

Eating Disorders: Proposing a New Model for Forced Treatment

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Introduction

Research and dialogue regarding eating disorders are relatively recent phenomena. Karen Carpenter, a musical sensation in the 1970's and 1980's, died at age 32 in 1983. Years of struggling with anorexia weakened Carpenter's heart and she died of a cardiac arrest. Prior to this public death, many people had not heard of the term Anorexia Nervosa as people rarely discussed the disease.¹ Since then, the struggles of other well-known figures have fueled further discussion and analysis of the disease by attracting media attention. Examples include the 1997 death of twenty-two year-old ballerina Heidi Guenther,² the 2004 parentally-sought treatment of Mary-Kate Olsen,³ the 2006 deaths of twenty-two-year-old Uruguayan model Luisel Ramos and twenty-one-year old Brazilian model Ana Carolina Reston,⁴ and the public weight struggles of Nicole Richie, Jamie-Lynn Sigler, Tracey Gold, and Justine Bateman. Public sufferers of eating disorders have brought attention to the subject and have helped increase recognition of the seriousness of eating disorders.

However, the standard for treating those with eating disorders is inadequate. Problems with diagnostic criteria, the common onset of eating disorders during the transition between child and adulthood, the treatment refusal inherent in eating disorders, and the inapplicability of the

1 Adena Young, *Battling Anorexia: The Story of Karen Carpenter*, <http://atdpweb.soe.berkeley.edu/quest/Mind&Body/Carpenter.html> (last visited Nov. 22, 2009).

2 *E.g.*, Sarah Van Boven & Geoffrey Cowley, *A Ballerina's Tragic Death*, NEWSWEEK, July 21, 1997, at 79.

3 Michelle Tauber et al., *Mary-Kate's Private Battle*, PEOPLE, June 24, 2004 ("Staging the intervention before Mary-Kate turned 18 meant that her parents still had a legal right to seek treatment for her.").

4 Tom Phillips, *Everyone Knew she was Ill*, OBSERVER, Jan. 14, 2007, available at <http://www.guardian.co.uk/lifeandstyle/2007/jan/14/fashion.features4>.

imminent danger requirements of civil commitment, support the adoption of a unique and more relaxed standard for treating those with eating disorders. Specifically, because eating disorders⁵ often affect adolescents and young adults at a time of transition when society is generally more willing to exercise greater *parens patriae* power, and because many afflicted with eating disorders do not receive the help they need, the standards governing forced treatment of eating disorders should be relaxed for those age twenty-five and younger.

I. Defining Eating Disorders as Mental Illnesses

A. Background

The American Psychiatric Glossary defines both mental disorder and mental illness as

[A] behavioral or psychological *syndrome* that causes significant distress (a painful symptom) or disability (impairment in one or more important areas of functioning), or a significantly increased risk of suffering death, pain, or an important loss of freedom. The syndrome is considered to be a manifestation of some behavioral, psychological, or biological dysfunction in the person (and in some cases it is clearly secondary to or due to a *general medical condition*)⁶

While some have confused the term mental illness (which for purposes of this paper is treated synonymously with the term mental disorder) with mental retardation, the terms represent different symptoms.⁷ A primary distinction is that people with mental illnesses suffer disturbances in thought and emotional processes while those with mental retardation suffer from

⁵ For purposes of this paper, eating disorders are discussed generally but the term anorexia nervosa is often used because it is considered the most serious form of eating disorders and has been the subject of much of the relevant research.

⁶ AMERICAN PSYCHIATRIC PRESS, AMERICAN PSYCHIATRIC GLOSSARY 81–82 (Jane E. Edgerton & Robert J. Campbell eds., 7th ed. 1994).

⁷ Susan Lee, *Heller v. Doe: Involuntary Civil Commitment and the “Objective” Language of Probability*, 20 AM. J.L. & MED. 457, 461 (1994). However, approximately thirty percent of mentally retarded individuals also suffer from a mental illness. *Id.*

limited learning abilities.⁸ Many mental illnesses are temporary, cyclical, or episodic whereas mental retardation is permanent.⁹ This distinction is important in assessing eating disorders within the confines of mental health. While eating disorders may begin at an early age and last many years, they are more often temporary or episodic as opposed to a permanent disability.

B. Brief history of Eating Disorders and the DSM

Previous commentary on eating disorders debated whether anorexia should be regarded as a severe mental illness, or whether it should be thought of as a choice representing conformity with societal promotion of thinness.¹⁰ Many believed anorexia would clearly qualify as a mental disorder and could subject those suffering to civil commitment since the perceptions occurring in the minds of anorexics impair their judgment such that they are incapable of sustaining their own existence.¹¹ While the Diagnostic and Statistical Manual of Mental Disorders, third edition (DSM-III), published in 1980 included a section on eating disorders, arguably ending the aforementioned debate, the disorders were included within the broader category of “Infancy, Childhood, or Adolescence Disorders.”¹² This categorization implies that an eating disorder was not perceived as a serious illness, but instead more of a phase that some experience when they are young and not fully developed. This classification implies a sense of normalcy about the onset of an eating disorder as one faces body changes. The DSM-III categorized eating disorders

⁸ *Id.*

⁹ *Id.*

¹⁰ Gerald F.M. Russell, *Involuntary Treatment in Anorexia Nervosa*, 24 *PSYCHIATRIC CLINICS N. AM.*, 337, 337-48, 341 (2001).

¹¹ *Id.*

¹² See AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 67 (3rd ed. 1980). The DSM-II did not contain a section acknowledging eating disorders, but it did mention generalized feeding disturbance. *Id.* at 383.

into Anorexia Nervosa, Bulimia, Pica, and Rumination Disorder of Infancy, and included the “residual category” of Atypical Eating Disorder.¹³ The diagnostic criteria for Anorexia Nervosa, per the DSM-III, required:

- A. Intense fear of becoming obese, which does not diminish as weight loss progresses,
- B. disturbance of body image, e.g., claiming to “feel fat” even when emaciated,
- C. weight loss of at least 25% of original body weight or, if under 18 years of age, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25%,
- D. refusal to maintain body weight over a minimal normal weight for age and height, [and]
- E. no known physical illness that would account for the weight loss.¹⁴

The DSM-III described the age of onset as usually being in “early to late adolescence,” and noted that many anorexics are “overly perfectionist ‘model children.’”¹⁵

C. Current Status of Diagnostic Criteria

The DSM-IV, published in 1994, includes a revised section devoted to eating disorders.¹⁶

The section no longer falls under the heading of “Infancy, Childhood, or Adolescence Disorders,” and is divided into a discussion of Anorexia Nervosa¹⁷ and Bulimia Nervosa¹⁸ and a mention of Eating Disorder Not Otherwise Specified.¹⁹ The DSM-IV also modifies the

¹³ *Id.* at 67.

¹⁴ *Id.* at 69.

¹⁵ *Id.* at 68–69.

¹⁶ See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 539 (4th ed. 1994). Although the DSM-IV-TR was published in 2000, the diagnostic criteria did not change.

¹⁷ See *id.* at 539–45 for the material relevant to Anorexia Nervosa.

¹⁸ See *id.* at 545–50 for the material relevant to Bulimia Nervosa.

¹⁹ See *id.* at 550 for the material relevant to Eating Disorder Not Otherwise Specified.

diagnostic criteria, including a change from a focus on weight loss to a focus on the maintenance of a low weight. The DSM-IV criteria read as follows:

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected),
- B. intense fear of gaining weight or becoming fat, even though underweight,
- C. disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight, [and]
- D. in postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles²⁰

A significant difference between the DSM-III and the DSM-IV is that the DSM-IV suggests that eating disorders occur on a continuum, indicating that anorexic individuals may have episodes of bulimia, and vice versa;²¹ the DSM-III imposed a dual-diagnosis in those circumstances.²² This change can indicate the uncertainty of definitions of diagnostic criteria and the lack of complete understanding of the way eating disorders operate. This change can also indicate the individualized nature of eating disorders, with varied presentation of symptoms among patients, and the need to approach eating disorders in a unique manner.

D. Criticism and Debate Regarding the Forthcoming DSM-V

Debate and criticism regarding the DSM-IV's Eating Disorder Not Otherwise Specified (ED NOS) category further emphasize problems with diagnostic criteria. While the authors of the DSM-IV intended the category to "provid[e] clinicians with a diagnostic option for rare

²⁰ AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 16, at 544–45.

²¹ *Diagnosing Eating Disorders: What's New in the DSM-IV*, 29 PATIENT CARE 93, 93 (1995).

²² *Id.*

cases,”²³ studies have found many patients that present to eating disorder services are diagnosed with ED NOS.²⁴ A study presented at the American Psychiatric Association (APA) 2007 Annual Meeting found that 89.1% of a group of 165 psychiatric outpatients that were diagnosed with a current eating disorder fell into the ED NOS category.²⁵ A rare, residual category should not logically receive close to 90% of a patient group unless the diagnostic criteria are flawed. This result led the presenters of the research to suggest the DSM-IV nomenclature for eating disorders is flawed and that the diagnostic threshold for anorexia nervosa and bulimia nervosa should be lowered.²⁶ The presenters noted that many of the patients diagnosed with ED NOS exhibited symptoms of anorexia nervosa and/or bulimia nervosa, but below the diagnostic threshold; the presenters observed that a loosening of the standards used in diagnosis would result in the inclusion of many of these patients.²⁷ This observation points out that the diagnostic criteria are such that small changes could alter the classification of many with eating disorders.

23 Marlene Busko, *DSM-IV Diagnostic Criteria for Eating Disorders May Be Too Stringent*, MEDSCAPE MED. NEWS, May 30, 2007, available at <http://www.medscape.com/viewarticle/557479>.

24 *Id.*

25 *Id.* This study utilized data from the Rhode Island Hospital Methods to Improve Diagnostic Assessment and Services (MIDAS) project. *Id.* The relevant portion of this clinical epidemiologic study concerned 2500 psychiatric outpatients who were given a Structural Clinical Interview for DSM-IV. *Id.* Following the 2500 interviews, 354 patients were diagnosed with a current or previous eating disorder; specifically 165 were diagnosed with a current eating disorder, 59 were diagnosed as being in remission, and 130 were diagnosed as having a past eating disorder. *Id.* 84 of the 165 patients receiving a diagnosis of a current eating disorder fit the criteria of ED NOS rather than Anorexia Nervosa or Bulimia Nervosa. *Id.* 63 of the patients were diagnosed with currently having Binge-Eating Disorder (which is included in the ED NOS section as an example in the DSM-IV and therefore the number of patients with this diagnosis were added to those diagnosed with ED NOS), 18 patients were diagnosed with currently having Bulimia Nervosa, and no patient was diagnosed with currently having Anorexia Nervosa. *Id.*

26 *Id.*

27 *Id.*

The presenters at the 2007 meeting are not alone in their criticism. Other researchers have stated that ED NOS is “the most common eating disorder diagnosis encountered in routine clinical practice: it is considerably more common than the two specified eating disorders, anorexia nervosa and bulimia nervosa.”²⁸ But, despite the high prevalence of the diagnosis, there have not been extensive descriptions of clinical characteristics of this group of patients.²⁹ A study published in 2007 led researchers to suggest altering the eating disorder section in the DSM-V.³⁰ This study found, in part, that ED NOS is not only the most commonly diagnosed eating disorder (in the context of adult outpatient care), that the psychopathology “closely resembles that of anorexia nervosa and bulimia nervosa,” and that ED NOS is comparable to bulimia nervosa in its severity, but that the high diagnosis rate is not attributable to sub-threshold symptoms of anorexia nervosa or bulimia nervosa.³¹ Instead, this study purports that many diagnosed with ED NOS possess the same psychopathology as those diagnosed with anorexia nervosa and bulimia nervosa but that they differ in clinical presentation; rather than exhibiting the sub-threshold symptoms, patients exhibit differing combinations of mixed symptoms of anorexia and bulimia nervosa.³² The researchers suggest including in the DSM-V a new

28 Christopher G. Fairburn et al., *The Severity and Status of Eating Disorder NOS: Implications for DSM-V*, BEHAV. RES. & THERAPY, August 2007 45(8): 1705-15.

29 *Id.*

30 *Id.* The study, conducted in England, diagnosed 170 patients with an eating disorder utilizing the DSM-IV criteria. *Id.* 102 of the patients were diagnosed with ED NOS, 8 with Anorexia Nervosa, and 60 with Bulimia Nervosa. *Id.*

31 *Id.*

32 *Id.*

diagnostic category encompassing this diagnosis³³ rather than loosening the current criteria while maintaining the current diagnostic categories.

Yet another view provides that anorexia, bulimia, and ED NOS should all be viewed as a single entity since they share a distinct psychopathology.³⁴ This view is partly based on one study's finding that patients frequently moved between different diagnoses under the DSM-IV so that an individual's diagnosis changed over time.³⁵ But, this could be a subset of the argument that DSM-IV criteria are too stringent. For the study cited found that "minor changes in weight or eating behavior can result in a person receiving an entirely different DSM-IV eating disorder diagnosis."³⁶ Although similarities may exist between the different diagnoses, this shifting between diagnoses could also be attributed to the diagnostic criteria being too limiting.

While a full analysis of the different versions of the DSM's sections on eating disorders and the various related studies, commentaries, and debates are beyond the scope of this paper, there is a clear lack of consensus regarding future diagnostic criteria, classification standards, and medical groupings of patients with eating disorders. This uncertainty suggests that eating disorders cannot be analyzed and categorized in the same manner as other mental disorders.

II. The Population of those Afflicted with Eating Disorders

A. General Statistics

³³ *Id.*

³⁴ Gabriella Milos et al., *Instability of Eating Disorder Diagnoses: Prospective Study*, BRIT. J. PSYCHIATRY (2005) 187, 573-78, at 577.

³⁵ *Id.* The study did note that anorexia nervosa was the most stable of the diagnoses.

³⁶ *Id.*

Eating disorders affect between approximately eight and eleven million people in the United States alone.³⁷ In America, between seven and ten million women and one million men suffer from an eating disorder.³⁸ Eating disorders affect individuals of all ethnic and socioeconomic groups.³⁹ The National Association of Anorexia Nervosa and Associated Disorders estimates that ninety percent of those who suffer from anorexia nervosa and bulimia nervosa are women.⁴⁰ Eating disorders most often develop in girls between the ages of twelve and twenty-five (although they do occur in both women and men, young and old), with seventeen being the average age at which an eating disorder develops.⁴¹ The National Institute of Mental Health has determined that Anorexia Nervosa is the cause of death with the highest mortality rate among females between the ages of fifteen and twenty-four.⁴²

In a 2000 study on individuals with anorexia nervosa, the results indicated that 38.8% of the patients were under the age of eighteen, while 39.9% of the patients were between the ages of eighteen and thirty-four; 54% of the individuals with bulimia nervosa were between the ages of eighteen and thirty-four while only 18% of those treated for bulimia nervosa were under the age of eighteen.⁴³ Those treated with ED NOS were divided fairly equally across the different age

37 See Nat'l Ass'n of Anorexia Nervosa and Associated Eating Disorders, Facts About Eating Disorders, <http://anad.studionorth.com/getInformation/abouteatingdisorders/> (last visited Nov. 3, 2009) (noting that ten million women and one million men suffer from eating disorders in the United States).

38 *Id.*

39 *Id.*

40 Nat'l Women's Health Res. Ctr., *Eating Disorders*, GALE GROUP, Mar. 16, 2005.

41 *Id.*

42 Nat'l Ass'n of Anorexia Nervosa and Associated Eating Disorders, *supra* note 37.

43 Ruth H. Striegel-Moore, et al., *One-Year Use and Cost of Inpatient and Outpatient Services Among Female and Male Patients with an Eating Disorder: Evidence from a National Database of Health Insurance Claims*, 27 INT'L J. EATING DISORDERS, 381, 384 (2000).

groups.⁴⁴ Statistically, eating disorders are not the childhood disorders once thought. This realization should impact treatment modalities. While parents may be able to control the treatment of young children afflicted with childhood illnesses, young patients comprise a smaller percentage of patients than originally thought, leaving many with eating disorders to decide their own treatment, or lack thereof. Because eating disorders do not typically disappear without treatment,⁴⁵ and because many individuals with eating disorders refuse treatment, the imposition of treatment in this area should be considered more liberally.

B. Causes of Eating Disorders

Although there is not one determined cause of eating disorders, biological, social, and psychological factors can contribute to their development.⁴⁶ There has been some research that suggests a genetic predisposition to developing an eating disorder,⁴⁷ while other research has found hormonal disturbances and imbalances in neurotransmitters have a causal connection with eating disorders.⁴⁸ Psychologically-damaging events, such as rape, and transition periods, such as puberty, beginning college, marriage, and divorce, can trigger the onset of eating disorders.⁴⁹ In addition, social pressures such as participation in sports with weigh-ins or a focus on a particular body-type, or the cultural emphasis on an “ideal” body can also promote eating

44 *Id.*

45 Nat’l Women’s Health Res. Ctr., *Eating Disorders*, GALE GROUP, Mar. 16, 2005.

46 *Id.*

47 *See id.* (estimating that an individual with an immediate relative with an eating disorder is five or six times more likely to develop an eating disorder.).

48 *Id.* (describing that neurotransmitters are chemicals in the brain that regulate mood and appetite).

49 *Id.*

disorders.⁵⁰ But, there must be multiple causal factors working together for an eating disorder to develop. Not everyone that experiences trauma develops an eating disorder, nor does every athlete who faces an ideal body-type. It seems then, that there must be a biological or genetic component that triggers the development of the illness. Every person has experience with food – it is not like a drug that an individual experiences once or twice before developing an addiction. Instead, there must be something that changes in the psyche that causes an individual’s relationship with food to transform into an eating disorder.

C. Affect on the Transition Age Group

Eating disorders present a unique problem due to their prevalent occurrence during the period of transition between childhood and adulthood. Many adolescent and young adult women face eating disorders when they are in their late teens and early twenties at ages when many of these women are attending colleges and universities. This age group presents particularities because some may live at home with their parents and others may be completely “on their own;” but, another large group may have technically left home to go away to school but are not yet living as autonomous adults. Many colleges and universities require students to live on campus and subscribe to a mandatory meal plan. Often these bills are paid by parents, relatives, or scholarships and the students do not face the responsibilities of paying bills associated with maintaining a residence, cleaning a residence, or making meals for themselves. Many in this transition stage continue to rely substantially on their parents for financial and emotional support as they did during their earlier years; but, after the age of eighteen, the parents no longer possess the same control over their children, especially when it comes to medical care. This age group is babied and protected in some ways and treated as adults in others.

⁵⁰ *Id.*

Society recognizes the difficulties involved with classifying members of this population as either children or adults. For example, while an eighteen-year old can vote, join the armed forces, buy lottery tickets, cigarettes, and pornography, he or she may not (generally) rent a car or hotel room. Further demonstrating the question of adulthood is the debate surrounding the proper drinking age. After years of most states providing twenty-one as the legal drinking age, in the early 1970's 29 states lowered the drinking age in response to the view that it was inappropriate that soldiers participating in the Vietnam War were not considered old enough to drink.⁵¹ The lowered drinking age led to a significant increase in alcohol-related traffic injuries and fatalities, causing many states to re-instate twenty-one as the legal drinking age, and in July 1984, President Reagan signed the Uniform Drinking Age Act requiring all states to adopt twenty-one as the drinking age within five years.⁵² Many have attributed the higher drinking age of twenty-one with increased public safety and decreased deaths;⁵³ but, the fact remains that this demonstrates society's willingness to create special rules for those still in the transition to adulthood. A similar action should be taken to decrease injuries and fatalities of those in the transition group who face the greatest dangers of eating disorders.

III. Treatment

A. Refusal of Treatment due to a Need for Control

One of the reasons treatment of eating disorders is an issue of concern is that many individuals with illnesses such as anorexia nervosa refuse medical and psychological treatment.⁵⁴

⁵¹ MADD, *Why 21?* (2007), available at <http://www.why21.org/history/>.

⁵² *Id.*

⁵³ *Id.*

⁵⁴ Elliot Goldner, *Treatment Refusal in Anorexia Nervosa*, 8 INT'L J. EATING DISORDERS, 297, 297 (1989).

While the ability to refuse treatment is generally a well-protected and established right,⁵⁵ it can be temporarily denied. Whether treatment should be forced on those with anorexia nervosa is a difficult decision, with indications of negative effects that result from the imposition of such treatment weighing against evidence that nonintervention can result in chronic morbidity and mortality.⁵⁶ Many individuals with anorexia nervosa have “an intense need for a sense of self-determination” which causes them to refuse treatment to avoid the loss of control over their private world.⁵⁷ This need for self-determination also prevents anorexic patients from developing trusting interpersonal relationships,⁵⁸ making it difficult for medical professionals and others to convince such patients treatment is in their best interest. Further, this self-determination also presents as perfectionism in many anorexic patients, causing individuals with anorexia to feel extreme disturbance, shame, and humiliation by the need for assistance.⁵⁹ Because an intense need to control one’s body is such an integral part of eating disorders, patients with eating disorders should be treated differently from patients with other illnesses who do not typically present with the same need for control.

B. Duty to Obtain Consent

55 See *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 277 (1990) (“the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment.”).

56 Goldner, *supra* note 54, at 297.

57 *Id.* at 299.

58 *Id.*

59 See Guido K. Frank et al., *Increased Dopamine D2/D3 Receptor Binding After Recovery from Anorexia Nervosa Measured by Positron Emission Tomography and [11C] Raclopride*, 58 *BIOLOGICAL PSYCHIATRY* 908, 908 (2005) (stating that individuals with anorexia often have “overcontrolled, perfectionist personalities.”).

A physician must obtain a patient's consent before performing any medical or surgical procedure to protect against claims of battery, malpractice, and civil rights violations.⁶⁰ The requirement of consent arises from "the patient's right to self-determination."⁶¹ However, the consent issue is less clear when the patient is a minor or is incompetent. As Justice Cardozo described, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages"⁶² Whether a patient is of "sound mind" to make such a determination, however, can be unclear and debatable.

The right of determination is not absolute. In cases in which an individual's refusal of treatment is challenged, courts first analyze whether the individual is competent, since an incompetent individual lacks the ability to make a decision as to their treatment.⁶³ An incompetent person's treatment refusal is not considered an actual invocation of the right to refuse treatment since it is not deemed a cognoscente decision.⁶⁴ The first competency consideration is whether the individual is able to express his desires.⁶⁵ If he is unable to make this assertion, the court must determine who possesses authority to make decisions regarding treatment.⁶⁶ When an individual does make a declaration as to medical treatment, the court then

60 Martha Swartz, *The Patient Who Refuses Medical Treatment: A Dilemma for Hospitals and Physicians*, 11 AM. J.L. & MED. 147, 148-49 (1985).

61 *Id.* at 149.

62 *Id.*

63 Martha Alys Matthews, Comment, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 CALIF. L. REV. 707, 724 (1987).

64 *Id.*

65 *Id.*

66 *Id.*

analyzes whether the preferences should be seriously regarded or thought of as irrational desires resulting from illness, senility, or medication.⁶⁷ In assessing an individual's competence to refuse medical treatment, courts have focused on the particular facts of each case and analyzed the individual's comprehension of his situation, available alternatives, and the risks and benefits of each.⁶⁸ Assessing competence regarding decisions as to medical care is tricky because a court cannot completely overlook the substance of the decision being made, since competency is not an independent characteristic and a person may be competent to make one decision but not another; but, a court also cannot deem an individual incompetent solely because it does not agree with the individual's decision.⁶⁹ If the individual is found competent to make a decision to refuse treatment, then the individual's interests in asserting his right of refusal is balanced against the state's interests in preserving life.⁷⁰

IV. Involuntary Commitment

When an individual is neither legally incompetent nor a minor, treatment may still be imposed if the individual is involuntarily committed.⁷¹ Generally, this will only occur when the individual is found to have a mental disorder and found to pose a danger to self or others.⁷² Involuntary commitment of anorexics is complex due to the unpredictable nature of associated

⁶⁷ *Id.*

⁶⁸ *Id.* at 725.

⁶⁹ *Id.* at 728.

⁷⁰ *Id.* at 729.

⁷¹ Goldner, *supra* note 54, at 302. See CONN. GEN. STAT. § 17a-543 (2009) (stating that medical procedures may not be performed and medicine may not be given without the patient's informed consent, but that if the patient has been declared incapable of caring for himself or herself or if the patient is an involuntary patient then a representative may provide consent).

⁷² Goldner, *supra* note 54, at 302.

risks. Yet, anorexics do possess the requisite mental disorder⁷³ and they are a danger to themselves as death can occur by starvation, suicide, or sudden cardiac arrhythmia, which is often unpredictable.⁷⁴ Commentators have suggested consideration of the following factors in the determination of whether to impose treatment on an uncooperative anorexic individual: “degree of physical compromise,” “vulnerability of treatment alliance,” “previous outcome of intervention,” “previous outcome of nonintervention,” “available resources and supports,” “duration of illness,” “accuracy of patient’s judgment and perceptions,” and “other prognostic indicators (e.g., personality factors, symptom profile).”⁷⁵ Commentators note that the risks and benefits of imposed treatment must be carefully assessed and that family members should be involved in developing a treatment plan.⁷⁶ When the patient is an adult, it is suggested that doctors ask the patient’s permission to involve their family but that even if permission is denied, to contact the family anyway since there is a risk to the patient’s life or health.⁷⁷ With anorexics, who strive to remain in control of their surrounding circumstances, contacting family members without consent may augment the distrust an anorexic patient feels towards his doctor. But, since physical deterioration can be difficult to predict, it may be necessary as the benefits of family presence may be deemed to outweigh the risks.

A. Justification and Logistics of Involuntary Commitment

73 See AM. PSYCHIATRIC A., *supra* note 16, at 539 (defining eating disorders as a mental illness).

74 Goldner, *supra* note 54, at 302.

75 *Id.* at 303.

76 See *id.* (noting that family involvement may help facilitate negotiation of a treatment plan between the patient and doctor and that such involvement “generally increases therapeutic leverage.”).

77 Russell, *supra* note 10, at 340.

Courts have generally recognized two justifications for involuntarily committing individuals suffering from a mental illness. First, the state is justified through their police power in protecting society from individuals who pose a danger to others.⁷⁸ Second, the state is justified through their police power and *parens patriae* authority in protecting citizens who cannot care for themselves or are “prone to self-destructive acts.”⁷⁹ In the case of individuals with eating disorders, the *parens patriae* protection justification can be used to argue for involuntary commitment and/or forced treatment with the rationale that the individual is both incapable of caring for himself and is prone to self-destructive acts (or in this case, self-destructive inaction).

While the Supreme Court’s decision in *O’Connor v. Donaldson*⁸⁰ has been interpreted to declare unconstitutional civil commitment statutes which permit commitment based on standards of the best interest of the patient, the revised statutes of many jurisdictions provide for involuntary commitment of individuals who are dangerous to others or to themselves – with danger to self including the inability to care for basic needs.⁸¹ The justification for statutes allowing for the involuntary hospitalization of a person found mentally ill and dangerous to self or unable to care for himself is that “people with mental illness lack the capacity to make decisions about treatment and hospitalization; thus, the state has the authority to make those

⁷⁸ Lee, *supra* note 7, at 461.

⁷⁹ *Id.*

⁸⁰ 422 U.S. 563, 567 (1975) (holding that “a State cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members and friends.”) Lee, *supra* note 7, at 461.

⁸¹ Lee, *supra* note 7, at 462 (1994) (citing Jillane T. Hinds, *Involuntary Outpatient Commitment for the Chronically Mentally Ill*, 69 NEB. L. REV. 346, 403).

decisions for them.”⁸² According to the West Virginia Supreme Court, “when it can be demonstrated that an individual has a self-destructive urge and will be violent towards himself, or alternatively that he is so mentally retarded or mentally ill that by sheer inactivity he will permit himself to die either of starvation or lack of care, then the State is entitled to hospitalize him.”⁸³ It is the danger to self through the inability to care for basic needs that is often overlooked or normalized with eating disorders. It is possible that social and societal factors lead some to rationalize that it is not an inability to care for the basic need of eating, but rather, an affirmative choice to be thin. While this is not the case with eating disorders, society’s obsession with weight simultaneously decreases the perception of the dangerousness and seriousness of the mental illnesses of anorexia nervosa, bulimia nervosa, and ED NOS.

B. Inapplicability of Statutory Requirements of Imminent Danger

State statutes govern involuntary commitment of patients. In Connecticut,

[a]ny person who a physician concludes has psychiatric disabilities and is dangerous to himself or others or gravely disabled, and is in need of immediate care and treatment in a hospital for psychiatric disabilities, may be confined in such a hospital . . . under an emergency certificate as hereinafter provided for not more than fifteen days without order of any court.⁸⁴

The requirement that the individual be in need of immediate care can be problematic in the case of eating disorders. In addition to situations in which individuals may be involuntarily committed because they are imminent dangers to themselves, individuals with anorexia nervosa present a further complication — the question of whether they can be involuntarily committed to

82 CHRISTOPHER SLOBOGIN ET AL., *LAW AND THE MENTAL HEALTH SYSTEM* 748, (Thompson/West 5th ed. 2009) (1985).

83 *State ex rel Hawks v. Lazaro*, 157 W.Va. 417, 438 (1974).

84 *CONN. GEN. STAT.* § 17a-502 (2009).

restore health as opposed to preserving life.⁸⁵ For example, some patients have avoided effective treatment for years and persist in states of deterioration, malnutrition, and depression⁸⁶ and could benefit from a more aggressive and invasive form of treatment. But, being unhealthy may not qualify individuals for involuntary commitment without the risk of imminent danger. Anorexia is more complicated than some other illnesses because of the difficulty in predicting when the patient will cross the fine line that separates a severely malnourished patient from one at the point of starving to death and therefore in imminent danger.

Those afflicted with eating disorders would likely derive a greater benefit from the “potential-for-deterioration” grounds for commitment recommended by the American Psychiatric Association (APA).⁸⁷ The APA promotes a model act that would provide for commitment when an individual “will if not treated suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason or behavior causing a substantial deterioration of his previous ability to function on his own.”⁸⁸ This standard would allow for the commitment of those generally excluded from commitment statutes but who are “moving toward sudden collapse.”⁸⁹ Since individuals with eating disorders may not be in imminent danger such that they would fall under the Connecticut’s statute for civil commitment, this standard would likely enable more people moving towards starvation or heart failure due to self-starvation to obtain necessary help at an early point when intervention could be most successful.

⁸⁵ Russell, *supra* note 10, at 340.

⁸⁶ *Id.*

⁸⁷ SLOBOGIN, *supra* note 82, at 778.

⁸⁸ *Id.*

⁸⁹ *Id.*

In *The Practical Limits of Patients' Rights* Darold Trefert describes a forty-nine year old with anorexia nervosa who refused to eat and suffered profound weight loss.⁹⁰ While the situation was life-threatening, the judge did not find imminent danger and therefore the patient was not involuntarily committed.⁹¹ The individual refused treatment, went home, and died three weeks later of inanition.⁹² This story demonstrates how the imminent danger requirement does not function well in the context of eating disorders. The point of imminent danger is too difficult to predict. A severely malnourished anorexic should be seen as in a constant state danger due to prolonged deterioration; anorexics are constantly moving toward a sudden collapse.

C. Forced Treatment of those with Eating Disorders

What is involved with involuntary commitment to treat anorexics without consent? Some may believe imposed treatment on anorexics inherently involves physical forced feeding through tubes, but that is often not the case. Studies have shown that compulsory treatment of anorexia “seldom or never requires the application of forced feeding.”⁹³ Rather, the defining characteristics of compulsory treatment are that the patients are admitted to an eating disorder unit involuntarily and cannot discharge themselves against medical advice.⁹⁴ Although there may be an absence of physical force and physical violation of one’s body, the feeding can still be viewed as “forced,” or at least compelled or extorted. In order to recover from the physical effects of an eating disorder, a patient must obtain a healthy weight. If the patient cannot leave

90 *Id.* at 781 (citing Darold Trefert, *The Practical Limits of Patients' Rights*, 5 *PSYCHIAT. ANNALS* 4 (1975)).

91 *Id.*

92 *Id.*

93 Russell, *supra* note 10, at 343.

94 *Id.*

the facility against medical advice it is only logical that the patient must be a healthy weight to leave and that in order to reach such a weight the patient must eat, even if he or she would not otherwise choose to do so.

Doctors may possess different views regarding the effectiveness of forced treatment in eating disorder cases. While forced treatment may negatively affect some individuals with anorexia, it also has benefits and may be necessary in some instances. Individuals with anorexia have distorted thinking,⁹⁵ which affects their ability to make decisions.⁹⁶ Cognitive distortions associated with anorexia nervosa can be amplified by mood disturbances, which are also typical among anorexic individuals.⁹⁷ Further, malnutrition can hinder the ability to think rationally and clearly, making it very difficult for an anorexic individual to realistically evaluate their medical condition and proposed treatment.⁹⁸

Arthur Crisp, a professor of psychiatry and researcher of anorexia has described some of the difficulties faced by those deciding whether to impose treatment on an anorexic individual:

One cannot be involved in the business of [treating] anorexia nervosa for long without being starkly confronted by the problem of free will versus determinism. Is the anorectic free to choose an alternate way of life or is she simply a product of biological forces and previous social experiences [?]⁹⁹

95 See AM. PSYCHIATRIC A., *supra* note 16, at 540 (stating that criterion C for a diagnosis of anorexia nervosa involves a distortion of body weight and shape and noting that individuals with anorexia nervosa generally deny medical implications of their weight even if they recognize their thinness.).

96 Goldner, *supra* note 54, at 300.

97 *Id.*

98 *Id.*

99 *Id.* at 301 (quoting A.H. CRISP, ANOREXIA NERVOSA: LET ME BE, Academic Press, Grune and Stratton, New York 1980 p.99).

Other commentators have also suggested that anorexic individuals lack the ability to make decisions, as they are controlled by their illness.¹⁰⁰ Marsha Garrison describes, “[d]espite clear understanding of the benefits of treatment and a wish to recover,’ [anorexics] often experience ‘difficulties making a decision to change their behaviour or accept treatment’ due to their powerful urge to control a body that seems, to the ill patient, much larger than it really is.”¹⁰¹ In addition, researchers have found that many individuals involuntarily hospitalized for treatment of eating disorders later show goodwill toward the treatment process and affirm the necessity of the involuntary treatment.¹⁰² This can be seen as comports with the view that if an anorexic patient possessed all of his faculties, he might be more amenable to treatment. Anorexia is problematic because individuals with the illness are typically competent in the sense that they usually understand the information presented, can retain the information, and communicate a choice regarding treatment, but the illness can “cloud their ability to make valid decisions.”¹⁰³ As Jacinta Tan points out, society may need to re-evaluate notion of competence because anorexia nervosa affects competence even though logic and understanding may be unharmed.¹⁰⁴

100 *Id.* One such commentator has compared an anorexic’s pursuit of thinness to a paranoid schizophrenic’s attempts “to elude supposed enemies.” *Id.* (quoting N. Fost, *Food for Thought: Dresser on anorexia*, WIS. L. REV. 375, 375-84 (1984)). See Jacinta Tan, *The Anorexia Talking*, 362 LANCET 1246, 1246 (2003) (noting that when doctors attempt to treat people with anorexia, patients often refuse treatment and leave the doctors wondering whether the patients are relaying their actual wishes, or whether it is “the anorexia talking.”).

101 Marsha Garrison, *The Empire of Illness: Competence and Coercion in the Health-Care Decision Making*, 49 WM. & MARY L. REV. 781, 812 (2007) (quoting Jacinta Tan et al., *Competence to Refuse Treatment in Anorexia Nervosa*, 26 INT’L J.L. & PSYCHIATRY 697, 703 (2003)).

102 *Id.* at 813-14.

103 Jacinta Tan, *The Anorexia Talking*, 362 LANCET 1246, 1246 (2003).

104 *Id.*

Under the theory that individuals with eating disorders are not fully capable of making competent decisions, imposing treatment is less controversial since the anorexic is not willfully refusing treatment; the idea is that if the individual possessed free will he would in fact choose not to die and hence, accept treatment.¹⁰⁵ But, not everyone subscribes to that theory.

Some are critical of medical paternalism and do not see eating disorders as an exceptional case worthy of forced treatment. Some may not feel it is the state's responsibility to care for its citizens when care is not sought, finding ethical problems with the loss of autonomy.¹⁰⁶ In addition, it may be difficult for a doctor to draw a line between acceptable dieting and an eating disorder if the doctor has not been privy to the patient's weight loss and medical history or if the patient's psyche is not examined. Two people may be the same weight and one may have an eating disorder and the other may not. It is the mental and psychological components of an eating disorder that need examination because those with eating disorders can be so obsessed with controlling what does and does not enter their bodies that they starve themselves to death. An individual at a low weight without an eating disorder may biologically function fine at that weight; but, more importantly, a mentally healthy individual will likely eat when hungry or light-headed while an individual with an eating disorder will not relinquish control to hunger.

D. Inapplicability of the Distinction Between Treatment Refusal and Suicide

The imminent danger model of involuntary commitment may promote committing those seen as suicidal. But one of the reasons that model fails to protect those with eating disorders is that there is a perceived distinction between individuals taking action to commit suicide and

¹⁰⁵ Goldner, *supra* note 45, at 300 (citing N. Fost, Food for Thought: Dresser on anorexia. Wis. L. REV. 375, 375-84 (1984)).

¹⁰⁶ *Id.* at 339.

individuals passively choosing or allowing themselves to die.¹⁰⁷ In 1983 Elizabeth Bouvia voluntarily entered a California hospital's psychiatric unit seeking "just [to] be left alone and not bothered by friends of family or anyone else and to ultimately starve to death."¹⁰⁸ While Bouvia was competent and intelligent, she wanted to end her struggle with cerebral palsy and degenerative arthritis, accompanied by some personal setbacks, and she requested a court order to prevent forced-feeding.¹⁰⁹ The court denied the order and two years later when Bouvia claimed she was physically unable to eat enough to sustain herself, doctors believed she was intentionally choosing not to eat and inserted a feeding tube against her wishes.¹¹⁰ Bouvia sought an injunction to have the tube removed.¹¹¹ The trial court denied the injunction on the grounds that Bouvia was seeking the state's assistance in committing suicide and was not refusing medical treatment in good faith.¹¹² The California Court of Appeals ordered the trial court to grant the injunction holding that regardless of motive, all competent patients have the right to refuse any and all medical treatment.¹¹³ Although the central legal question in *Bouvia* concerned the extent of a competent adult's right to refuse life-sustaining medical treatment, and it is unclear at least in some cases whether an individual with an eating disorder is competent, the case illustrates broader issues concerning the relationship between the refusal of medical

107 Matthews, *supra* note 63, at 707.

108 *Id.* at 707-08 (internal quotations omitted).

109 *Id.*

110 *Id.* at 708.

111 *Id.*

112 *Id.* at 708-09.

113 *Id.*

treatment and suicide.¹¹⁴ Where the refusal of medical intervention is equivalent to suicide, many argue that the individual's right to refuse treatment should be restricted.¹¹⁵ This could relate to imminent danger in the sense that if a person is essentially beginning to commit suicide, they are inherently in imminent danger of losing their life. In addition, it could be that society places a high value on an individual's right to make decisions regarding their bodies; but, that society values life even more and therefore will not assist in any manner with suicide.

Although courts have generally distinguished suicide from refusal of treatment,¹¹⁶ and some have pointed to the distinction between the active nature of committing suicide and the passive nature of refusing treatment,¹¹⁷ the refusal of life-sustaining treatment, including forced feeding, can be considered suicide since the concept of suicide provides that an individual who no longer desires to live takes definitive and effective steps to end his life "whether by actively killing [himself] or by avoiding available ways of preventing [his] own death."¹¹⁸ Since people require nourishment to survive, intentionally refusing nourishment is a definite way to end life.

Some courts have distinguished forced feeding from other forms of lifesaving treatment that patients can refuse due to the fact that refusing to eat immediately sets the individual on a course to death by means of starvation.¹¹⁹ This reasoning has been utilized to prevent prisoners

114 Matthews, *supra* note 88, at 709.

115 *Id.*

116 *Id.* at 735. Courts have found an absence of the necessary specific intent to kill oneself through the refusal of treatment by reasoning that the individuals refuse treatment to avoid pain, unwanted procedures, or violations of religious principles and that their actual intent is not to cause death. *Id.* at 736.

117 *Id.* at 739.

118 *Id.* at 710-11.

119 *Id.* at 739-40.

from choosing to starve to death.¹²⁰ The Supreme Court of New Hampshire, faced with the case of a competent inmate who contended he was “allowing himself to die, rather than committing suicide” by starving himself, distinguished the refusal to eat from the refusal of other forms of medical treatment in other situations. The court stated “[t]his is not a situation where an individual, facing death from a terminal illness, chooses to avoid extraordinary and heroic measures to prolong his life, albeit for a short duration.¹²¹ Rather, the defendant has set the death-producing agent in motion with the specific intent of causing his own death and any comparison of the two situations is superficial.”¹²² The court held that in this instance the State’s interest in preserving life dominated the prisoner’s privacy interests.¹²³ While the court noted the State’s interest in maintaining control over prisons, and that a prisoner’s self-caused death could hinder that control, the distinction between refusal of treatment when an individual could not control the onset of the illness requiring the treatment and when the individual intended to reach the point where treatment is required, applies outside the prison context as well.

Eating disorders do not fit into this bifurcated analysis of treatment refusal. The problems with fitting eating disorders into this model of analysis lie in causation and definition of the illness. If one views anorexia as an illness that forms autonomously and controls the individual to prevent him from eating, then following the aforementioned analysis the individual should be permitted to refuse treatment involving forced treatment, since the onset of illness was beyond the individual’s control. But, if one views anorexia as resulting from actions of

¹²⁰ *Id.* at 740.

¹²¹ *In re Caulk*, 125 N.H. 226, 232 (1984).

¹²² *Id.* (internal citations omitted).

¹²³ *Id.*

individuals who obsess over being thin and dieting, then it can be said that the individual caused the illness and the progression to starvation and therefore should not be allowed to prevent forced treatment, under the same model. With a lack of consensus regarding the cause, or multiple causes of eating disorders, it does not make sense to base something as important as the right to refuse medical treatment on such uncertainty. In addition, eating disorders do not fit within the typical model of the right to refuse treatment because of the unique situation where refusal of the prescribed treatment goes to the heart of the illness. Anorexia revolves around the controlled restriction of food intake. Cancer does not revolve around the controlled refusal of chemotherapy. And although schizophrenia may be controlled by psychotropic drugs, the refusal of such medication is not a defining characteristic of the illness.

Anorexia can be distinguished from other instances of individuals refusing food with the intent to commit suicide. Under the premise that anorexia is a mental illness, it can be argued that the individual is more a passive host subject to the control of the illness than a competent individual capable of making informed decisions as to the actions involving his body. An anorexic with altered mental processes is different than an individual suffering physical pain or incarcerated whose food restriction is not directly related to their suffering. Instead, the restriction is intended to be an escape. Individuals with anorexia are prolonging their illness with such food restriction rather than cognitively seeking an escape. Anorexics typically are on their way to committing suicide without being aware of the likely result. Because these individuals do not generally recognize the extent of the harm they cause their body through malnourishment,¹²⁴ it cannot be said that they are actively attempting suicide.

E. Alternatives to Involuntary Commitment

¹²⁴ See Frank, *supra* note 59, at 911 (describing that individuals with anorexia are often in denial and ignore messages regarding “their precarious state of health.”).

A major problem is that individuals with eating disorders who are not involuntarily committed may not receive any treatment under most states' mental health systems,¹²⁵ making involuntary commitment the only viable option for the very ill. While personal autonomy and liberty are important individual interests, they are achieved at a cost.¹²⁶ This is especially true in the context of eating disorders. If an adult suffering from anorexia has such disordered thoughts and perceptions that he cannot bring himself to eat, how is the individual to recover if he is on his own? The distortions continue, depression can grow, and the individual does not receive the necessary help in learning to properly care for himself. Yet, it is true that the individual is autonomous and makes the decision as to what he will or will not eat. In this situation, as in others, the right to liberty conflicts with welfare rights, i.e. the right to treatment.¹²⁷ While involuntary commitment may seem severe, it may be the only way to compel an ill individual to seek the necessary help to regain health.

While a full assessment of the deinstitutionalization that has occurred in the mental health arena and the development of the "revolving door" hospitalization¹²⁸ of many who suffer from mental illness are beyond the scope of this paper, the phenomenon is applicable to analyzing eating disorders. "This revolving door draws them into a cycle of multiple hospitalizations, short-term involuntary treatment, and release, until they have deteriorated to the point where they are hospitalized in acute crisis, frequently via the criminal justice system."¹²⁹ Although this criticism directly targeted the failures of deinstitutionalization and the negative effect on the

125 Lee, *supra* note 7, at 463.

126 *Id.*

127 *Id.*

128 *Id.* at 458.

129 *Id.*

mentally retarded and mentally disabled, it is clear that if one suffering from an eating disorder cannot be treated (other than completely voluntarily) until they pose an imminent danger to themselves, then the same cycle occurs. It makes sense that one will, as a result of their mental disorder of anorexia nervosa, bulimia nervosa, or ED NOS, continue in their downward cycle, refusing treatment, until the point where a parent, friend, or doctor has the ability to intervene. This point, i.e. the point where one is recognized as being in imminent danger, is too late in the case of eating disorders. Harm has already been done to the body, bones have weakened, teeth have decayed, the heart has slowed, etc. And, the person suffering has likely pushed away loved ones and sunken into a depression. Further, if one suffering from an eating disorder can only be held while they pose an imminent danger to themselves, they will be released via the revolving door. Without services to ease a patient back into reality, without a support system, encouragement, and education, it is not surprising that old habits reappear. Relaxing the standards to compel treatment for individuals with eating disorders could help end this cycle by helping people obtain proper treatment when it can be most effective.

V. Conclusion and Discussion

My research on eating disorders began with a curiosity surrounding the illness and the imposition of treatment in this context. Eating disorders have the highest rate of mortality of any mental illness and the mortality rate of individuals with anorexia nervosa is twelve times the mortality rate of all causes of death for females ages fifteen through twenty-four.¹³⁰ In addition, the suicide rate for women suffering from eating disorders is fifty-eight times greater than the rate would be otherwise.¹³¹ A major factor contributing to the deadly impact of eating disorders

130 South Carolina Department of Mental Health, *Eating Disorder Statistics*, <http://www.state.sc.us/dmh/anorexia/statistics.htm> (last visited Nov. 14, 2009).

131 Margo Maine, *Securing Eating Disorders Treatment: Ammunition for Arguments with Third Parties*, National Eating Disorders Association (2004) available at

is the difficulty in obtaining treatment. While studies examining the treatment of individuals with eating disorders are relatively new,¹³² some information does now exist. Only one of ten people who suffer from an eating disorder receive treatment and about eighty percent of those who do receive treatment encounter curtailed periods of treatment which send them home before reaching the recommended stays,¹³³ reducing the chance for effective recovery.¹³⁴ These statistics show that the current treatment model is ineffective.

Eating disorders are sometimes seen as illnesses of the un-ill. Eating disorders are rampant on college campuses, affecting “perfect” girls who are smart and articulate and do not otherwise show signs of a serious mental disorder. These girls often appear put-together and strong and while they strive for perfection, they are driven to poor choices concerning their health. And although eating disorders are technically considered a mental illness, there are still those who do not believe individuals with eating disorders are sick, just skinny. For example, although costs associated with the treatment of anorexia and bulimia are comparable to those associated with the treatment of schizophrenia, and significantly higher than costs associated with the treatment of obsessive compulsive disorder,¹³⁵ insurance companies contribute a much greater portion of costs associated with treatment of schizophrenia and obsessive-compulsive

<http://www.nationaleatingdisorders.org/nedaDir/files/documents/handouts/SecrTxAm.pdf>.

132 Striegel-Moore, *supra* note 43, at 385 (“To date, in the United States, little is known about health services utilization among individuals with an eating disorder.”).

133 South Carolina Department of Mental Health, *supra* note 130.

134 *See* Maine, *supra* note 131 (stating that “shorter periods of treatment for eating disorders are associated with less successful outcomes” and citing a 2000 study by Halmi et al which found that between 1985 and 1998 “readmissions of eating disorder patients increased steadily as length of stay became briefer and weight at discharge was lower.”).

135 Striegel-Moore, *supra* note 43, at 388.

disorder than those associated with treatment of an eating disorder.¹³⁶ This discrepancy demonstrates a prejudice towards individuals with eating disorders and represents the view that eating disorders are a choice of diet. Otherwise those with eating disorders would not be distinguished from those with other mental illnesses.

Unfortunately, there is not much research regarding the imposition of treatment on young women (or men) with eating disorders. This research will likely take time to evolve, as a researcher noted that just twenty years ago any research regarding the outcome of involuntary treatment for anorexia did not exist.¹³⁷ In the past twenty years there has been progress in recognizing the seriousness of eating disorders and classifying them as mental illnesses. But, possibly because many individuals with eating disorders do not present as mentally ill to the same degree as some individuals with other illnesses, such as schizophrenia, those with eating disorders often struggle without receiving the help they need. In addition, a study regarding the effect of the inclusion of eating disorders in the DSM on the number of people involuntarily committed for treatment of eating disorders would be helpful. It is possible that the recognition of eating disorders as a mental disorder may have changed the manner in which those suffering are treated, if at all, but this information does not seem to be available at this time.

It is clear current treatment models are not working well in the context of eating disorders. Problems with diagnostic criteria, the treatment refusal inherent in eating disorders, and the inapplicability of imminent danger requirements of civil commitment statutes suggest that eating disorders may need to be examined differently than other mental illnesses. While I

¹³⁶ See *Devito v. Aetna, Inc.*, 536 F.Supp.2d 523, 526 (D.N.J. 2008) (discussing that plaintiff's insurance carrier provided more coverage for biologically-based mental illnesses, including schizophrenia and obsessive-compulsive disorder, than it did for non-biologically-based mental illness, including eating disorders).

¹³⁷ Russell, *supra* note 10, at 337.

personally support the APA model of potential for deterioration standard of involuntary commitment, I do not think it is practical in broad application. Even if only applied in the eating disorder context, society may not be ready to accept either the recognition of eating disorders as such a serious illness requiring such a model or such an expansion of *parens patriae* power. However, adopting this relaxed standard as the standard to be applied for forced treatment for those age twenty-five and younger is both feasible and advisable. Society generally treats this age group as a transition group between childhood and adulthood and has demonstrated its willful exercise of *parens patriae* power over this group in other contexts. Law-makers and insurance companies do not abide strictly by the minor/adult distinction and there is no reason the mental health and medical arenas have to. Because the majority of eating disorders present between the ages of twelve and twenty-four, this standard would allow a much greater number of individuals with eating disorders to obtain treatment when it could be most helpful. Using this standard would prevent a great number of individuals with eating disorders from slipping through the cracks in the treatment system. Avoiding the nearly impossible task of attempting to pinpoint the time one becomes in imminent danger in favor of recognizing the broader stage of potential for deterioration will save lives in this context. The benefits likely to result from the application of this model surely outweigh the impingement on liberty resulting from the slight restriction on the right to refuse medical treatment for this narrow group of individuals.