Australian Psychologist, September 2007; 42(3): 198–211

The Australian Psychological Society Ltd

Ethical re-evaluation of contemporary treatments for anorexia nervosa: Is an aspirational stance possible in practice?

IZABELA EWA FEDYSZYN & GAVIN BRENT SULLIVAN

School of Psychiatry, Psychology and Psychological Medicine, Monash University, Melbourne, Victoria, Australia

Abstract

Anorexia nervosa is a complex disorder that occurs mainly among young women and evokes strong reactions in treating health professionals. While the reactions of psychologists are shaped by treatment guidelines, considerations of professional practice and theories of anorexia, ethical features of contemporary treatment have not been explicitly or critically examined. This paper examines representations of current best and evidence-based practice that are often motivated by a well-intentioned, but limited, risk-reduction perspective. An alternative approach, based on an aspirational ethical stance, is presented along with detailed arguments as to how optimal care for all individuals with the disorder can be achieved. The implications of this stance are specifically explored with regard to the heterogeneity of anorexia, in relation to the chronic course of the disorder and with regard to alternatives that could be described as palliative.

In popular consciousness, anorexia nervosa is a relatively modern condition. Although the history of anorexia nervosa as a diagnostic entity can be traced to the 17th century, until recently it did not have cultural currency as a way of evaluating women's and, increasingly, men's bodies and dieting behaviour (Beumont & Vandereycken, 1998; Bruch, 1978; Dolan, 1994; Gordon, 1990; Palmer, 1980; Slaby & Dwenger, 1993). Improved understanding of anorexia has emerged with research in psychology and sociology as well as through the contributions of cultural and feminist theorists (e.g., Garrett, 1998; Gilbert & Thompson, 1996; Katzman & Lee, 1997; Lester, 1997; MacSween, 1993; Malson, 1998, 1999; Malson & Swann, 1999; Nasser, 1999; Orbach, 1987; Rubin, Fitts, & Becker, 2003). These empirical studies and critical discourses have not only shaped public awareness but also have challenged traditional biomedical theories. In addition, they have countered moralistic constructions of anorexia as a product of self-obsessed vanity, by demonstrating how the female body and food denial may become "an instrumental means of negotiating the transition, disconnection and oppression" (Katzman & Lee, p. 385).

Anorexia nervosa is recognised on the basis of several fundamental characteristics, including a refusal to maintain a normal body weight for one's age and height, an intense fear of gaining weight or becoming fat that continues even when underweight, and a distorted perception of one's body weight and shape (DSM-IV-TR; American Psychiatric Association [APA], 2000a). Restricting or bulimic types of anorexia are diagnosed, depending on whether individuals predominantly reduce food intake or engage in complementary cycles of binge eating and purging. In this paper, however, the term *anorexia* is used in a manner that includes both subtypes.

Despite considerable variability in the course, duration and outcome of anorexia, the disorder usually lasts between 1 and 8 years, with an average of 5 years (Beumont, Hay, & Beumont, 2003); after 8 years, anorexia is considered to be chronic (Draper, 1998). Moreover, high premature mortality is widely acknowledged to be associated with anorexia (e.g., Birmingham, Su, Hlynsky, Goldner, & Gao, 2005; Crow, Praus, & Thuras, 1999; Deter & Herzog, 1994; Sullivan, 1995; Zipfel, Löwe, Reas, Deter, & Herzog, 2000), as is the fact that traditional psychiatric treatment approaches have not been very

Correspondence: Dr G. B. Sullivan, School of Psychiatry, Psychology and Psychological Medicine, Monash University, Caulfield Campus, Vic. 3145, Australia. E-mail: gavin.sullivan@med.monash.edu.au

ISSN 0005-0067 print/ISSN 1742-9544 online
Published by Taylor & Francis
DOI: 10.1080/00050060701326962

successful (e.g., Ben-Tovim et al., 2001; Deter & Herzog; Zipfel et al.). Several studies have demonstrated that approximately half of the patients do not meet the diagnostic criteria for anorexia nervosa at long-term follow up. However, many of these individuals continue to experience significant psychological disturbances, eating disturbances, or both.

The treatment of anorexia nervosa raises difficult questions for affected individuals, family members and health professionals. For example, when is it appropriate to invoke a duty of care to protect the best interests of the persons with anorexia? Do anorectic individuals have the right to refuse treatment even when their health is severely compromised or their life is at risk? Would the duration of the illness ever be a factor in such deliberations? Can new considerations of ethical excellence in psychotherapy (e.g., Tjeltveit, 2006) encourage critical reflection that provides an important addition to clinical experience and research findings with specific disorders?

Accordingly, the aims of this paper were to critically examine ethical features of current practices in the treatment of anorexia nervosa as represented by clinical practice guidelines, and to explore whether and how an aspirational ethical stance inspires alternatives to standard treatments of this disorder. (Given the similarity of the guidelines developed by National Institute for Clinical Excellence [NICE], 2004, of the UK; APA, 2002b, and the Royal Australian and New Zealand College of Psychiatrists [RANZCP], 2003, 2004, the arguments presented are relevant to all these documents; specific guidelines are quoted only as an example.) The aspirational stance is derived from positive ethics that promote the highest ethical conduct (Handelsman, Knapp, & Gottlieb, 2002), in contrast to contemporary conceptions of professional ethics, which focus heavily on "doing the least risky option that can be thoroughly accounted for in terms of laid-down procedures" (McBeath & Webb, 2002, p. 1017). Central to the idea of the aspirational ethical stance is the principle of beneficence and psychologists are encouraged to strive for ethical excellence in practice through careful reflection about how psychological interventions can properly benefit others (Tjeltveit, 2006).

The specific argument here is that an alternative, aspirational clinical approach to treatment of anorexia nervosa calls for interventions that are both effective and meaningful for affected individuals. The implication of this approach is that optimal care for all individuals with the disorder can be achieved by recognising and aiming to address their treatment needs based on the duration of the illness and the degree to which recovery is endorsed.

Ethics of contemporary treatment practices for anorexia nervosa

A range of psychological theories have been put forward in an attempt to explain how and why individuals develop, and later maintain, an anorexic condition. Some examples of models include the psychodynamic (Sayers, 1988), cognitive behavioural (Hollin & Levis, 1988), familial (Eisler, 1988) and the widely recognised biopsychosocial model of anorexia (Andersen, Bowers, & Evans, 1997; Giordano, 2003b; Nemerof & Cavanaugh, 1999). However, because the research has not yet produced a cure, the international trend has been to establish treatment guidelines (APA, 2000b; NICE, 2004; RANZCP, 2003, 2004; Yager et al., 1993). These guidelines have been developed on the basis of scientific evidence and clinical consensus; their purpose is to provide treatment recommendations and to improve care by reducing morbidity and mortality associated with anorexia through the application of empirically validated treatments. The guidelines attempt to accord with other features of good practice, such as respecting the person's autonomy and a related principle of using the least restrictive interventions. The overall treatment approach for anorexia nervosa can be described as risk-reducing, because primacy is given to protecting individuals from the harm associated with the condition (Handelsman et al., 2002; Hart, 2004; McBeath & Webb, 2002). While these characteristics traditionally have been the cornerstone of ethical practice, they deserve more thoughtful consideration. In other words, it is important to consider whether and how anorexia treatment can "move toward ethical excellence regarding therapy goals and outcomes" (Tjeltveit, 2006, p. 187).

Clinical practice guidelines for treatment of anorexia nervosa

Despite variations in the theoretical positions that underpin commonly used psychological interventions for anorexia nervosa, the overall focus for clinicians working with anorexia patients is constructed by the guidelines around symptom resolution (Hsu, 1999; NICE, 2004; Palmer, 1980; RANZCP, 2003, 2004). Specifically, "psychological treatment should be provided that has a focus on eating behaviour and attitudes on weight and shape, and on wider psychosocial issues with the expectation of weight gain" (NICE, p. 11). The primary goal of interventions for anorexia is to reverse malnutrition (Madden, 2004). To support weight gain, structured assistance with eating is provided and being weighed as well as confronting body image disturbances are viewed as essential treatment components (Swain-Campbell, Surgenor, & Snell, 2001). Malnutrition re-feeding is managed on an outpatient basis, as part of a more structured day-patient program or in an inpatient setting (APA, 2000b; Beumont et al., 2003; NICE; RANZCP). The appropriate treatment setting for an individual patient is determined by clinical evaluation including the medical, psychiatric and behavioural assessment (APA). Also, it is now generally agreed that treatment should proceed from the least restrictive (i.e., outpatient) procedures to more directive and controlled approaches (i.e., inpatient).

However, more intensive alternatives are considered for patients with a history of prior treatment, those who demonstrate rapid or persistent decline in the oral intake of food and drink, or individuals who do not show improvement with adequate outpatient psychological intervention (Adolescent Medicine Committee [AMC], 1998; APA, 2000b; Bentovim, 2000; Beumont et al., 2003; Werth, Wright, Archambault, & Bardash, 2003). According to the guidelines, individuals weighing <75% of the healthy weight for their height or children/adolescents whose weight loss proceeds at a rapid rate are likely to require hospital admission for supervised re-feeding, which is usually achieved via a naso-gastric tube (APA). The patient's consent and cooperation are sought whenever possible, but under exceptional circumstances, such as acute medical or psychiatric crisis or when the person's physical status is severely compromised, the clinician may resort to involuntary hospitalisation (AMC; Bentovim; Beumont et al.; NICE, 2004; Neiderman, Zarody, Tattersall, & Lask, 2000; Werth et al.).

Features of good practice and ethical considerations in the contemporary treatments for anorexia nervosa

At present, clinical practice is regarded as ethical if it adheres to the parameters of good practice, namely, respecting personal autonomy, providing the least restrictive intervention for a given clinical circumstance and using treatments that have been empirically demonstrated to be effective. The appropriateness of compulsory hospitalisation as part of the treatment for anorexia has raised concerns due to its restrictiveness and consequent infringement of the patient's autonomy. The issue has been extensively debated from the ethical, clinical and legal perspectives (Draper, 1998, 2000, 2003; Dresser, 1984; Fost, 1984; Gans & Gunn, 2003; Giordano, 2003a; Griffiths & Russell, 1998; Hébert & Weingarten, 1991; Kluge, 1991; MacDonald, 2002; Melamed, Mester, Margolin, & Kalian, 2003; Neiderman, Farley, Richardson, & Lask, 2004; Rathner, 1998; Robb et al., 2002; Strasser & Giles, 1988; Tan, 2003; Tan, Hope, & Stewart, 2003b). While this is not the place to review these arguments, the position reflected in the clinical practice guidelines is that the professional obligation of clinicians is to act in the patients' best interests. Thus, while the individual's right to self-determination is acknowledged, a duty to protect requires clinicians to proceed with treatment even if this is against the patient's express wishes (e.g., Griffiths & Russell; Haas & Malouf, 1995; Werth et al., 2003).

Little attention has been paid in the eating disorders literature to the requirement that clinical interventions are also to be guided by ethical reflection. The scientist–practitioner model of practice in psychology has the goal of optimising patient outcomes by informing clinical practice with empirical research. However, critical and feminist psychologists (e.g., Brown, 1997; Prilletensky, 1997; Prilletensky & Fox, 1997; Sesan, 1997; Tjeltveit, 2000; Zerbe, 1995) and opponents of evidence-based practice (e.g., Wampold, 2001; Wampold & Bhati, 2004) have challenged the idea of ascribing value to interventions only in so far as they can demonstrably lead to symptom reduction, curtail health threats associated with a given disorder, or achieve both goals. For example, Kisch and Kroll (1980, as cited in Vandereycken & Meerman, 1992) argue that: "the application of scientific methodology to the evaluation of psychotherapy leads to an emphasis upon that which is measurable, although possibly not relevant, certain narrow parameters of effectiveness and on ignoring of that which is most relevant, meaningfulness" (p. 11).

As indicated by Vandereycken and Meerman (1992), there seems to be consensus regarding the use of weight or body mass index (BMI) as a reliable (sometimes even a single) indicator of effectiveness of the interventions for anorexia nervosa. Because anorexia is a complex illness, the suitability of a symptom focus can be questioned on ethical grounds. As Tjeltveit (2006) notes, "when we claim . . . that therapy's goal is to reduce symptoms, we are, in part, making an ethical argument about bad dimensions of client's lives" (p. 192). Such an approach also means that meaningfulness or subjective value of the intervention for the patient currently has no place in treatment evaluation. Moreover, it fails to acknowledge that "one challenge therapists . . . face is seeing, as moral strangers, the ethical world view of clients whose vision of the good life, and hence therapy goals, are radically – or perhaps even more challenging, subtly but significantly – different from our own" (Tjeltveit, p. 194).

The strong emphasis of the treatment programs on symptoms also reflects the heritage of the medical model in which illness is defined strictly in terms of abnormalities or deficits in bodily or mental functioning that need to be addressed (Fulford, 1995; Katzman & Lee, 1997; Malson, 1998, 1999; Malson & Swann, 1999; Prilletensky, 1997). From this perspective, the patient's experience with the illness or its treatment is peripheral to the core of the clinician's expertise and advice. It has been argued, however, that although clinicians' intentions may be laudable and their interventions performed in the name of good practice, through their actions even the most competent professionals risk losing sight of the individual (Haliburn, 2002; McFarlane, 1988). In other words, affected individuals may become "the objects of intervention rather than . . . the subjects of experience" (Danzinger, 1990, as cited in Wampold & Bhati, 2004, p. 568).

Studies examining the subjective perspectives of anorectic individuals have consistently identified that the perceived key to a meaningful intervention is to be recognised by the therapist as a person (Bell, 2003; Garrett, 1998; Swain-Campbell et al., 2001; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003). Although this may hold true for the majority of recipients of psychological treatments and, indeed, be the core ingredient of all bona fide interventions (Hubble, Duncan, & Miller, 1999), it is of particular importance for anorexia patients. The accounts of anorexia patients often suggest that both outpatient and inpatient treatment lacks the poignant and personally experienced feeling of being cared for (Garrett; Haliburn, 2002; Shelley, 1997; Surgenor, Plumridge, & Horn, 2002; Tan, Hope, Stewart, & Fitzpatrick, 2003). Moreover, individuals subjected to involuntary hospitalisation as well as those who entered inpatient treatment voluntarily, frequently describe hospitalisation as a difficult experience akin to punishment and imprisonment (Tan et al.). Such accounts have raised concerns additional to the autonomy–beneficence dilemma discussed above. Specifically, Tan et al. have asked whether (except for circumstances of acute medical crisis) even voluntary hospitalisation is morally permissible, regardless of how well-meant it is and despite any demonstrable outcome.

The utility of hospitalisation as a risk-reducing intervention has been questioned because it may be psychologically traumatic, particularly for individuals who have been victims of physical, emotional or sexual abuse (Bentovim, 2000; Beumont & Vandereycken, 1998). Studies have also demonstrated that despite the short-term benefits such as re-establishment of adequate caloric intake and weight, admitted individuals had significantly worse outcome compared to those who had never been admitted (Ben-Tovim et al., 2001; Gowers, Weetman, Shore, Hossain, & Elvins, 2000; Molly, Willer, Thuras, & Crow, 2005). Not only is hospitalisation associated with increased long-term mortality in general, but mortality is even higher among the patients admitted against their will (Ramsay, Ward, Treasure, & Russell, 1999).

From another perspective, although hospitalisation is typically reported as a negative experience, some patients appreciate the safe environment and being removed from the pressures of the daily life (Gowers et al., 2000). When this is the case, the return to the outside world with its obligations, responsibilities and stresses related to eating creates an enormous adjustment demand. Unfortunately, but not infrequently, such experiences result in the resumption of anorexic behaviours (Cockell, Zaitsoff, & Geller, 2004; Gowers et al.). It is important to note also that the rate of inpatient admissions is increasing (Molly et al., 2005; Nielsen, Moller-Madsen, & Nystrup, 1996) and rather than a change in the severity of the illness, this trend seems to reflect a change in clinical practice.

Hospitalisation is one, albeit the most restrictive, aspect of traditional symptom-focused interventions. While many individuals with anorexia may benefit from symptom-focused approaches, there are also patients who do not and these are not necessarily singular cases (Geller, Williams, & Srikameswaran, 2001). Restricting treatment to such interventions, however, means restricting benefits to a particular subset of individuals while excluding others, an issue that will be elaborated upon in the section of the paper dealing with chronic anorexia (Brown, 1997; Prilletensky & Fox, 1997). It is therefore crucial to rethink what counts as "good outcome", "beneficial" and "ethical" in the treatment of anorexia as well as any implicit "notion of the good life against which outcomes are evaluated" (Tjeltveit, 2006, p. 195).

Assumptions underlying current clinical practice for treatment of anorexia nervosa

In addition to the previously mentioned parameters of good practice, the ethical character of clinical practice is shaped by assumptions about mental illness and the individuals who are affected by it. These widely held ideas, which range from the traditional to the postmodern, dictate the treatment goals, therapeutic techniques and the dynamics of the professional relationship. Moreover, they influence the notion of the patient's best interests and hence play a role in clinical decisions (Prilletensky, 1997; Tjeltveit, 2000). As Andersen (2007) puts it, "many outdated assumptions and frank mistruths exist about eating disorders, especially anorexia nervosa" (p. 9); several assumptions that have been articulated in the literature are discussed next to illustrate how these notions are inseparable from the current treatments for anorexia nervosa.

First, because anorectic individuals "feel" fat and, consequently, do not recognise the need to gain weight, they are considered to be unaware that they have an illness and to not understand the damage they are inflicting on themselves (Dresser, 1984; Werth et al., 2003). Second, individuals with anorexia are generally regarded as irrational because they are willingly starving themselves to the point of severe emaciation and even death; yet however much destruction they have wrought on their bodies, they express no intent of committing suicide (Draper, 2003; Dresser; Hébert & Weingarten, 1991; Strasser & Giles, 1988). It is further believed that if anorexia patients were capable of acting rationally, they would seek help instead of denying the illness and refusing treatment (Dresser; Hébert & Weingarten; MacDonald, 2002). It is therefore argued that the disorder may compromise the individuals' authentic wish to seek wellness, particularly in case of the long-standing or severe course of the illness (Manley, Smye, & Srikameswaran, 2001). For these reasons the expressed wishes of anorexia patients regarding treatment are believed not to be reliable (Draper, 2000).

In fact, there are clinicians who regard treatment refusal as one of the central features of anorexia nervosa (Gans & Gunn, 2003; Swain-Campbel et al., 2001; Tan, Hope, Stewart, & Fitzpatrick, 2003). Adherence to the specific treatment components of a specialist eating-disorders service or the use of a more restrictive intervention – when the clinician judges this to be appropriate – are therefore perceived to be a necessary means to halt the course of the illness even when faced with the patient's frustration or ferocious objection (Bentovim, 2000; Werth et al., 2003). A view that treatment refusal might in part reflect the often punitive and controlling nature of traditional treatment programs tends to be given less consideration. A study by Swain-Campbell et al. illustrates the implications of the varying perspectives (patients' vs. clinicians') on the issue of treatment refusal. The authors began with a worthy goal of investigating the patients' feedback on treatment, highlighting its role in quality assurance. Surprisingly, despite 42% of comments in which changes in the components of the program were requested, the suggestions were dismissed on the grounds that consumer dissatisfaction is to be expected in service provision for eating disorders, because the majority of these patients value their symptoms and do not wish to change. Such non-recognition or misrecognition of the message conveyed by anorectic individuals devalues their perspective and, in a broader sense, hinders the development of alternative practices that have the potential to be, if not ethically excellent, at least ethically preferable to current clinical practices.

Another clinical belief that warrants attention is that of the biological effects of starvation. In the now classical Minnesota Studies, healthy volunteers were systematically food deprived for several months. The subsequent weight loss resulted in poor concentration, reduced libido, irritability, apathy and social withdrawal. Interestingly, participants also became preoccupied with food and developed patterns of eating characteristic of anorectic individuals (Keyes, Brozec, Henschel, Nichelsen, & Taylor, 1950). It is thus currently assumed that the longer or more severe the condition, the more starvation interferes with a person's perception, mood and cognition (Bentovim, 2000; Werth et al., 2003). According to clinical consensus, when individuals are at 75% of their healthy weight or under, their nutritional status precludes insight, reduces the possibility of meaningful progress in the outpatient setting and discourages considered decisions about their life, health and wellbeing (APA, 2000b; Becker, 2003). This presumption, nevertheless, may lead to erroneous conclusions about the individuals' capacity for insight and judgment with clear ethical implications, particularly in relation to enforced hospitalisation and hospital treatment for chronically ill patients (Werth et al.). Russon and Alison (1998) argue along similar lines, pointing out that although progressive weight loss (cachexia) is a prevalent symptom in cancer patients, its potential effects on cognitive functioning have not received much attention in the clinical field. Moreover, clinicians tend not to question decisions about treatment made by this patient group.

Last, contemporary treatment of anorexia nervosa rests on a belief that it is a self-limiting, or reversible, condition (Draper, 2003; Manley et al., 2001; Theander, 1992). Reports of cases where recoveries occurred following $\geq$10 years of illness have strengthened the view that even individuals with long-lasting anorexia "can and do recover" (Manley et al., p. 146). Because anorectic patients are regarded as "potential recoveries", active treatment is understood as clinicians' professional responsibility and ethical duty, as exemplified by the excerpt from the RANZCP (2004) clinical practice guidelines: "Prompt recognition and treatment is likely to improve the prognosis, but recovery is yet possible, even after many years of illness. It is never too late to apply vigorous treatment" (p. 660; i.e., where vigorous treatment means active, symptom-focused interventions).

Encouraging an aspirational stance in the treatment of anorexia nervosa

A recent criticism of the clinical practice guidelines for the treatment of anorexia nervosa is that descriptions of psychological experience are entirely excluded from the discussion despite a broad coverage of such aspects as epidemiology, risk factors, course and outcome, medical assessment and management, and current evidence on treatment (Haliburn, 2005). A corollary of the current clinical focus on symptom resolution is the implicit belief that anorectic individuals share a similar psychological make-up and will benefit from the same interventions. The view of anorexia as a reversible illness and of patients as potential recoveries further supports the general tendency to "homogenise . . . 'anorexic' women" (Malson, 1998, p. 191) with regard to treatment components and goals. However, a broader engagement with anorectic personhood is called for to set the stage for practices that recognise and address a range of treatment needs and goals. We argue that a useful starting point in developing more responsive aspirational alternatives is to focus on: the patient's appraisal of the effects of the illness, his or her readiness to change, the duration of the disorder, the ethical character of therapy goals and outcomes, and differing views of the good life of an anorexia patient.

Heterogeneity of anorexia and the trans-theoretical model of change

While it is not unusual to hear an individual with anorexia say of people who suggest treatment "they're jealous of me, they want me to get fat" (Surgenor et al., 2002, pp. 28–29), there are commentators who object to the assumptions that anorexia patients seek and value their symptoms, cannot realise the damaging effects of their illness or are unmotivated to recover (e.g., Beumont & Vandereycken, 1998; Dresser, 1984; Garner, Vitousek, & Pike, 1997). These clinicians claim that although such statements might be true of some, many anorectic individuals are aware of their need for help, but remain ambivalent about changing aspects of their behaviour. This is not surprising given that the anorexia often represents their best attempt to cope and patients typically express the fear that parting with the symptoms will exacerbate their distress, confusion and a lack of a sense of self or identity (Beumont & Vandereycken; Cockell et al., 2004; Dresser; Garner et al.; Tan, Hope, & Stewart, 2003a).

A move towards recognition of the heterogeneity among individuals affected by any psychological disorder is evident in the work of Prochaska and DiClemente (1983, 1992). Initially developed for smoking cessation, their trans-theoretical model of change (TTM) reflects a more complex account of the experience of the disorder as well as of the process of change, which has been used to develop new practices in the treatment of anorexia. The TTM stresses the differences between individuals regarding their cognitive and affective reappraisal of the disorder and the degree to which they endorse recovery (Blake, Turnbull, & Treasure, 1997; Kaplan, 2002). In generic terms, the model identifies the five stages of precontemplation, contemplation, preparation, action and maintenance. When applied to anorexia, at the precontemplation stage, individuals typically deny having the disorder and thus exhibit no intention to recover, as in the following account: "I cannot convince myself that I am sick and that there is anything from which I have to recover" (Bruch, 1978, p. 2; Touyz, Thornton, Rieger, George, & Beumont, 2003). Contemplation is characterised by insight and resulting concern about the harmful effects of the disorder, for example: "I feel sorry for my body, sorry for what it feels like and how it is struggling to keep up with my sick head" (A. Filek, personal communication, September 17, 2004). Individuals are nonetheless ambivalent about change, weighing up the pros and cons of engaging in the process of recovery (Cockell, Geller, & Linden, 2003). Alternatively, they may resist or refuse treatment if they perceive recovery as more burdensome than suffering and distress brought by the illness (Blake et al.; Kaplan; Prochaska & DiClemente; Touyz et al.). In the preparation stage, there is a clear intent to recover that is supported by small behavioural changes initiated by an anorectic patient, whereas action is the stage when the individual invests a considerable amount of time and energy aiming at concrete changes. Maintenance is primarily about consolidating treatment gains and preventing relapses (Blake et al.; Kaplan; Prochaska & DiClemente).

Over the past decade the application of the TTM to anorexia nervosa has received increasing research and clinical attention. This is particularly due to the role that the model ascribes to readiness and motivation for change in treatment and recovery. Several papers have focused on the development of appropriate assessment tools, including global measures of "stage change" and detailed, symptom-specific measures of readiness and motivation for treatment (e.g., Blake et al., 1997; Geller, 2002a; Geller & Drab, 1999; Geller, Zaitsoff, & Srikameswaran, 2005; Gusella, Butler, Nichols, & Bird, 2003; Jordan, Redding, Troop, Treasure, & Serpell, 2003; Ward, Troop, Todd, & Treasure, 1996). Studies have also supported the contention that individuals with eating disorders can be distributed across the stages of change (Blake et al.; Gusella et al.; Ward et al.), and that patients who begin treatment further along the continuum rather than at earlier stages of change, demonstrate a greater improvement following the intervention (Katzman, Troop, Schmidt, Treasure, & De Silva, 1997, as cited in Treasure & Schmidt, 1999). Other articles have elaborated on motivational interviewing and motivational enhancement therapy (the therapeutic approaches derived from the TTM) and their appropriateness for anorexia patients (e.g., Feld, Woodside, Kaplan, Olmsted, & Carter, 2001; Geller, 2002b; Treasure & Ward, 1997).

The model explains the varied response of anorectic individuals to treatment in terms of a mismatch between the patient's stage of change and the goals of the intervention. According to the TTM, current symptom-focused treatment is an action-based approach and, as such, not appropriate for people who are in a precontemplative or contemplative stage of change. Anecdotal evidence suggests that a mismatch increases patients' sense of hopelessness and resistance to treatment (Touyz et al., 2003). The TTM approach to anorexia also clearly articulates that at each stage individuals present with some specific treatment needs and it is the role of clinicians to "meet" the person psychologically and to tailor interventions to the patient's present stage. Furthermore, it is recognised that the decision to change has to come from within the individual rather than be externally imposed and that individuals may experience setbacks and revert to earlier stages before achieving maintenance. Evidently, the TTM represents an approach to treatment wherein the focus on the patient helps to diminish what was earlier referred to as the feeling of being an object of a psychological intervention rather than a subject of the experience, regardless of the treatment setting or the techniques that are being used. Thus, the TTM can be seen as in accord with the aspirational ethical stance that is encouraged in this paper.

Despite the notable features of the TTM approach, to date only one article describes the hospital programs for patients with anorexia that were developed using the TTM as a paradigm (Touyz et al., 2003). Because the authors are in the process of data collection, the programs await evaluation. It is also worth mentioning that the TTM has recently been subject to scientific debate (e.g., Hodgins, 2005; Prochaska, 2006; West, 2005, 2006), with West (2005) making a bold claim that in light of theoretical and empirical shortcomings "even in the absence of a new theory, simply reverting to the common sense approach [about motivation for change] that was used prior to the transtheoretical model would be better than staying with the model" (p. 1036). Because of space limitations, we refer the readers interested in the main arguments of the critics and supporters of the model to the original sources. Nonetheless, we support Hodgins' contention that there is abundant evidence that the TTM stimulates testable hypotheses that advance our understanding of complex phenomena. Moreover, the eating disorders literature exemplifies the usefulness of the TTM as a framework for understanding and working with ambivalence about recovery and treatment refusal, which are common aspects of the presentation of anorectic individuals. We argue for the inclusion of the model in the clinical practice guidelines on ethical grounds given the aforementioned research support for the notion of heterogeneity of anorexia patients and, further, because of the clear set of TTM criteria that can assist clinicians to better understand and respond to specific treatment needs of their patients as well as the arguments thus far for psychologists to combine research and ethical reflection even in situations where difficult treatment dilemmas occur.

Current treatment approach for chronic anorexia

A previously mentioned criticism of the existing clinical practice guidelines is that despite the widely accepted multifactorial nature of the disorder, the recognition of the complexity of the psychological dimension of anorexia has been neglected (Haliburn, 2005). Other than the distinction regarding the degree to which individuals view their disorder as a problem and their expressed interest in recovery, the duration of the disorder is of paramount importance due to the associated psychological impact and clinical as well as ethical relevance. Put simply: "There is a difference between the 20-year-old woman who has been starving herself in private for a year and the 50-year-old patient, diagnosed with chronic anorexia nervosa" (Gans & Gunn, 2003, p. 682).

Gans and Gunn (2003) are not alone in their appraisal of particular treatment needs of individuals with long-standing anorexia nervosa that may not parallel the needs of patients with a shorter duration of the illness; a few other clinicians have also commented on this issue (e.g., Garfinkel, 2002; Hsu, 1999; Kaplan, 2002; Palmer, 1980). Surprisingly, though, of all clinical practice guidelines for anorexia nervosa only those developed by the APA (2000b) briefly mention the treatment goals for individuals with a chronic course of the disorder: fewer relapses and smaller weight gains (i.e., achieving weight that is safe rather than optimal). Societal notions of the implicit goodness of youth and health and personal wellbeing as life-affirmation (Ellis, 1991; Mittler, 1988; Pellegrino, 2000; Prilletensky, 1997), combined with the predominantly medical conceptualisation of anorexia in the clinical setting, result in the curative approach to treatment of chronic anorexia patients. Moreover, there is a strong sense among clinicians and the general public that any death occurring after years of anorexia is preventable.

In contrast to these intuitions, suicide is at least as common a cause of death as is starvation or any of the associated medical conditions, and individuals with the protracted course of the disorder are particularly at risk (Birmingham et al., 2005; Eckert, Halmi, Marchi, Grove, & Crosby, 1995; Franko et al., 2004; Patton, 1988). A frequently reported clinical observation is that of acute suicidality among chronic anorexia patients following demands to make substantial changes in their lifestyle in general, and food, weight and eating in particular (Theander, 1992). This observation clashes with the existing interventions and although it is not to say that these practices are responsible for death from suicide among chronic anorexia patients, the suitability of the risk-based, curative approach for this group is questioned.

It has been argued that repeatedly exposing chronically ill individuals to day-patient or inpatient interventions violates their dignity and subjects them to continued mental suffering as a result of the continued cycles of therapy (Draper, 2003). Draper (1998, 2000) argues that anorexia patients who have had the disorder beyond its natural course (1–8 years) are in a strong position to know what life with anorexia is and to decide whether living with the cycle of treatment is worth the accompanying burdens. Draper emphasises that in such circumstances clinicians should view treatment refusal as a decision about the person's quality of life. Specifically, she states that:

> ...until this point [of chronic stage of the illness] is reached someone with anorexia nervosa is *less* competent to make...[such decisions]: it is only at this point that they have experienced the dreadfulness of living with the condition in the long-term. Until they have lived with the chronic anorexia nervosa and the treatment for it, they are not in a position to claim that living with this cycle is not worth it for them. (Draper, 2003, p. 285)

It makes sense now to ask if there are any interventions tailored to chronically ill individuals who refuse the current curative, symptom-focused treatment that might also engage with the issue of ethical excellence. For this group of patients, assistance in coping with symptoms and genuine human contact with a therapist who can alleviate the sense of isolation and aloneness they often feel may be of utmost importance (Garfinkel, 2002; Garner et al., 1997; Kaplan, 2002; Palmer, 1980). These are usually the goals of palliative care. The contemporary ethical stance, however, firmly objects to the challenging idea of offering palliative care to individuals suffering from anorexia nervosa (Russell, 1995; Williams, Pieri, & Sims, 1998).

Can palliative approach for anorexia nervosa approach ethical excellence?

Palliative care refers to the total care of patients whose illness is not responsive to curative treatment, with the main goal of helping a person achieve the best quality of life (World Health Organization [WHO], 1990). The palliative approach usually involves withdrawing active treatment and, instead, controlling pain as well as providing support for psychological suffering and addressing any social or spiritual issues a patient may raise (WHO). The argument for withholding specialist palliative care cannot be separated from the view of anorexia as a self-limiting rather than terminal illness. To highlight the difference, while the former is defined as an illness from which almost all afflicted individuals can recover given appropriate treatment, in the case of terminal illness death will result despite the treatment provided (Draper, 1998; Vandereycken & Meerman, 1992). From a medical perspective, undernutrition, malnutrition and many associated physical consequences of anorexia can be reversed (Beumont et al., 2003; MacDonald, 2002; Newman, 1993). From a psychological and moral perspective the issue is more complex and controversial: can a patient ever be judged by the clinician as incurable (Beumont & Vandereycken, 1998)? Therefore, the current ethical stance on the issue, implicit in treatment approaches and clinical practice guidelines, is that palliative care for chronically ill anorexia patients essentially means collusion with or giving up on the patients (Griffiths & Russell, 1998; Russell, 1995; Williams et al., 1998).

The debate on the appropriateness of palliative care for anorexia nervosa often becomes interchangeable with the issue of passive euthanasia, because it usually centres on discussing specific clinical cases. These individuals tend to represent the extreme end of the spectrum of the disorder and either are in a state of medical collapse requiring immediate re-feeding yet refuse it (e.g., see the case report in Hébert & Weingarten, 1991), or request the option to refuse life supports when their medical condition warrants such an intervention (e.g., the case history of Mrs Black presented by Gans & Gunn, 2003). As in the case of involuntary hospitalisation for individuals with mental illness or when working with clients making end-of-life decisions, this clinical circumstance becomes partly a legal issue and revolves around the question of the patient's competence, or capacity, to make informed decisions (Beumont & Vandereycken, 1998; Dresser, 1984; Shuster, Breibart, & Chochinov, 1999; Tan et al., 2003b; Werth & Rogers, 2005). Given a variety of presentations of patients with chronic anorexia, we argue that a broader conceptualisation of palliative approach is consistent with an aspirational ethical stance.

In contrast to physical conditions such as cancer or AIDS, a clinician who admits that their anorectic patient is not responsive to available curative treatment does not necessarily deem the patient incurable. Hence, the idea of adopting a palliative approach to treatment does not imply clinical nihilism, but rather a change in focus:

> The difference is that the end of cure is replaced by the end of comfort . . . In the palliative hierarchy of patient good, the medical good takes a lesser place, while primacy is given to other dimensions of patient good – his own assessment of the good, his notion of quality of life, his good generically as a human being, and his spiritual good. (Pellegrino, 2000, p. 338)

Another way in which Pellegrino (2000) defines the goal of palliation and the role of the clinician is to ease the violence of a condition instead of attempting to cure it. In the case of anorexia, this could involve interventions such as supportive, or non-directive, therapy that centres on recomposing the person within the confines of their illness, thereby improving the psychological and emotional quality of the patient's life (Greenstein & Breitbart, 2000; Pellegrino; Rodin & Gillies, 2000). In a context in which individuals are not overloaded with advice, directions and are not under the pressure to change, once a relationship of trust is established they may more freely talk about themselves: that is, the relationship can encourage them to explore and discover thoughts and feelings that have been denied, ill defined or left unspoken (Geller et al., 2001; Palmer, 1980). Proponents of supportive therapy believe such a psychotherapeutic climate is a useful means to help individuals to see themselves and their situation in a new and, if not a hopeful, at least a more helpful way. Helping patients find meaning in their illness and suffering may be the most trying task for clinicians, but also the most important for affected individuals (Geller et al.; Palmer). Another suggestion is to focus on addressing specific issues that arise from dealing with the condition on a day-to-day basis; such an approach is part of psychological treatment for cancer patients, which could also prove beneficial to individuals with chronic anorexia (Greenstein & Breitbart).

To illustrate the potential use of the palliative approach, consider a description of one patient from a Swedish study on the long-term outcome of anorexia nervosa:

> This patient fell ill at the age of 17. She was married between 24 and 30 years of age, still having severe anorexia nervosa. As she could not become pregnant, the couple adopted a child. At the divorce when she was 30, her body weight was extremely low (27 kg; BMI 10.2) and she was treated in hospital for 6 months, but without much success. In spite of her serious illness, [she] managed to take care of her adopted child after the divorce and to work full time as a qualified secretary. Since the age of 40 she has been working part time, having a partial disability pension. She is now 55 years of age and still working part time. (Theander, 1992, p. 226)

According to the current clinical treatment guidelines, the patient – like many other chronically ill individuals whose weight is typically below the minimum of the healthy range and who usually suffer from various somatic complications of the anorexia (Theander, 1992) – meets the criteria for inpatient treatment (e.g., APA, 2000b). However, would this woman be better off institutionalised due to the severity of her illness and thereby denied an opportunity to work, have a family and generally lead a good life for her? Or is it possible that she could have a meaningful, albeit restricted, life? While it is true that many chronically ill individuals have been deprived of a "normal" existence, some have been able to establish a *modus vivendi*, leading a relatively normal life with the condition, despite its severity (Garner et al., 1997; Palmer, 1980). From the perspective of the improved quality of life, both could benefit from the supportive therapy typically used in the context of palliative care (Kluge, 1991; Rodin & Gillies, 2000).

We acknowledge that from a current risk-reducing perspective a decision not to re-feed and not to focus on the symptoms of the disorder can create ambivalence if not overt objection among mental health professionals. However, the high incidence of suicide particularly among chronic anorexia patients and the lack of treatment approaches that are tailored to the needs of this group warrant increased attention being given to interventions such as supportive therapy, addressing the quality of life issues and restoring psychological equilibrium. The contemporary ethical stance on the issue of palliative care for anorexia has precluded the development of alternative approaches in any detail, let alone allowed for empirical evaluation of their impact on the wellbeing of chronic anorexia patients. Nevertheless, future research in this area would be instructive.

To reiterate the point, in our view a palliative approach for treatment of chronic anorexia does not imply that a patient is considered to have progressed beyond the point of no return. What we express as a shift in focus from cure to care (Pellegrino, 2000), is the suggestion of an alternative psychological intervention for patients who do not respond to or do not wish to continue with the standard curative approach, based on quality of life considerations. Although the palliative approach may be regarded as passive given its primary objective of improved psychological wellbeing and symptom control, rather than an active pursuit of change in patients' eating behaviours and attitudes, it is not interchangeable with doing nothing; supportive therapy must be engaged in by a clinician purposefully and the clinician should be always vigilant to the signs of change or spontaneous improvement (Geller et al., 2001; Pellegrino; Portency, 2000; Rathner, 1992). From this perspective and the perspective of improved quality of life, palliative care as treatment for chronic anorexia patients may resist being deemed unethical and even claim a degree of ethical excellence.

Conclusion

The purpose of this paper was to encourage critical reflection on the contemporary treatments for anorexia nervosa and to demonstrate that adopting an aspirational stance in treatment of this disorder is not only possible, but could also help clinical practice to accord with the aspirational ideas or standards that are called for in codes of ethics for psychologists.

By encouraging ethical excellence our aim was not to imply that professionals are not doing their best, but rather, to consider what is currently meant by "good practice", "good outcome" and "ethical" in treatment of anorexia, and what are the foundations upon which these beliefs rest (as well as their limitations).

A recurrent theme in our deliberations is that relatively little attention is given to the issue of patients' experience of treatment, treatment meaningfulness and subjective feeling of being cared for. Thus, an argument was made that ethical excellence in treatment of this eating disorder calls for intervention strategies that are both effective and meaningful. This requires recognition of the complexity of the psychological dimension of anorexia, which has been neglected in clinical practice guidelines, and, consequently, recognition of a spectrum of treatment needs of anorectic patients contingent on the degree of their appraisal of the effects of the illness, his/her readiness to change and the duration of the illness.

Specifically, the use of the TTM as a framework to shape treatment goals and approaches was suggested, which may be particularly beneficial for engaging individuals at precontemplative and contemplative stages of change who typically refuse treatment or are ambivalent about recovery. While the TTM represents an invitational, person-oriented approach, the model aims to help individuals move along the stages and thus assumes that anorexia is a reversible illness. While the TTM has the laudable goal of seeking change at any point, it may not be optimal for chronically ill persons who have gone through the cycles of treatment and decided not to seek change, based on quality-of-life considerations. We suggest that such individuals may benefit from psychological interventions, for example supportive therapy, that are typically part of palliative care.

It could be argued that acknowledgement of the unique psychological construction of each patient is inherent in clinical practice and the apparent assumption of the homogeneity of anorexia patients does not imply a lack of individualised treatment planning and careful case management on the clinician's part. Neither do we imply that clinicians are a homogenous group. Yet, by "complexity" we do not mean "individuality", but rather a set of psychological criteria that would assist clinicians to understand and respond to their individual patients akin to the current medical criteria outlined in the guidelines. There is a difference between a professional aspiring to do the best for the patients they treat given their expertise and the practice guidelines, and having a set of guidelines that would attempt to articulate more complexity to do the best by all patients. Arguably, adopting an aspirational ethical stance would help to address the criticism regarding a lack of complex representation of psychological dimensions of anorexia in the treatment guidelines.

Finally, the risk-reducing approach is not antithetical to aspirational practice, nor are these two approaches mutually exclusive. An aspirational ethical stance does not avoid the difficulties and dilemmas inherent in treatment of this clinical population, nor does it have perfect answers to such critical questions as what constitutes "good outcome" or "effective treatment" for anorexia nervosa. Rather, the distinctions that were identified and discussed represent a matter of focus, emphasis and orientation, and if the paper has stimulated reflection on the part of the reader, it is the first step in a new direction.

Acknowledgements

We would like to acknowledge the many insights shared by Ania Filek, which, together with accounts of anorectic individuals in the literature, were invaluable in developing the ideas of this paper. Thank you to Ellen Digre for challenging comments in the early stages of the paper. We also would like to thank the anonymous reviewers for their feedback and, last but not least, Professor Susan Paxton for her encouragement and helpful comments on the manuscript.

References

Adolescent Medicine Committee (1998). Eating disorders in adolescents: Principles of diagnosis and treatment. *Paediatrics & Child Health*, *3*, 189 – 192.

American Psychiatric Association (2000a). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association (2000b). Practice guideline for the treatment of patients with eating disorders (revision). *American Journal of Psychiatry*, *157*, 1 – 39.

Andersen, A. (2007). Eating disorders and coercion. *American Journal of Psychiatry*, *164*, 9 – 11.

Andersen, A., Bowers, W., & Evans, K. (1997). Inpatient treatment of anorexia nervosa. In D. Garner, & P. Garfinkel (Eds.), *Handbook of treatment for eating disorders* (pp. 327 – 354). New York: Guilford Press.

Becker, A. (2003). Outpatient management of eating disorders in adults. *Current Women's Health Reports*, *3*, 221 – 229.

Bell, L. (2003). What can we learn from consumer studies and qualitative research in the treatment of eating disorders? *Eating and Weight Disorders*, *8*, 181 – 187.

Ben-Tovim, D. I., Walker, K., Gilchrist, P., Freeman, R., Kalucy, R., & Esterman, A. (2001). Outcome in patients with eating disorders: A 5-year study. *Lancet*, *357*, 1254 – 1257.

Bentovim, M. (2000). Ethical and legal issues. In B. Lask, & R. Bryant-Waugh (Eds.), *Anorexia nervosa and related eating disorders in childhood and adolescence* (pp. 349 – 360). East Sussex: Psychology Press.

Beumont, P., Hay, P., & Beumont, R. (2003). Summary Australian and New Zealand clinical practice guideline for the management of anorexia nervosa. *Australasian Psychiatry*, *11*, 129 – 133.

Beumont, P., & Vandereycken, W. (1998). Challenges and risks for health care professionals. In W. Vandereycken, & P. Beumont (Eds.), *Treating eating disorders: Ethical, legal and personal issues* (pp. 1 – 22). New York: New York University Press.

Birmingham, C. L., Su, J., Hlynsky, J. A., Goldner, E. M., & Gao, M. (2005). The mortality rate from anorexia nervosa. *International Journal of Eating Disorders*, *38*, 143 – 146.

Blake, W., Turnbull, S., & Treasure, J. (1997). Stages and process of change in eating disorders: Implications for therapy. *Clinical Psychology and Psychotherapy*, *4*, 186 – 191.

Brown, L. S. (1997). Ethics in psychology: *Cui Bono?* In D. Fox, & I. Prilletensky (Eds.), *Critical psychology: An introduction* (pp. 51 – 68). London: Sage Publications.

Bruch, H. (1978). *The golden cage: The enigma of anorexia nervosa.* London: Open Books.

Cockell, S. J., Geller, J., & Linden, W. (2003). Decisional imbalance in anorexia nervosa: Capitalizing on ambivalence. *European Eating Disorders Review*, *11*, 75 – 89.

Cockell, S. J., Zaitsoff, S. L., & Geller, J. (2004). Maintaining change following eating disorder treatment. *Professional Psychology: Research and Practice*, *35*, 527 – 534.

Crow, S., Praus, B., & Thuras, P. (1999). Mortality from eating disorders: A 5 – 10-year record linkage study. *International Journal of Eating Disorders*, *26*, 97 – 101.

Deter, H., & Herzog, W. (1994). Anorexia nervosa in a long-term perspective: Results of the Heidelberg-Mannheim study. *Psychosomatic Medicine*, *56*, 20 – 27.

Dolan, B. (1994). Why women? Gender issues and eating disorders: Introduction. In B. Dolan, & I. Gitzinger (Eds.), *Why women? Gender issues and eating disorders* (pp. 1 – 14). London: Athlone Press.

Draper, H. (1998). Treating anorexics without consent: Some reservations. *Journal of Medical Ethics*, *24*, 5 – 8.

Draper, H. (2000). Anorexia nervosa and respecting a refusal of life-prolonging therapy: A limited justification. *Bioethics*, *14*, 120 – 133.

Draper, H. (2003). Anorexia nervosa and refusal of naso-gastric treatment: A reply to Simona Giordano. *Bioethics*, *17*, 279 – 289.

Dresser, R. (1984). Feeding the hunger artists: Legal issues in treating anorexia nervosa. *Wisconsin Law Review*, *2*, 297 – 374.

Eckert, E. D., Halmi, K. A., Marchi, P., Grove, W., & Crosby, R. (1995). Ten-year follow-up study of anorexia nervosa: Clinical course and outcome. *Psychological Medicine*, *25*, 143 – 156.

Eisler, I. (1988). Family-therapy approaches to anorexia. In D. Scott (Ed.), *Anorexia and bulimia nervosa* (pp. 95 – 108). London: Croom Helm.

Ellis, T. (1991). The nature of morality. In P. J. Barker, & S. Baldwin (Eds.), *Ethical issues* (pp. 13 – 25). London: Chapman and Hall.

Feld, R., Woodside, D. B., Kaplan, A., Olmsted, M., & Carter, J. C. (2001). Pretreatment motivational enhancement therapy for eating disorders: A pilot study. *International Journal of Eating Disorders*, *29*, 393 – 400.

Fost, N. (1984). Food for thought: Dresser on anorexia. *Wisconsin Law Review*, *2*, 375 – 384.

Franko, D. L., Keel, P. K., Dorer, D. J., Blais, M. A., Delinsky, S. S., Eddy, K. T., et al. (2004). What predicts suicide attempts in women with eating disorders? *Psychological Medicine*, *34*, 843 – 853.

Fulford, K. W. (1995). Psychiatry, compulsory treatment and the value-based model of mental illness. In B. Almond (Ed.), *Introducing applied ethics* (pp. 148 – 161). Cambridge, MA: Blackwell.

Gans, M., & Gunn, W. (2003). End stage anorexia: Criteria for competence to refuse treatment. *International Journal of Law and Psychiatry*, *26*, 677 – 695.

Garfinkel, P. E. (2002). Eating disorders. *Canadian Journal of Psychiatry*, *47*, 225 – 226.

Garner, D., Vitousek, K., & Pike, K. (1997). Cognitive-behavioral therapy for anorexia nervosa. In D. Garner, & P. Garfinkel (Eds.), *Handbook of treatment for eating disorders* (pp. 94 – 144). New York: Guilford Press.

Garrett, C. (1998). *Beyond anorexia: Narrative, spirituality and recovery.* Cambridge: Cambridge University Press.

Geller, J. (2002a). Estimating readiness for change in anorexia nervosa: Comparing clients, clinicians, and research assessors. *International Journal of Eating Disorders*, *31*, 251 – 260.

Geller, J. (2002b). What a motivational approach is and what a motivational approach isn't: Reflections and responses. *European Eating Disorders Review*, *10*, 155 – 160.

Geller, J., & Drab, D. (1999). The readiness and motivation interview: A symptom-specific measure of readiness for change in the eating disorders. *European Eating Disorders Review*, *7*, 259 – 278.

Geller, J., Williams, K. D., & Srikameswaran, S. (2001). Clinician stance in the treatment of chronic eating disorders. *European Eating Disorders Review*, *9*, 365 – 373.

Geller, J., Zaitsoff, S. L., & Srikameswaran, S. (2005). Tracking readiness and motivation for change in individuals with eating disorders over the course of treatment. *Cognitive Therapy and Research*, *29*, 611 – 625.

Gilbert, S., & Thompson, J. K. (1996). Feminist explanations of the development of eating disorders: Common themes, research findings, and methodological issues. *Clinical Psychology: Science and Practice*, *3*, 183 – 202.

Giordano, S. (2003a). Anorexia nervosa and refusal of naso-gastric treatment: A response to Heather Draper. *Bioethics*, *17*, 261 – 278.

Giordano, S. (2003b). Persecutors or victims? The moral logic at the heart of eating disorders. *Health Care Analysis*, *11*, 219 – 228.

Gordon, R. (1990). *Anorexia and bulimia: Anatomy of a social epidemic.* Massachusets: Basil Blackwell.

Gowers, S. G., Weetman, J., Shore, A., Hossain, F., & Elvins, R. (2000). Impact of hospitalization on the outcome of adolescent anorexia nervosa. *British Journal of Psychiatry*, *176*, 138 – 141.

Greenstein, M., & Breitbart, W. (2000). Cancer and the experience of meaning: A group psychotherapy program for people with cancer. *American Journal of Psychotherapy*, *54*, 486 – 500.

Griffiths, R., & Russell, J. (1998). Compulsory treatment of anorexia nervosa patients. In W. Vandereycken, & P. Beumont (Eds.), *Treating eating disorders* (pp. 127 – 150). New York: New York University Press.

Gusella, J., Butler, G., Nichols, L., & Bird, D. (2003). A brief questionnaire to assess readiness to change in adolescents with eating disorders: Its application to group therapy. *European Eating Disorders Review*, *11*, 58 – 71.

Haas, L., & Malouf, J. (1995). *Keeping up the good work: A practitioners guide to mental health ethics.* Sarasota: Professional Resource Press.

Haliburn, J. (2002). Anorexia nervosa: A psychotherapeutic approach. In R. Meares (Ed.), *The self in conversation* (pp. 161 – 182). Sydney: Australian and New Zealand Association of Psychotherapy.

Haliburn, J. (2005). Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa. *Australian and New Zealand Journal of Psychiatry*, *39*, 639 – 640.

Handelsman, M. M., Knapp, S., & Gottlieb, M. C. (2002). Positive ethics. In C. R. Snyder, & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 731 – 744). Oxford: Oxford University Press.

Hart, M. (2004). Implementing refeeding in anorexia nervosa in a safe and sensitive way. *The Clinician*, *2*, 43 – 48.

Hébert, P., & Weingarten, M. (1991). The ethics of forced feeding in anorexia nervosa. *Canadian Medical Association Journal*, *144*, 141 – 144.

Hodgins, D. C. (2005). Weighing the pros and cons of changing change models: A comment on West (2005). *Addiction*, *100*, 1042 – 1043.

Hollin, C., & Levis, V. (1988). Cognitive-behavioral approaches to anorexia and bulimia. In D. Scott (Ed.), *Anorexia and bulimia nervosa* (pp. 108 – 123). London: Croom Helm.

Hsu, L. K. (1999). Treatment of anorexia nervosa. In D. Goldstein, & A. Stunkard (Eds.), *The management of eating disorders and obesity* (pp. 59 – 69). New Jersey: Humana Press.

Hubble, M., Duncan, B. L., & Miller, S. D. (Eds.). (1999). *The heart and soul of change: What works in therapy*. Washington, DC: American Psychiatric Association.

Jordan, P. J., Redding, C. A., Troop, N. A., Treasure, J., & Serpell, L. (2003). Developing a stage of change measure for assessing recovery from anorexia nervosa. *Eating Behaviors*, *3*, 365 – 385.

Kaplan, A. S. (2002). Psychological treatments for anorexia nervosa: A review of published studies and promising new directions. *Canadian Journal of Psychiatry*, *47*, 235 – 242.

Katzman, M. A., & Lee, S. (1997). Beyond body image: The integration of feminist and transcultural theories in the understanding of self-starvation. *International Journal of Eating Disorders*, *22*, 385 – 394.

Keyes, A., Brozec, J., Henschel, A., Nichelsen, O., & Taylor, H. L. (1950). *The biology of human starvation.* Minneapolis: University of Minnesota Press.

Kluge, E. (1991). The ethics of forced feeding in anorexia nervosa: A response to Hébert and Weingarten. *Canadian Medical Association Journal*, *144*, 1121 – 1124.

Lester, R. J. (1997). The (dis)embodied self in anorexia nervosa. *Social Science and Medicine*, *44*, 479 – 489.

MacDonald, C. (2002). Treatment resistance in anorexia nervosa and the pervasiveness of ethics in clinical decision making. *Canadian Journal of Psychiatry*, *47*, 267 – 270.

MacSween, M. (1993). *Anorexic bodies: A feminist and sociological perspective on anorexia nervosa.* London: Routledge.

Madden, S. (2004). A condition in focus: Anorexia nervosa in children and adolescents. *The Clinician*, *2*, 14 – 18.

Malson, H. (1998). *The thin woman: Feminism, post-structuralism and the social psychology of anorexia nervosa.* London: Routledge.

Malson, H. (1999). Womæn under erasure: Anorexic bodies in postmodern context. *Journal of Community and Applied Social Psychology*, *9*, 137 – 153.

Malson, H., & Swann, C. (1999). Prepared for consumption: (Dis)orders of eating and embodiment. *Journal of Community and Applied Social Psychology*, *9*, 397 – 405.

Manley, R., Smye, V., & Srikameswaran, S. (2001). Addressing complex ethical issues in the treatment of children and adolescents with eating disorders: Application of a framework for ethical decision-making. *European Eating Disorders Review*, *9*, 144 – 166.

McBeath, G., & Webb, A. (2002). Virtue ethics and social work: Being lucky, realistic, and not doing ones duty. *British Journal of Social Work*, *32*, 1015 – 1036.

McFarlane, J. (1988). Nursing: A paradigm of caring. In G. Fairbairn, & S. Fairbairn (Eds.), *Ethical issues in caring* (pp. 10 – 21). Aldershot: Avebury.

Melamed, Y., Mester, R., Margolin, J., & Kalian, M. (2003). Involuntary treatment of anorexia nervosa. *International Journal of Law and Psychiatry*, *26*, 617 – 626.

Mittler, P. (1988). Quality of life and services for people with disabilities. In G. Fairbairn, & S. Fairbairn (Eds.), *Ethical issues in caring* (pp. 147 – 162). Aldershot: Avebury.

Molly, G., Willer, B. A., Thuras, P., & Crow, S. J. (2005). Implications of the changing use of hospitalization to treat anorexia nervosa. *American Journal of Psychiatry*, *162*, 2374 – 2376.

Nasser, M. (1999). The new veiling phenomenon: Is it an anorexic equivalent? A polemic. *Journal of Community and Applied Social Psychology*, *9*, 407 – 412.

National Institute for Clinical Excellence (2004). *New guidelines to standardize care for adults, adolescents and older children with eating disorders.* Retrieved 18 October 2004, from http://www.nice.org.uk

Neiderman, M., Farley, A., Richardson, J., & Lask, B. (2004). Tube feeding in children with anorexia nervosa. *The Clinician*, *2*, 36 – 42.

Neiderman, M., Zarody, M., Tattersall, M., & Lask, B. (2000). Enteric feeding in severe adolescent anorexia nervosa: A report of four cases. *International Journal of Eating Disorders*, *28*, 470 – 475.

Nemeroff, C., & Cavanaugh, C. (1999). The ethics of emaciation: Moral connotations of body, self and diet. In M. Siegal, & C. Peterson (Eds.), *Children's understanding of biology and health* (pp. 183 – 209). Cambridge: Cambridge University Press.

Newman, M. M. (1993). The hospital treatment of eating disorders. In A. J. Gianni, & A. E. Slaby (Eds.), *The eating disorders* (pp. 185 – 195). New York: Springer-Verlag.

Nielsen, S., Moller-Madsen, S., & Nystrup, J. (1996). Utilisation of psychiatric beds in the treatment of ICD-8 eating disorders in Denmark 1970 – 1993: A register study. *European Psychiatry*, *11*(Suppl. 4), 221S.

Orbach, S. (1987). *Hunger strike: The anorectic's struggle as a metaphor for our age.* London: Faber.

Palmer, R. L. (1980). *Anorexia nervosa: A guide for sufferers and their families.* New York: Penguin Books.

Patton, G. C. (1988). Mortality in eating disorders. *Psychological Medicine*, *18*, 947 – 951.

Pellegrino, E. D. (2000). Ethical issues in palliative care. In H. M. Chochinov, & W. Breitbart (Eds.), *Handbook of psychiatry in palliative medicine* (pp. 337 – 348). Oxford: Oxford University Press.

Portency, R. K. (2000). Physical symptom management in the terminally ill: An overview for mental health professionals. In H. M. Chochinov, & W. Breitbart (Eds.), *Handbook of psychiatry in palliative medicine* (pp. 99 – 125). Oxford: Oxford University Press.

Prilletensky, I. (1997). Values, assumptions, and practices: Assessing the moral implications of psychological discourse and action. *American Psychologist*, *52*, 517 – 535.

Prilletensky, I., & Fox, D. (1997). Introducing critical psychology: Values, assumptions, and the status quo. In D. Fox, & I. Prilletensky (Eds.), *Critical psychology: An introduction* (pp. 3 – 21). London: Sage Publications.

Prochaska, J. O. (2006). Moving beyond the Transtheoretical Model. *Addiction*, *101*, 768 – 774.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages of change of smoking: Toward an integrated model of change. *Journal of Consulting and Clinical Psychology*, *51*, 390 – 395.

Prochaska, J. O., & DiClemente, C. C. (1992). Stages of change in the modification of problem behaviors. *Progress In Behavior Modification*, 28, 183 – 218.

Ramsay, R., Ward, A., Treasure, J., & Russell, G. (1999). Compulsory treatment in anorexia nervosa: Short-term benefits and long-term mortality. *British Journal of Psychiatry*, *175*, 147 – 153.

Rathner, G. (1992). Aspects of the natural history of normal and disordered eating and some methodological concerns. In W. Herzog, H-C. Deter, & W. Vandereycken (Eds.), *The course of eating disorders* (pp. 272 – 303). Berlin: Springer-Verlag.

Rathner, G. (1998). A plea against compulsory treatment of anorexia nervosa patients. In W. Vandereycken, & P. Beumont (Eds.), *Treating eating disorders* (pp. 179 – 216). New York: New York University Press.

Robb, A. S., Silber, T. J., Orrell-Valente, J. K., Valadez-Meltzer, A., Ellis, N., Dadson, M. J., et al. (2002). Supplemental nocturnal nasogastric refeeding for better short-term outcome in hospitalized adolescent girls with anorexia nervosa *American Journal of Psychiatry*, *159*, 1347 – 1353.

Rodin, G., & Gillies, L. A. (2000). Individual psychotherapy for the patient with advanced disease. In H. M. Chochinov, & W. Breitbart (Eds.), *Handbook of psychiatry in palliative medicine* (pp. 189 – 196). Oxford: Oxford University Press.

Royal Australian and New Zealand College of Psychiatrists (2003). *Clinical practice guidelines: Anorexia nervosa.* Retrieved 18 October 2004, from http://www.ranzcp.org.

Royal Australian and New Zealand College of Psychiatrists (2004). Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa. *Australian and New Zealand Journal of Psychiatry*, *38*, 659 – 670.

Rubin, L. R., Fitts, M. L., & Becker, A. E. (2003). "Whatever feels good in my soul": Body ethics and aesthetics among African American and Latina women. *Culture, Medicine and Psychiatry*, *27*, 49 – 75.

Russell, J. (1995). Treating anorexia nervosa. *British Medical Journal*, *311*, 584.

Russon, L., & Alison, D. (1998). Does palliative care have a role in treatment of anorexia nervosa? Palliative care does not mean giving up. *British Medical Journal*, *317*(7152), 196 – 197.

Sayers, J. (1988). Psychodynamic and feminist approaches to anorexia and bulimia nervosa. In D. Scott (Ed.), *Anorexia and bulimia nervosa* (pp. 85 – 95). London: Croom Helm.

Sesan, R. (1997). How I practice: Can we create feminist inpatient treatment environments for eating disordered women? *Eating Disorders: Journal of Treatment and Prevention*, *5*, 232 – 237.

Shelley, R. (Ed.) (1997). *Anorexics on anorexia*. London: Jessica Kingsley Publishers.

Shuster, J. L., Breitbart, W., & Chochinov, H. M. (1999). Psychiatric aspects of excellent end-of-life care. *Psychosomatics*, *40*, 1 – 3.

Slaby, A., & Dwenger, R. (1993). History of anorexia nervosa. In A. J. Gianni, & A. E. Slaby (Eds.), *The eating disorders* (pp. 1 – 16). New York: Springer-Verlag.

Strasser, M., & Giles, G. (1988). Ethical considerations. In D. Scott (Ed.), *Anorexia and bulimia nervosa: Practical approaches* (pp. 204 – 212). Sydney: Croom Helm.

Sullivan, P. F. (1995). Mortality in anorexia nervosa. *American Journal of Psychiatry*, *152*, 1073 – 1074.

Surgenor, L., Plumridge, E., & Horn, J. (2002). "Knowing one's self" anorexic: Implications for therapeutic practice. *International Journal of Eating Disorders*, *33*, 22 – 32.

Swain-Campbell, N., Surgenor, L., & Snell, D. (2001). An analysis of consumer perspectives following contact with an eating-disorders service. *Australian and New Zealand Journal of Psychiatry*, *35*, 99 – 103.

Tan, J. (2003). The anorexia talking? *The Lancet*, *362*, 1246.

Tan, J., Hope, T., & Stewart, A. (2003a). Anorexia nervosa and personal identity: The accounts of patients and their parents. *International Journal of Law and Psychiatry*, *26*, 533 – 548.

Tan, J., Hope, T., & Stewart, A. (2003b). Competence to refuse treatment in anorexia nervosa. *International Journal of Law and Psychiatry*, *26*, 697 – 707.

Tan, J., Hope, T., Stewart, A., & Fitzpatrick, R. (2003). Control and compulsory treatment in anorexia nervosa: The views of patients and parents. *International Journal of Law and Psychiatry*, *26*, 627 – 645.

Theander, S. (1992). Chronicity in anorexia nervosa: Results from the Swedish long-term study. In W. Herzog, H-C. Deter, & W. Vandereycken (Eds.), *The course of eating disorders* (pp. 214 – 227). Berlin: Springer-Verlag.

Tjeltveit, A. C. (2000). There is more to ethics than codes of professional ethics: Social ethics, theoretical ethics and managed care. *Counseling Psychologist*, *28*, 242 – 252.

Tjeltveit, A. C. (2006). To what ends? Psychotherapy goals and outcomes, the good life, and the principle of beneficence. *Psychotherapy: Theory, Research Practice, Training*, *43*, 186 – 200.

Tozzi, F., Sullivan, P. F., Fear, J. L., McKenzie, J., & Bulik, C. M. (2003). Causes and recovery in anorexia nervosa: The patient's perspective. *International Journal of Eating Disorders*, *33*, 143 – 154.

Touyz, S., Thornton, C., Rieger, E., George, L., & Beumont, P. (2003). The incorporation of the stage of change model in the day hospital treatment of patients with anorexia nervosa. *European Child and Adolescent Psychiatry*, *12*(Suppl. 1), 65 – 71.

Treasure, J., & Schmidt, U. (1999). Beyond effectiveness and efficiency lies quality in service for eating disorders. *European Eating Disorders Review*, *7*, 162 – 178.

Treasure, J., & Ward, A. (1997). A practical guide to the use of motivational interviewing in anorexia nervosa. *European Eating Disorders Review*, *5*, 102 – 114.

Vandereycken, W., & Meerman, R. (1992). The significance of follow-up investigations. In W. Herzog, H-C. Deter, & W. Vandereycken (Eds.), *The course of eating disorders* (pp. 3 – 14). Berlin: Springer-Verlag.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods and findings.* NJ: Erlbaum.

Wampold, B. E., & Bhati, K. S. (2004). Attending to the omissions: A historical examination of evidence-based practice movements. *Professional Psychology: Research and Practice*, *35*, 563 – 570.

Ward, A., Troop, N., Todd, G., & Treasure, J. (1996). To change or not to change: 'How' is the question? *British Journal of Medical Psychology*, *69*, 139 – 146.

Werth, J., & Rogers, J. R. (2005). Assessing for impaired judgment as a means of meeting the "duty to protect" when a client is a potential harm-to-self: Implications for clients making end-of-life decisions. *Mortality*, *10*, 7 – 21.

Werth, J., Wright, K., Archambault, R., & Bardash, R. (2003). When does the "duty to protect" apply with a client who has anorexia nervosa? *Counseling Psychologist*, *31*, 427 – 450.

West, R. (2005). Time for a change: Putting the transtheoretical (stages of change) model to rest. *Addiction*, *100*, 1036 – 1039.

West, R. (2006). The transtheoretical model of behaviour change and the scientific method. *Addiction*, *101*, 774 – 778.

Williams, C. J., Pieri, L., & Sims, A. (1998). We should strive to keep patients alive. *British Medical Journal*, *317*, 195 – 197.

World Health Organization (1990). *Cancer pain relief and palliative care. Technical report series 804.* Geneva: Author.

Yager, J., Andersen, A., Devlin, M., Mitchell, J., Powers, P., & Yates, A. (1993). American Psychiatric Association practice guidelines for eating disorders. *American Journal of Psychiatry*, *150*, 207 – 228.

Zerbe, K. J. (1995). Integrating feminist and psychodynamic principles in the treatment of an eating disordered patient: Implications for using countertransference responses. *Bulletin of the Menninger Clinic*, *59*, 160 – 176.

Zipfel, S., Löwe, B., Reas, D. L., Deter, H., & Herzog, W. (2000). Long-term prognosis in anorexia nervosa: Lessons from a 21-year follow-up study. *Lancet*, *355*, 721 – 722.