negotiate with the client on some aspects of treatment. Treatment planning should be proactive so both clients and clinicians know in advance how potential crises will be handled.

Another collaborative recommendation made by Rathner (1998) encourages participatory shared decision making, where the treatment provider and client are mutually contributing partners in treatment decisions. The benefits of participatory shared decision making include enhanced autonomy and the client's ownership of treatment and recovery. The risks of this joint approach include potential power struggles, stalemates due to differences of opinion, and the possibility that clients will distort information to promote their eating disorder rather than recovery. Avoiding battle and scare tactics along with ensuring that treatment methods are not inherently punitive both optimizes cooperation and decreases the likelihood of power struggles eroding the therapeutic alliance or escalating symptoms (Goldner, 1989). Transparent and honest presentation of the rationale for treatment and the decision-making process increases trust and enhances the therapeutic alliance. Lastly, clients' motivation to change and willingness to engage in treatment that involves weight gain can be enhanced through motivational interviewing techniques (Treasure & Ward, 1997) and engagement with important people whom the client desires to have involved in her care. All of these strategies can reduce the sense of treatment being imposed upon her. In the following sections we review ethical dilemmas related to the use of a variety of prevalent coercive strategies as well as the use of involuntary commitment and forced tube feeding.

When, if ever, should clients with severe eating disorders be coerced into treatment or treated involuntarily?

Although the actual segment of the eating disorder population severely ill enough to require involuntary commitment is quite small (Appelbaum & Rumpf, 1998; Watson, Bowers, & Andersen, 2000), the potential for this situation to arise for the specialist in adolescent medicine or eating disorders is inevitable. Limited prior research has explored the circumstances under which clinicians pursue legal commitment, but there has been a fair amount of consensus on the factors that typically stand out as important in guiding the decision. These include: (1) the client's current health risk (assessed by body mass index or risk for re-feeding syndrome); (2) long illness duration, intractable course and number of prior hospitalizations; and (3) a complicated psychiatric presentation, including the presence of other psychiatric comorbidities and/or a history of trauma (Carney et al., 2008; Ramsay, Ward, Treasure, &

Russell, 1999; Watson et al., 2000). Perhaps the most perplexing ethical dilemma facing treatment providers involves deciding when an eating disordered client is considered medically compromised enough to warrant compulsory treatment. Treatment providers and bioethicists struggle with the important legal and ethical question of when, if ever, any person should be treated against their will. This topic has been written about extensively (e.g. Andersen, 2007; Griffiths & Russell, 1998; Melamed, Mester, Margolin, & Kalian, 2003; Mitchell, Parker, & Dwyer, 1988; Richmond, 2001; Strasser & Giles, 1988), and there is no definitive resolution to the perplexing ethical dilemma of involuntary treatment for the severely eating disordered client presenting for inpatient treatment. Experts in the eating disorders field adamantly argue both for and against involuntary treatment, and compelling rationales have been given for both perspectives.

Arguments for compulsory treatment

Professionals advocating for legal and/or medical intervention argue in favour of involuntary treatment to prevent clients from becoming another mortality statistic, which at 10–19% (for anorexia) is the highest of all psychiatric conditions (Andersen, 2007; Birmingham, Su, Hlynsky, Goldner, & Gao, 2005). Mental health professionals advocating for voluntary and involuntary inpatient treatment of clients with severe eating disorders argue that the structure and close monitoring is necessary to break eating disordered habits and form healthier habits (Bentovim, 2000; Werth et al., 2003). Evidence from Watson et al.'s (2000) study of an inpatient program suggests that involuntarily admitted clients experienced similar short-term rates of weight gain relative to those who were admitted voluntarily. Furthermore, most involuntary clients retrospectively indicated that they needed treatment and demonstrated a more positive mind set towards their treatment. Advocates amenable to compulsory treatment in some circumstances report that clients often want to eat and refrain from restricting and/or purging behaviour, yet the tenacious hold of their symptomatology prevents them from doing so (Tan, Hope, & Stewart, 2003). In essence when eating is enforced by treatment providers it may actually be easier for some clients to overcome their guilt about eating and give them permission to do so (Goldner et al., 1997).

Arguments against compulsory treatment

Conversely, mental health professionals arguing against involuntary treatment recognize that while involuntary treatment prolongs life, in the long term it may actually be more destructive and counterproductive for the client's autonomy to be usurped, leaving her feeling out of control and desperate to resort to more drastic measures to return to her former weight upon discharge from the hospital (Dresser, 1984a; Dresser & Boisaubin, 1986; Tiller, Schmidt, & Treasure, 1993). Furthermore, those opposed to involuntary treatment argue that such treatment is not curative and indicative of longer chronicity and an increased risk of suicide (Birmingham et al., 2005). A major tenet of those against involuntary treatment involves the ruptured therapeutic alliance and decreased likelihood of seeking subsequent treatment after a compulsory admission (Dresser, 1984a; Giordano, 2005; Lanceley & Travers, 1993; Richmond, 2001).

Empirical evidence regarding involuntary treatment

Similar to professionals' diverging opinions on the function and value of involuntary treatment, research indicates that coerced eating disordered clients vary in terms of their retrospective gratitude and perceived need for involuntary treatment. The proponents of compulsory treatment claim that most clients originally resistant to involuntary treatment come around to be very thankful for the insistence of their caregivers and would want to be treated in a similar fashion again (Goldner, 1989; Goldner et al., 1997; Griffiths & Russell, 1998; Honig & Bentovim, 1996; Russell, 1995; Serfaty & McCluskey, 1998; Watson et al., 2000). However, this argument has been largely anecdotal and dismissed by some professionals because it violates principles of autonomy and informed consent (Carney, Tait, Touyz, Ingvarson, Saunders, & Wakefield, 2006; Fedyszyn & Sullivan, 2007).

In recent years, the claim that compulsory treatment irreparably impairs the therapeutic alliance and undermines the likelihood of seeking future treatment (Dresser, 1984a; Giordano, 2005; Lanceley & Travers, 1993; Richmond, 2001) has gained increased attention (Fedyszyn & Sullivan, 2007) and empirical support (Vandereycken & Vansteenkiste, 2009). Two studies

(Guarda et al., 2007; Vandereycken & Vansteenkiste, 2009) published to date have empirically investigated clients' perceptions of coercive treatment for eating disorders. Prior to these two empirical studies, qualitative studies (Surgenor, 2003; Tan, Hope, Stewart et al., 2003) ascertained involuntarily committed clients' perceptions either during or closely after treatment ended.

In Guarda et al.'s (2007) study of perceived need for hospital admission among 139 clients with eating disorders, 46 individuals (33% of the sample) initially reported that they did not need to be admitted into a hospitalization program for eating disorders. However, of these 46 clients, 20 (i.e. 43% of those who refused) decided after 2 weeks that they actually required admission and reported that treatment was beneficial. Notably, far more adults than minors were among the 43% who changed their minds about needing and benefiting from treatment. Vandereycken and Vansteenkiste (2009) conducted a quasi-experimental investigation of inpatient eating disordered clients who were admitted under a previous strategy which minimized choice in comparison to clients admitted under a new strategy which maximized personal choice. They reported significantly lower drop out rates within the first month of admission under the new strategy relative to the old strategy. The authors emphasized the importance of autonomy, personal choice and the value in granting choice over coercion. Further empirical research on the harm and benefit associated with compulsory admission will enhance the burgeoning research base on the efficacy of involuntary treatment for clients with life-threatening eating disorders.

Nevertheless whether or not professionals can impose treatment rests on whether or not clients with severe eating disorders are competent to make treatment decisions. If a particular client is mentally incompetent then treatment against her will is 'appropriately called involuntary but not necessarily a violation of her autonomy' (Strasser & Giles, 1988, p. 204). Alternatively, if a particular client is competent and treatment commences against her will, such an imposition violates her autonomy and is unethical. A growing body of literature debates when and whether or not this clinical population is competent and capable of making sound treatment decisions (Grisso & Appelbaum, 2006; Starzomska, 2006a; Tan, Stewart, Fitzpatrick, & Hope, 2006) and this literature is summarized in a subsequent section of this review.

The duty to protect: Considerations for minors and adults

Determining whether involuntary treatment is necessary and when there is a duty to protect a client medically compromised by an eating disorder involves the assessment of immediate physical risk (e.g. physical collapse, bradycardia, electrolyte imbalance) as well as longer-term physical risk (e.g. osteoporosis, infertility). Such assessments are made by medical doctors and skilled nurses but clinicians need to be well-versed in warning signs and collaborate with professionals from other disciplines to offer the best standard of care. In addition to collaborating with allied health professionals, clinicians may intervene to protect a client if she is unable to manage behaviours which have the potential to cause her significant damage or death (Werth et al., 2003). In other words clinicians have the right to initiate the appropriate level of care under the auspice of grave disability and a psychiatric disorder even if there is no expressed intention to die. However, resolving the ethical dilemma of when and how to protect a client varies when the client is a minor opposed to an adult.

The initiation of compulsory admission among adults occurs far less frequently and with far greater caution than with minors (Carney, Tait, Saunders, Touyz, & Beumont, 2003). This difference between adults and minors may be attributed to the more expansive legal rights extended to adults, the privileging of autonomy over beneficence and paternalism for adults, and the privileging of the duty to protect over autonomy for minors. Furthermore, law in the United States privileges parental power so youths presenting for involuntary admission commonly find parents (or legal guardians) over-riding youths' treatment decisions and initiating invasive treatment options such as the insertion of a nasogastric (NG) tube (Bentovim, 2000; Carney et al., 2003). Most other countries allow legal guardians to act in this manner without obtaining the minor's assent to treatment (Lewis, 1999; Stewart & Tan, 2007).

The duty to protect youths may be initiated more liberally than with adults, but the same ethical and medical standards apply. From a legal perspective minors are not capable of giving consent, and treatment imposed against their will is not considered assault and battery as it is for competent adults. Instead medicine and the law justify the duty to protect minors based on

the beneficent desire to protect children and adolescents' welfare, health and lives. Any client under the age of 18 years can be treated against her wishes, although children 12 years or older are considered capable of comprehending and offering informed assent to treatment (Manley et al., 2001). Despite the general ability to comprehend and offer informed assent by age 12, most children under the age of 16 are presumed to be automatically incompetent to make treatment decisions, while teens aged 16–17 are more readily accepted as competent to make their own treatment decisions (Lewis, 1999).

Ethical challenges when working with minors

Children and adolescents with eating disorders present unique challenges in making ethical decisions regarding treatment. First of all, clinicians struggle with wanting to grant minors the agency to make their own treatment decisions, but treatment providers often feel compelled to over-ride their choices out of a desire and obligation to protect minors from harm (Bentovim, 2000). This is particularly the case with young clients, whose physical health can deteriorate very quickly, thus heightening medical risk. Clinicians also contend that there is a heightened risk among minors to develop chronic eating disorders and thus, feel pressure to intervene early to improve the prognosis and probability of recovery (Strober, Freeman, & Morrell, 1997). Although medical complications are damaging regardless of age, the ramifications of the physiological consequences of eating disorders (e.g. permanently stunted growth, osteopenia and infertility) are particularly devastating on young, developing bodies during critical periods of growth (Manley et al., 2001).

Additionally, clinicians must navigate the different perspectives and conflicting goals of the young client and other concerned family members (Stewart & Tan, 2007). Clinicians treating severely eating disordered youths frequently find themselves straddling the competing demands of concerned loved ones and the minor's ambivalence and resistance towards treatment. Stewart and Tan (2007) propose that in order to respect young eating disordered clients' autonomy while simultaneously protecting their health and welfare, professionals should take the time to explore the basis of the minor's resistance and provide a caring context of appropriate protection and boundaries to facilitate minors' exploration of various treatment options. To optimize personal agency providers should make the options, pros/cons, and the dilemmas transparent to minors to avoid power struggles. Furthermore, developing a plan proactively rather than reactively during an acute crisis is of paramount importance. Proactive treatment and crisis planning establishes expectations for both parties should the young client's medical situation turn precarious. Regardless of whether a client is an adult or minor, providers should show respect for clients' wishes/rights while also offering the best treatment options that consider both immediate and the long-term health risks and benefits.

Developmental considerations

Notably, the course treatment providers take depends on the developmental stage of the client (i.e. childhood, early, middle or late adolescence) and a variety of developmental considerations pertaining to ethical treatment of youths with eating disorders. To begin with, clinicians must ascertain the minor's stage of cognitive development (i.e. concrete or formal operations) and the maturation of decision-making abilities (Manley et al., 2001). These determinations impact how information will be communicated to the youth (i.e. in concrete versus more abstract terms) and how treatment decisions will be reached. Secondly, special considerations with younger clients (8–12 years old) require a more active role of the clinician and family in treatment (Stewart & Tan, 2007). Thirdly, preteens and teens (11-16 years old) experience heightened sensitivity to being scrutinized, observed and evaluated. Since treatment involves frequent observation, evaluation and scrutiny of caloric consumption and expenditure, clinicians must take great care to dissipate any hostility and treatment resistance resulting from such surveillance. Lastly, the loss of voice many youths with eating disorders experience should be addressed (Manley et al., 2001). Clinicians should foster and encourage adolescents to regain or develop their voice by engaging adolescent clients in the treatment decision-making and recovery processes.

Determining competence and capacity for clients with eating disorders

From a medico-legal standpoint severe eating disorders requiring medical and/or psychological intervention

present unique challenges in determining competence to refuse treatment. An examination of competence and capacity introduces the question of: when or at what point does an individual's disturbed relationship with food (i.e. irrational avoidance or compulsive bingeing and purging of food) render her incompetent to make treatment decisions? Part of the problem with determining competence can be attributed to the clear discrepancy between the client's ability to understand the disorder in general (i.e. being aware of and able to list the health risks) and being able to apply that understanding to oneself and one's condition (Gans & Gunn, 2003; Tan, Hope, Stewart, & Fitzpatrick, 2003). This discrepancy raises the question of whether or not the severely eating disordered client has the capacity to understand and appreciate the severity of her disorder. More specifically there is a concern of whether or not the client can appropriately interpret health dangers and risk of death, given the frequent denial of risk among this clinical population despite overwhelming objective evidence to the contrary. The tenacity to which some individuals with eating disorders hold their overvalued beliefs (e.g. at any cost I must lose more weight because I am fat) and distorted perceptions (e.g. I am uncomfortably full after objectively under-eating) border on the delusional (Treasure, 2002). Melamed et al. (2003) also emphasize that reality testing may be impaired among individuals with life-threatening AN. For some of these clients their actual behaviour consistently demonstrates that, in spite of no verbalized intention to die, all of their behavioural actions will likely lead to death. In sum, such concerns raise the issues of capacity and competence.

Capacity to consent to treatment is a legal concept whereas competence is the clinically comparable term for capacity (Tan, Hope, & Stewart, 2003). Capacity involves 'the ability to understand treatment information, process this information to arrive at a choice, and [the ability] to communicate that choice' (Stewart & Tan, 2007, p. 345). Competence, on the other hand, also considers relevant components such as 'the consistency of a decision over time, the impact of mental disorders, the basis of relevant beliefs (i.e. overvalued beliefs, delusions, etc.), and the ability to apply information to the self' (Stewart & Tan, 2007, p. 345). In keeping with a clinical focus, this review concentrates on determining competence in clients starving or suffering from severely debilitating eating disordered behaviour as opposed to determining legal capacity to consent to treatment.

Impairment in reasoning and cognitive abilities

Two important considerations in determining capacity among clients with eating disorders pertain to the client's lack of or fluctuating insight about the gravity of her disorder and health status, as well as the presence of organic impairments that affect the client's cognitive abilities (Webster, Schmidt, & Treasure, 2003). In particular, anorexic clients suffering from the effects of starvation may struggle with impaired reasoning and cognitive abilities (Werth et al., 2003) which may impede their ability 'to appraise their condition rationally or shift to other patterns of thought and behaviour' (Vitousek, Watson, & Wilson, 1998, p. 393). Cognitive impairments can affect judgment and decision-making when a client with AN experiences cerebral pseudoatrophy and/or biochemical changes as a result of nutritional deficiencies (Vitousek et al., 1998). In all starvation-related situations a physical threshold may exist where a person can no longer think rationally as a result of chemical changes in the body related to the effects of starvation (Carney et al., 2006). The evidence identifying this specific starvation-related biological threshold continues to be debated, although 75% or less of ideal body weight (IBW) is one commonly held threshold. Below this level many clinicians believe that a client has great difficulty weighing the evidence and making rational decisions regarding her treatment (Carney et al., 2006). To summarize, rational decisions require the ability to generate cogent reasons which will likely produce a reasonable outcome. The inability to make rational decisions ultimately compromises the client's competence to make decisions about her treatment and can thus be used to justify involuntary treatment.

As noted above, competence also pertains to the consistency of a decision over time and the impact of the mental disorder (Stewart & Tan, 2007). These two stipulations raise the question of whether or not an individual immersed in the symptoms of anorexia nervosa (AN), bulimia nervosa (BN), or eating disorder not otherwise specified (EDNOS) would make the same treatment decisions if she was not in the throes of a life-threatening eating disorder. In such instances, there is a therapeutic benefit of having previously mutually

agreed upon a course of action in the event that the client's life becomes jeopardized by the symptoms of the disorder. If the course of action has been previously agreed upon by the client, the clinician's role in commencing treatment is in line with the client's wishes, rather than a coercive action taken against her consent.

Incompetence versus irrationality

The presence and basis of the overvalued beliefs, extreme thought distortions and perceptual distortions which accompany eating disorders complicate the determination of competence. For instance, the client with AN often perceives herself as fat when in actuality she is severely emaciated. The perceptual and accompanying thought distortions in this example raise questions about the difference between incompetence and irrationality. Draper (2000) argues that clinicians should attempt to distinguish between these two concepts. In her argument Draper (2000) posits that irrationality may be an indication of possible incompetence, but taken alone irrationality is not a definitive sign of incompetence. Draper (2000) provides two justifications for associating irrational thoughts with incompetence: (1) the client's desire not to eat undermines her own stronger desire to live; and (2) her compulsion not to eat sufficient food is actually involuntary (or beyond her control), and is determined by false and distorted beliefs about her body. However, Draper (2000) also cautions against confusing irrationality with the clinician's strong disagreement with the client's beliefs and redirects readers to the specific criteria for competence. She notes that the client's competence is typically questioned when the client disagrees with the therapist's judgments about necessary food intake. However, simply being diagnosed with an eating disorder or refusing a recommended treatment are not sufficient indications of incompetence. Therapists need to remain open to the possibility that *some* clients are competent to refuse therapy, and the therapist needs to develop skill in working with the tension involved in respecting autonomy while also promoting life. In each instance, it is critical for the therapist to listen carefully to the client's reasons for refusing a specific treatment and to examine her own values and need for control. Ultimately, Draper (2000) concludes that a competent decision to refuse treatment can be made on 'rational or irrational grounds' provided the individual meets the established criteria for competence (p. 127). From an ethical standpoint Draper's (2000) claim that professionals are bound to accept a competent client's refusal of treatment is hardly contestable if the client is truly competent.

Formal assessment of competence

Determining whether or not clients with life-threatening eating disorders are competent to refuse treatment poses the problem of how to assess this accurately and formally across individuals. Clients with eating disorders found incompetent to make decisions regarding their medical and psychological care can be overridden by doctors and courts of law (e.g. Brahams, 1997). While such precedent exists in prior case law, assessing competence among clients with severe eating disorders is incredibly complicated. For instance, Tan and colleagues' (2003, 2006) research introduces concern that the current criteria for determining competence fails to capture the difficulties with thought processing and changes in values among seemingly competent anorexic clients according to psychological evaluations and standardized assessment instruments such as the MacArthur Competence Assessment Tool (MacCAT-T; Grisso, Appelbaum, & Hill-Foutohi, 1997). The MacCAT-T allows trained interviewers to formally assess clients' specific competence to make informed and rational treatment decisions. To date, the MacCAT-T is the most sophisticated assessment tool used to formally assess competence (Vollmann, 2006). Yet even the use of this standardized instrument has been hindered by the complexities associated with AN. Often the ego-syntonic nature of AN negatively impacts thought processing and changes in values (i.e. valuing the eating disorder over life and health) and creates problems related to clients' specific competence to make decisions about diet, exercise and treatment (Tan et al., 2003, 2006).

Global versus specific competence

An important distinction in the assessment of competence resides in the difference between global versus specific competence. Global competence refers to overall competence whereas specific competence pertains only to a particular domain. In general, clients with eating disorders function quite well in most other domains of their lives (i.e. they work, succeed in school,

and manage all other aspects of their lives independently). Questioning this clienteles' competence is particularly relegated to their ability to make rational decisions about the domains of eating, activity level, nutrition, physical health, and treatment.

That being said, clients with eating disorders, by the very nature of their diagnosis, are not automatically rendered incompetent to make treatment decisions (Dolan, 1998; Draper, 2000; Giordano, 2003). Moreover, clients with eating disorders (without other specific co-morbid diagnoses) are not characterized by psychosis or active suicidality (Andersen, 2007), two caveats which generally warrant involuntary treatment. Even without the expressed intention to die, actions such as continued food and water refusal or extreme laxative, emetic, and diuretic abuse can result in death in more chronic and severe cases. Yet Tiller et al. (1993) maintain that arriving at the conclusion that severe, self-imposed weight loss and/or severe electrolyte imbalance placing the client at risk for death consequently means that the client wants to die is flawed logic; rather these are psychiatric symptoms of the eating disorders.

Should health professionals be allowed to coerce feeding by nasogastric tube?

Contrary to popular belief and the plethora of literature on force-feeding anorectics (Devereux, 1995; Draper, 2003; Giordano, 2003; Goldner, McKenzie, & Kline, 1991; Hébert & Weingarten, 1991; Kluge, 1991; Lanceley & Travers, 1993; Leichner, 1991; Lewis, 1999; McSherry, 1997; Starzomska, 2006b), forced tube feeding occurs relatively infrequently among this population (Russell, 2001). More commonly clients in this position opt to eat solid foods or liquid supplements in order to gain privileges and prevent more restrictive treatment options from occurring (such as bed rest). However, medically necessitated and/or legally mandated tube feeding does occur.

Re-feeding (i.e. nutritional rehabilitation through reversing the effects of malnutrition) is recognized by law, medicine and psychology as a necessary part of treatment, although re-feeding in and of itself is not considered sufficient treatment (Treasure, 2002). Re-feeding reverses the effects of malnutrition and the associated cognitive impairments which ultimately facilitates clients' active participation in psychotherapy. Unfortunately, re-feeding is often achieved through enforced feeding, and clients frequently perceive the practice of enforced feeding as analogous to literally forcing food down their throats. While the practice of literally forcing solid food down a client's throat is universally regarded as an unethical and inappropriate treatment for an eating disorder, it is legal for treatment providers to force-feed liquid nutrition by NG tube, pressure clients to feed themselves, and for parents to give consent for tube feeding minors.

Regardless of whether or not treatment is voluntary, the aspects of treatment found to be most repugnant are the coercive elements necessary to secure weight gain. It is a delicate balance to improve the client's nutritional status while still granting the client some form of autonomy on this non-negotiable aspect of treatment. For clients who abhor eating orally, the placement of the NG tube can remove some of the guilt and the messiness associated with eating solid food until this issue can be adequately addressed in therapy, once the client is at a more stable weight. Furthermore, some clients perceive the ingestion of calories to be alarming but less so when asleep and not fully conscious of the nocturnal tube feeding (N. Koehler, personal communication, February 2005). For some clients tube feeding is a welcome alternative demonstrating that all instances of tube feeding are not perceived to be coercive. Treatment teams find themselves forced to make value-laden decisions to either respect a client's explicit wish to forgo treatment or to potentially save her life through imposed hospitalization and/or tube feeding. Clearly both benefits and drawbacks to forcibly admitting and force-feeding clients exist. In the short-term, clients successfully achieve weight gain, but the long-term benefits and consequences remain unclear given the lack of satisfactory evidence for the efficacy of forced feeding in the long term (Robb et al., 2002). All in all imposed hospitalization and tube feeding should not be undertaken lightly, but should follow a realistic appraisal of all of the potential outcomes (Russell, 2001). Only after a thorough analysis should one arrive at a decision that could be viewed as coercive by some but compassionate by others.

As evidenced by this discussion of the literature, imposing enforced hospitalization for a suicidal client with a specific plan and the means to carry out the act is relatively straightforward compared to committing a low-functioning client plagued by the medical complications of chronic starvation. Since the eating

disordered client is not typically considered psychotic and imminent risk of death must be satisfied before a client can be committed, most often this clinical population is pressured by doctors, family and friends to enter treatment 'voluntarily' (Vitousek et al., 1998). Unfortunately, commitment to treatment under such circumstances can be tenuous at best, often resulting in an acquiescence to gain weight, only to re-engage in old behaviours after 'eating their way out of the hospital' (Dresser, 1984a, p. 321). Suffice it to say this cycle more frequently occurs among those later committed involuntarily (Griffiths, Beumont, Russell, Touyz, & Moore, 1997; Watson et al., 2000).

Do clinicians have the right to use other types of coercive tactics with eating disordered clients?

The fourth ethical dilemma posed at the start of this review questions whether or not clinicians have the right to use other types of coercive tactics to manage and control clients in treatment for an eating disorder. Coercion, as defined by Szasz (1997), includes actual or implied 'deprivation of another's right to life, liberty and property' (p. 486). Such coercion may be threatened to be invoked (i.e. formal legal compulsion) or actually acted upon (i.e. the imposition of therapeutic interventions on clients against their will). Furthermore, coercion can be conceptualized on a continuum where influence, persuasion and force move towards greater degrees of coercion. Formal legal compulsion is rarely invoked in the United States (Carney et al., 2003) due to financial complications of the managed care system (Andersen, 1998) in which most specialty units refuse to accept the transfer of an involuntary patient from a medical unit out of safety concerns and because many providers respect the high value placed on autonomy and the right to self-determination. Consequently, many medically compromised patients are only admitted to medical units for stabilization and their refusal to transfer to a specialty unit is honoured. In spite of the infrequent use of formal legal compulsion, smaller scale coercive strategies are ubiquitously used to manage treatment resistance and treatment refusal among clients with eating disorders.

Several professionals (Giordano, 2005; Mitchell et al., 1988; Rathner, 1998) argue that coercion has no place in psychotherapy since the very enterprise is based on tenets of volition and a joint working collaboration with the clinician. Yet many treatment programs, hospital units, and outpatient therapists use coercive strategies to treat clients with eating disorders. To illustrate the pervasive use of coercive strategies Macdonald (2002) states: 'clinicians must decide 100 times a day whether a certain treatment, limitation or requirement is justified' (p. 269). Many clinicians justify the use of these coercive strategies as necessary limits to promote safety and recovery. Some go a step further and suggest that smaller scale impositions are preferable to more restrictive and invasive treatment measures. Naturally, this raises the questions of how ethical these coercive practices are and whether these coercive strategies are caring, punitive or both.

Others, like Szasz (1997), propose that psychiatric coercive strategies are incompatible with respect for individual liberty and are a misuse of power. Specific to eating disorders, the precedence of behaviour modification programs in the 1970s and 1980s offers some historical context for the wide-spread use of coercive measures. Even though popular treatments have shifted from behaviour modification to cognitive-behavioural therapy, the legacy of rewards and punishments continues to operate in the treatment of eating disorders (see Table 1). A number of critics question the motivation of coercive tactics. For example, Starzomska (2006b) construes strict behavioural interventions, such as demanding clients to eat 100% of their meals, as an example of mistreatment. Furthermore, Tan and colleagues (2003) boldly state that 'coercive tactics are counterproductive and anti-therapeutic' (p. 630), which leads to our last question exploring the actual efficacy of coerced treatment.

Is coerced treatment effective in treating clients with eating disorders?

Tied to the ethical dilemma of whether or not coercive strategies are ethical is the issue of whether or not coercion promotes better treatment outcomes and recovery. An early study by Touyz, Beumont, Glaun, Phillips, and Cowie (1984) found that more lenient treatments were just as effective as the more coercive operant conditioning treatments with systems of rewards and punishments in place. While solitary confinement for not finishing a meal is no longer

common practice, remnants of rewards and punishments enumerated in Table 1 pervade treatment centres using the most current evidence-based therapies and treatment practices.

As for whether or not coercive strategies work, the current research base suggests that the relative success of current therapies for eating disorders too often leads to only temporary behavioural change with a significant proportion of clients who never recover (Ben-Tovim, Walker, Gilchrist, Freeman, Kalucy, & Esterman, 2001; Carney et al., 2006; Eckert, Halmi, Marchi, Grove, & Crosby, 1995; Molly, Willer, Thuras, & Crow, 2005). For instance, the marginal benefit of only 18 AN patients (out of 76) achieving full recovery at 10 year follow-up (Eckert et al., 1995) illustrates that best-practice treatments with coercive elements are not yielding good treatment outcomes for AN. Recovery following the currently available treatments is temporary and in some scenarios only makes people worse (Carney et al., 2006; Kraatz, 2006). Clearly psychiatry and psychology as a whole need a clearer understanding of the risks to recovery inherent in coercive tactics. As Kraatz (2006, p. 81) highlights in *Radical Recovery* 'disordered eating cannot possibly be affected in any positive way by nagging, cajoling, badgering, scolding, shaming, force-feeding or any other form of interaction that is anything less than compassionate'. Yet some of the disciplining practices are necessary to promote order and provide a safe treatment milieu. Clearly allowing clients to eat as much (or as little) as desired and permitting exercise in medically dangerous situations will not promote good treatment outcomes or recovery from eating disorders. Furthermore, 'every action that infringes upon another's autonomy is not always ethically wrong' (Macdonald, 2002, p. 270). Ultimately the coercive and non-coercive elements of treatment need to be examined empirically to disentangle the active ingredients promoting lasting behavioural change and to provide clearer ethical guidelines in making treatment decisions.

Furthermore, the empirical evidence has demonstrated limited efficacy of available treatments and the ineffectiveness of forced feeding to cure an eating disorder (Fedyszyn & Sullivan, 2007). Working from the principles of beneficence and non-maleficence, it only makes sense to enforce treatment if one is reasonably confident that the treatment will bring about benefit to the client (Carney et al., 2006; Dresser, 1984b; Mitchell et al., 1988). Consequently, clinicians may be more justified in imposing treatment for clients with BN or EDNOS since the effectiveness of the treatments and the recovery rates are more promising than the current psychological treatments and medical interventions for AN (Ben-Tovim et al., 2001; Eckert et al., 1995; Molly et al., 2005). For AN, weight-restoration may be achieved temporarily by tube feeding or compelling clients to feed themselves, but frequently AN clients relapse and are hesitant to engage in further treatment (Cockell, Zaitsoff, & Geller, 2004).

Issue of palliative care

As for clients who have suffered from AN beyond the natural course of the disorder, that is beyond a decade or more (Draper, 2000), some professionals advance the argument that some of these clients may be able to make a competent assessment about the quality of their life, and consequently, refuse further forced feeding. In these rare circumstances, some professionals do advocate for palliative care, support the right to die and view chronic AN as a chronic and possibly terminal illness (Draper, 2000; Fedyszyn & Sullivan, 2007; Gans & Gunn, 2003; O'Neill, Crowther, & Sampson, 1994). Those holding this position do not propose that individuals with severe and chronic eating disorders *require* palliative care. Rather, they acknowledge that there may be limited circumstances under which a client's refusal to give consent for treatment should be respected. The compelling case example presented by Gans and Gunn (2003) illustrates this dilemma very well and reveals how in this case (and potentially others), the most compassionate decision may be to offer palliative care by making the client comfortable and attending to end of life issues instead of embarking upon yet another coercive round of tube feeding and all of the restrictive elements that come with living on a hospital unit. Furthermore, Fedyszyn and Sullivan (2007) advise providers to re-think what is beneficial and in the client's best interest based on the client's treatment history and her personal values of what constitutes a good life worth living. These authors advance an argument that palliative care is not synonymous with giving up on a client or colluding with a client's eating disorder. Rather it is a shift from symptom-focused treatment where the client is the object of treatment interventions to one where she becomes an active subject in treatment interventions based on her own personal values, autonomous wishes

and prognosis. In effect, palliative care should be reserved for extreme situations and an arrival at this decision should follow an extensive ethical decision-making process.

Overall we fully recognize the dangers of prematurely giving up on a client with a severe and chronic eating disorder and respect experts' assertion that eating disorders are always reversible (except in the case of organ failure). Arriving prematurely at the conclusion that the client's AN has reached the stage of a terminal illness is intensely problematic because presumably hopeless cases sometimes do recover (Yager, 1995). Furthermore, Ratnasuriya, Eisler, Szmukler, and Russell's (1991) research illustrates a steady rate of recovery up to 12 years after the initial onset of AN. Ratnasuriya et al.'s finding suggests that even long-standing and severe cases of AN can achieve recovery beyond Draper's (2000) decade mark of chronic AN. As a result, in some cases the outcome of applying an ethical decision-making model may result in the decision to sacrifice autonomy in order for the client to have the chance to recover. This is particularly true if the client's weight has dropped below a certain level and precludes the ability to make voluntary and rational decisions regarding treatment (Dresser, 1984a; Griffiths et al., 1997). However, in such difficult and chronic cases, a collaborative partnership that has reached treatment decisions prior to a life-threatening crisis provides clearer guidance in cases of long-standing AN, and fosters respect for the client's right to make quality of life decisions.

Additional factors to consider prior to commencing with coerced treatment

Clinicians need to proceed with extreme caution and personal reflection when coercive tactics become a significant part of treatment. Bruch (1978) speculated that individuals with eating disorders often seek autonomy through their eating disordered behaviours. Further restriction of autonomy with imposed treatment presents a serious problem and may intensify, rather than diminish, the client's need to exercise control over her weight following discharge from the hospital. Along similar lines, the clinician contemplating involuntary treatment for an eating disordered client with a history of childhood sexual abuse should proceed with special caution because impositions against the client's will are reminiscent of past violations of her personal rights (Bentovim, 2000; Honig & Bentovim, 1996). Such deprivation of control similar to earlier life experiences can result in the client becoming even more uncooperative and recalcitrant (Oliver, 1997). Fundamentally, we are in agreement with Rathner (1998) that compulsory treatment, for a particular client, can signify 'one coercion too much' (p. 206) and advise against paternalistic action whenever this is possible.

Countertransference considerations

It is also essential that clinicians explore their own values, motivations and frustrations that might lie beneath their efforts to coerce. In light of compelling reasons not to engage in coercive tactics, one plausible explanation for the continued practice of coercion might be the countertransference elicited by seemingly impertinent and willfully stubborn clients. Something about the denial and stubborn determination of this clientele pulls for an intense response to change the client's eating behaviours that is unseen in other client populations (e.g. cancer patients) where the presence of malnutrition and loss of appetite does not elicit such negative countertransferential responses (Zerbe, 2008). Perhaps treating clinicians can attribute this difference in countertransference to eating disordered clients' strict adherence to their self-destructive symptomatology, their intense fear of losing control, and their general mistrust of treatment providers (Melamed et al., 2003). A common countertransferential response of treatment providers is to react with coercion or force (McEneaney, 2007). This response may prompt a dangerous dynamic between the client and clinician because many severely ill clients with eating disorders 'would rather die than give in to what they perceive as the therapist's desire for control' (Zerbe, 2008, p. 262). To avoid this dangerous dynamic Zerbe (2008) advises continual supervision to process feelings of excessive burden, defeat and anxiety about losing clients through death and highlights the importance of clinicians' monitoring their own need to change clients and to be in control of the treatment process.

The impact of co-morbid conditions on countertransference

Finally, an additional client factor that might potentially influence the clinician's countertransference

response relates to the substantial co-morbidity between Eating Disorders and Axis II pathology, particularly Cluster B (dramatic) and C (anxious) (Satir, Thompson, Brenner, Boisseau, & Crisafulli, 2009). Prior research in this area has indicated that therapists' reactions to clients with personality disorders are often particularly intense and quite negative (Betan, Heim, Conklin, & Westen, 2005; Rossiter, Agras, Telch, & Schneider, 1993). Additional research exploring the therapist–client relationship might provide important and much needed information regarding countertransference enactments, excessive use of coercion and poorer therapeutic alliances as factors in treatment failure (Satir et al., 2009).

Application of an integrative, collaborative and culturally sensitive ethical decision-making model

The discussion of the immediate danger warranting the duty to protect directly leads into one of the most difficult ethical dilemmas posed at the start of this paper: when is it permissible to usurp the client's autonomy and force either hospitalization or feeding by NG tube? Utilizing this dilemma we will delineate the steps involved in ethical decision-making outlined by Garcia et al.'s (2003) transcultural integrative model for a 25 year-old woman with AN binge eating-purging type presenting for inpatient treatment at 82 pounds at 5′5″ with significant physical health concerns. The client has received outpatient psychotherapy intermittently over the past 7 years with some, albeit minimal, improvement and is currently living with her romantic partner.

The first step involves interpreting the situation with self-awareness and engaging in fact-finding. At this juncture the various options should reflect the world-views of the client, the treatment team, and any other key stakeholders (family members, romantic partner, etc.). Professionals involved should strive for an integration of critical thinking, personal responsibility, transparency, a genuine sensitivity to and openness with the client and other stakeholders, and careful reflection on their own values and biases. In the case of enforced feeding and/or hospitalization the fact-finding mission should include an assessment of immediate threat to the client's life, medical, nutritional and psychological assessments, the client's previous response to prior rounds of inpatient and outpatient treatment, quality of life issues, and attendance to family values, community relationships and other relevant cultural information. Every effort should be made to approach the treatment decision collaboratively, recognizing that when a decision to embark on treatment is chosen by the client, rather than imposed by family or the treatment team, the effects of any behavioural change that ensue are likely to be more lasting. Throughout this assessment process, the relationship between the client and therapist, and active, empathic reflection of the client's concerns is of the utmost importance. In this framework, client resistance to treatment is viewed in relational terms, as a reaction that can be elicited, in part, by the therapist's pushing the client too strongly in a contrary direction. This philosophy is congruent with motivational models (Vansteenkiste, Soenens, & Vandereycken, 2005) which postulate that confrontational or authority driven approaches often increase client defiance or result in passive compliance and externally motivated reasons for change which are often short lived. Thus, it is critical that the clinician engage in dialogue that explores treatment options that enhance the client's personal autonomy and strengthen her internal motivation to change (Vansteenkiste et al., 2005).

The second step, formulating an ethical decision, involves the process of reviewing the dilemma and 'determining whether or not the dilemma has changed in light of any new information gathered in Step 1' (Garcia et al., 2003, p. 273). It is important to note that relevant ethical codes and principles, laws and institutional policies or procedures should be consulted at this point with keeping an eye towards potential conflict between the laws, ethics, the client's cultural perspectives, and the desires of family members and significant others. Next, all possible and probable courses of action are generated using the relational and social constructivist techniques (negotiating, consensualizing and arbitrating) to reach some agreement on the options listed. Some of the options drawn up and discussed with the client may include:

(1) Honoring the client's choice to live at a less than ideal body weight (that is reaching 110 pounds at 5′5″ for a BMI of 18.3 within a specified time frame), re-engaging in more intensive outpatient treatment, and living within the comfort of her own home.

(2) Recognizing a possible threat to her life and insisting that the client eat a particular amount each day, but allow the feeding to occur through her own efforts on an outpatient basis, with monitored meal support (eventually achieving a goal weight of 115 pounds for a BMI of 19.1).
(3) Increasing the level of care and support to an intensive outpatient or day treatment hospital program. Client will achieve goal weight set out in option two.
(4) For options 1–3, a caveat can be stipulated that if progress is not made within several weeks time, hospitalization will ensue.
(5) Commencing inpatient hospitalization with or without NG tube feeding to achieve goal weight set out in option two. The option of nocturnal tube feeding may be offered for medically compromised clients overwhelmed by the sheer volume of food required for weight gain.

After generating all of the possible acceptable courses of action, all of the stakeholders and professionals involved in deriving a decision should then consider and list all of the possible positive and negative potential consequences for each course of action from the cultural worldviews of each of the individuals involved. Due to the idiosyncratic nature of each individual case and space limitations we will not list all of the possible pros and cons. Here again the relational and social constructivist techniques can facilitate the process of analysing consequences and reaching consensus. After generating all of the pros and cons for each course of action and prior to selecting the best ethical course of action, the professionals involved should seek out consultation with other knowledgeable professionals to guard against potential blind spots compromising the decision-making process.

After a rational analysis of the potential benefits and consequences of each course of action and a thorough examination of the ethical principles underlying the competing courses of action, the group as a whole selects the best ethical treatment plan and develops a reasonable sequence of agreed upon therapeutic actions and goals. Barriers and impediments to the proposed plan should be actively considered and processed, with attention given to strengthening protective factors (e.g. social support) and personal resources (e.g. motivation to change). After a decision has been reached, planning and executing the chosen course of action occurs. Lastly, Garcia et al. (2003) advise professionals to reflect upon the decision and evaluate the course of action after it has been implemented. Adherence to these steps of the process need not be absolute. Rather this example strives to illustrate the benefits associated with the structure and guidance of the transcultural integrative decision-making model.

Summary

In conclusion, in regards to the specific ethical dilemmas covered in the current review, the guiding ethical principles frequently conflict. Consequently, the determination of: (1) whether or not professionals should usurp clients' autonomy and force either hospitalization or feeding, (2) when there is a duty to protect, (3) competence and capacity and (4) the extent to which mental health professionals have the right to employ coercive tactics, is far from straightforward and needs to be determined on a case by case basis. To discern the best course of action such complex decision-making warrants a comprehensive health risk assessment, consideration of all of the possible treatment options, a review of the evidence for the potential effectiveness of each of these options, and the acceptability of the options to the individual client (Stewart & Tan, 2007). Ultimately, providers should keep the ethical imperatives at the forefront of decision-making and make the personal values of both clinician and client explicit.

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