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Bioethical aspects in the approach to anorexia nervosa

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Abstract

This article aims to discuss the bioethical dilemma arising from how anorexic patients face treatment and recovery. Since the first reports in the 14th century, there has been a strong opposition by anorexic patients to attempts by relatives or health professionals to convince them to eat the necessary amount to meet their needs and maintain adequate weight. Much ethical discussion arises from this strong anorexic stance against treatment, especially in cases of severe and long-lasting anorexia. Are patients competent to refuse treatment? Should health professionals, in the name of the bioethical principles of beneficence and non-maleficence, be allowed to order compulsory treatment? Health professionals, dedicated to life, can oppose illness or death through self-imposed fasting. Patients are bothered by the lack of understanding and empathy and the refusal to examine the logical foundations of their position, which are contrary to biomedical logic.

Keywords: Anorexia Nervosa. Treatment Refusal. Bioethics.

Resumo

Aspectos bioéticos envolvidos na abordagem da anorexia nervosa

Este artigo busca discutir o dilema bioético decorrente de como os pacientes anoréxicos enfrentam o tratamento e a recuperação. Desde os primeiros relatos, no século XIV, descreve-se a forte oposição por pacientes anoréxicos às tentativas de parentes ou profissionais de saúde de convencê-los a comer a quantidade necessária para suprir suas necessidades e manter peso adequado. Grande discussão ética decorre dessa forte posição anoréxica contra o tratamento, especialmente em casos de anorexia grave e duradoura. Pacientes são competentes para recusar o tratamento? Profissionais de saúde, em nome dos princípios bioéticos de beneficência e não maleficência, devem ter permissão para determinar tratamentos compulsórios? Profissionais de saúde, dedicados à vida, podem se opor ao adoecimento ou à morte pelo jejum autoimposto. Pacientes se sentem incomodados pela falta de compreensão e empatia e com a recusa em examinar os fundamentos lógicos de sua posição, contrários à lógica biomédica.

Palavras-chave: Anorexia nervosa. Recusa do paciente ao tratamento. Bioética.

Resumen

Aspectos bioéticos involucrados en el abordaje de la anorexia nerviosa

Este artículo discute el dilema bioético sobre cómo los pacientes anoréxicos enfrentan el tratamiento y la recuperación. Desde el siglo XIV se reporta la fuerte oposición de los pacientes anoréxicos a los intentos de familiares o profesionales sanitarios de convencerlos de comer la cantidad necesaria para satisfacer sus necesidades y mantener un peso adecuado. Parte de la discusión ética se deriva de esta fuerte postura anoréxica contra el tratamiento, especialmente en casos de anorexia grave y duradera. ¿Los pacientes son competentes para rechazar el tratamiento? ¿Los profesionales sanitarios, en nombre de los principios bioéticos de beneficencia y no maleficencia, pueden determinar los tratamientos obligatorios? Los profesionales sanitarios dedicados a la vida pueden oponerse a la enfermedad o la muerte mediante el ayuno autoimpuesto. Los pacientes reportaron molestarse con la falta de comprensión y empatía y la negativa a examinar los fundamentos lógicos de su posición contrariamente a la lógica biomédica.

Palabras clave: Anorexia nerviosa. Negativa del paciente al tratamiento. Bioética.

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Brief historical context

The earliest reports of anorexia can be found among mystical female saints in the 14th century. The most renowned of these is Catherine of Siena, who, at the age of seven, chose to pledge her virginity to the Virgin Mary. She then resolved to purge her flesh of any other flesh. She began refusing to eat meat, giving her share to her brothers or tossing it to animals. She ate progressively less, and her body deteriorated. She believed that God had granted her this illness to correct the vice of gluttony. At the beginning of 1380, Catherine decided to stop eating entirely, declaring: *My body no longer accepts any food, not even a drop of water* [1,2]. She died of starvation.

In medical literature, the first references to the disease appear in the 17th century. In 1689, English physician Richard Morton published a Latin treatise titled *Phthisiologia, or a Treatise of Consumptions*, in which he described the disease of consumption or nervous atrophy, characterized by three main symptoms: loss of appetite, amenorrhea, and significant weight loss [3]. In 1789, a century later, Naudeau—writing in France—described *a nervous disorder characterized by an intense aversion to food* [4], which was later reexamined and questioned as a case of anorexia nervosa, though it was ultimately identified as a hysterical condition. Around the same time, Philippe Pinel categorized the disorder as a neurosis of the nutritional functions. He understood eating behavior within a broader social and cultural framework, viewing dietary practices as part of a system of rules, rituals, and prohibitions shaped by the context of each era [5].

In 1868, English physician William Gull introduced the term "hysterical anorexia," soon followed by the expression "anorexia nervosa." At the same time in France, Lasègue identified the disorder as a form of hysteria. According to Lasègue, *the defining feature of the hysterical mental state is, above all, a calmness—almost a pathologically serene contentment. Not only does the patient not long for recovery, but she takes satisfaction in her condition, despite the many restrictions it imposes. The anorexic holds complete power within her anorexia*; Lasègue also warns *with the hysterical patient, a single early medical error is never corrected. At that initial stage, the only prudent approach is to observe and remain silent* [5]. In various passages of his work, Freud refers to anorexia as a hysterical manifestation, whether in theoretical writings [6,7] or in clinical case reports [8,9]. He also suggests that anorexia could be a manifestation of melancholia [10].

After volunteering with the International Brigades during the Spanish Civil War and joining the French Resistance, philosopher Simone Weil later worked in the Renault automobile factory, as a way to experience the life of a laborer, since, in Antonio Gramsci's terms, she was an organic intellectual. She then began consuming only the same rations given to French soldiers at the front and, eventually, nothing more than tiny portions of oat porridge, in solidarity with the starving French population. She died of starvation at the age of 34 in a sanatorium in Kent, England, in 1943 [11].

Refusal to eat

Can this mystical philosopher be considered anorexic? Could she have been subjected to forced feeding? Or does her social and political engagement constitute sufficient reason to distinguish her from other anorexic individuals who are not dedicated to such causes? A seminal work on anorexia highlights the behavioral shift in the young anorexic girl, who transforms from a well-behaved and compliant child into one who is oppositional, angry, and distrustful—who stubbornly rejects help and care, claiming she does not need them and insisting on the right to be as thin as she wishes; the term "right" is necessary here both to remain faithful to the author's language ("the right to be as thin as they want to be") and to support the present discussion [12].

More recently, several publications have sought to showcase an organic origin for anorexia, which is a relevant issue for this discussion, as it tends to reduce or remove the responsibility of individuals with anorexia nervosa for their refusal to eat. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association (APA) [13], eliminated the term "refusal"—which had been present in the fourth edition [14]—from the diagnostic criteria for anorexia nervosa because it implies a conscious and deliberate psychological process not evident in these patients. This revision reflects a psychological model in which individuals initially begin dieting to lose weight, without necessarily aiming to develop anorexia [15,16]. The active maintenance of weight loss through fasting may occur in cases where this behavior triggers a hypothesized biological mechanism in individuals with a predisposition. Supporters of removing the term "refusal" argue that the tendency to interpret common weight loss behaviors as intentional and deliberate has unduly shaped how anorexia is understood.

Could there be distinct types of anorexia, or different forms of anorexic commitment? One that is deliberate and purposefully motivated by a desire for spiritual transcendence, solidarity with the hungry and oppressed, or an assertion of hard-won autonomy; and another that stems from a psychiatric disorder, for which the health field ought to seek therapeutic intervention?

A related dietary pattern is orthorexia, a condition defined by the extreme selection of foods considered healthy. Those who adopt this pattern obsessively avoid foods that may contain artificial coloring, preservatives, pesticides, genetically modified ingredients, unhealthy fats, or excessive salt, sugar, and other additives. Food preparation and the materials used in this process can take on ritualistic significance. People with orthorexic tendencies often share histories or personality traits with individuals diagnosed with anorexia, as they tend to be meticulous, orderly, and show an excessive need for self-care and protection [17]. Should this dietary behavior be regarded as culturally and socially acceptable, or placed under the anorexia umbrella?

What is clear is that anorexia blurs the boundary between culture and pathology; it cannot be fully explained by the biomedical paradigm alone, having been interpreted since the 13th century as asceticism, hysteria, a reaction to controlling mothers and passive fathers, a political stance, resistance to patriarchy, or more recently, the internalization of a diffuse ideal—or even as a neurochemical disorder in which the subject has no active involvement. Yet none of the prevailing interpretations fully accounts for the complex set of factors that lead one individual, exposed to the same objectification, measurement, and commodification of the body as the rest of us, down a path toward potentially fatal starvation.

The anorexic, as written by Lasègue in 1873 [18], may be someone who *suffers from an emotion they either confess or conceal*. They often experience chronic physical complications such as hypokalemia, hyponatremia, bradycardia, and osteoporosis, and face life-threatening risks including seizures, cardiac failure, and suicide. Anorexia has one of the highest mortality rates among mental disorders. Twenty percent of these deaths are due to suicide. People with anorexia are four times more likely to take their own lives than those suffering from depression alone [19].

A personal account from an individual with anorexia illustrates the complexity of the condition, which far exceeds the explanatory scope of the biomedical model and raises multiple ethical concerns:

> *I do not come out the other side healed. This is only the beginning. Like clockwork, I must wage war three times a month with unyielding psychiatrists who want to tear anorexia out of my body. My fear of taking up space is so overwhelming that for 17 years I couldn't work, study, or socialize, and I was hospitalized more than 20 times. I spent years roaming the city—fast and alone—in a kind of agony that moved through me until I was nearly stripped bare. I'm not getting better; I'm getting worse. I am deeply in love with my illness. It doesn't make me feel more attractive—it kills whatever's inside; it rests on its laurels behind me when I look in the mirror, unable to see where my body ends and my mind begins, so blurred are my boundaries. Here's something else. I am told again and again—by clinicians and laypeople alike—that my neurosis is not actually a neurosis. As someone once told me while I was lying in the emergency room with hypophosphatemia and a white blood cell count near zero, entirely convinced that I didn't need to weigh more than an eleven-year-old child: "Your torment is a product of your imagination"* [20].

The so-called "leper of psychiatry." The one no one wants to touch. Attachment to the anorexic condition and refusal to view anorexia as something to be treated are illustrated by a list of extreme measures individuals have reportedly taken to maintain their eating disorder: licking a dirty hospital bowl in the hope of contracting an appetite-suppressing viral infection; faking a cancer diagnosis to conceal an aggressive laxative habit; and accidentally swallowing toothbrushes, spoons, and other foreign objects used to induce vomiting. The notion that something so powerful could be reduced to a mere act of vanity is deeply insulting. Thus, anorexia must be approached at the intersection of the social, the psychic, the biomedical, and the philosophical. To confront anorexia is to confront delusion and self-relationship through a truly biopsychosocial lens. Despite major etiological discoveries and growing emphasis on advocacy and awareness in recent years, we remain far from truly understanding what anorexia nervosa is.

Approach to severe forms of anorexia and bioethical dilemmas

Efforts to reclassify certain cases of severe and enduring anorexia nervosa as terminal have been shaped by developments in human rights, which emphasize individual autonomy and the principle of non-discrimination, giving rise to complex tensions. Clinicians must balance the patient's preferences with their own assessment of the condition; the value of autonomy and control versus coercion; short-term harm versus long-term harm reduction; and the management between containment and cure. In practice, there exists a plurality of perspectives on the prognosis and treatment options for patients with severe and enduring anorexia nervosa.

The question of whether it is rational to refuse treatment for anorexia nervosa leads into the broader discussion of palliative care for anorexic patients. Ambivalence is a hallmark of anorexia nervosa, with patients typically valuing the disorder and wishing to maintain it, despite suffering and clear evidence of harm if treatment is refused. Another challenge is that these patients are often articulate, yet may struggle to see anorexia as contingent rather than constitutive of their identity, experiencing themselves as inextricably bound up with the values, desires, and will of anorexia nervosa.

This attachment to the disorder can be so profound that some patients may prefer death to weight gain, valuing the disorder above their own lives. As a result, it is essential to carefully examine the motivations and reasoning behind an expressed wish to live or die, death being considered as an alternative by some patients suffering from severe and enduring anorexia. Thus, the question of whether the desire to die stems from hopelessness and a wish to end the struggle, or from a deliberate preference for death overweight gain, is central when evaluating the patient's capacity to understand and weigh information.

The assessment of a person's capacity must include their reasoning regarding the value of continued treatment. For some individuals with anorexia nervosa, non-oral nutrition under varying degrees of coercion may be the only available means of sustaining life. This approach must take into account whether the goal of treatment is viewed from a short- or long-term perspective. A short-term view may be relevant in severe cases involving immediate risk, especially if life prolongation aligns with the patient's values and wishes [21].

A significant portion of anorexia cases follow a prolonged course. Recovery rates vary by study, ranging from 50% within six years [22] to 70% within five years [23]. Severe and enduring anorexia nervosa is a condition that can persist for decades. Some individuals do recover, but the likelihood of full recovery tends to decrease over time [24]. The condition is often associated with psychopathologies such as mood swings and anxiety disorders, post-traumatic stress disrder, obsessive-compulsive spectrum disorders (including body dysmorphic disorder), substance and alcohol abuse, as well as personality disorders. In a publication on severe and enduring anorexia, Yager [25] notes that attitudes contributing to chronicity include weak attachment to life, distrust of the medical system due to repeated treatment failures, and self-loathing with masochistic features. Among social factors, he highlights interpersonal dynamics such as negative emotional expression in the form of overprotection and family blame, persistent interpersonal conflict, sociodemographic insecurities (housing, finances, neighborhood, etc.), and limited or poor access to healthcare[25].

To what extent is a recommended intervention likely to be helpful—to whom, by what criteria, and within which value system? To what extent is it likely to be futile, that is, lacking any clear benefit, by what standards, for how long, and at what cost? To what extent might it be harmful—physiologically, psychologically, socially, or financially—and harmful to whom? And how should we weigh short-term harm against long-term harm? Some argue that individuals with severe anorexia should be deemed legally incapable of refusing life-saving artificial nutrition, thereby reversing the legal presumption in favor of protecting their liberty and personal values[26]. Others view this proposal as discriminatory.

Moreover, it is not possible to actually demonstrate a lack of autonomous decision-making capacity in the majority of these individuals. The presumption of capacity to refuse treatment is a cornerstone of modern bioethics and medical law; it arises as a safeguard against clinical authoritarianism and prevents clinicians' values from overriding those of patients, thereby preserving patients' control over the direction of their lives, and, if they so choose, their deaths. There is no justification for labeling someone as incapable solely based on a diagnosis. For this reason, the implicit discrimination in proposals to deem individuals with severe and enduring anorexia incapable of decision-making should be rejected[27]. In this context, there is significant disagreement among clinicians regarding the acceptability and efficacy of nasogastric tube feeding, whether voluntary or not.

Despite these disagreements, in some jurisdictions, coercion is occasionally used in the management of severely ill patients with anorexia nervosa[28]. There is a consensus that coercion should be a measure of last resort and that legal intervention must be applied with extreme caution. Legal coercion would only be appropriate in managing severe and enduring anorexia nervosa, particularly in cases involving extremely low body mass index, though this carries the risk of irreparably damaging the therapeutic alliance, making compulsory treatment for anorexia a highly contentious issue. Patients who are involuntarily hospitalized often return, sometimes in even more critical condition.

Coercion can undermine the patient's trust in caregivers. Attitudes toward involuntary hospitalization for anorexia swing like a pendulum—from recognition of the necessity of compulsory treatment in life-threatening situations to defense of the individual's bodily autonomy and the corresponding right to refuse care. In Israel, existing legislation (the Patient Rights Act of 1996; the Guardianship Law of 1962; and the Treatment of the Mentally Ill Act of 1991)[29] does not provide a satisfactory solution for emergencies in which anorexia becomes life-threatening. There, it has been proposed that the Treatment of the Mentally Ill Act of 1996 be used, as it allows for compulsory treatment and may be interpreted to include life-threatening conditions[29]. Is this Israeli workaround ethically defensible? In the United Kingdom, it is estimated that 7.9% of all individuals with anorexia are admitted under the Mental Health Act[30].

Assessing competence

Although many individuals with anorexia do not wish to die, they may lack the insight needed to recognize the imminence of the threat to their survival. In such cases, compulsory hospitalization may be the only available option to preserve the anorexic patient's life.

However, a more nuanced understanding of what competence entails is necessary. The concept is seemingly more complex than suggested by existing guidelines, which typically define competence as the individual's ability to arrive at a logical decision, generally including the ability to understand relevant information, retain it for application in decision-making, and communicate a choice. Yet this notion of competence becomes an issue when applied to a disorder like anorexia nervosa, because although individuals with the condition often understand their treatment options, the disorder may impair their capacity to make valid decisions. People suffering from eating disorders frequently draw on elements of a health- and care-oriented *habitus* to rationalize and justify their behaviors.

Bourdieu's concept of *habitus*, along with ethnographic accounts of care, offers insight into how individuals with eating disorders incorporate health-related practices as a form of care and social distinction [31].

The pursuit of health has become one of the most defining practices of contemporary life, demanding significant resources, shaping all major institutional fields, and driving widespread professionalization and commercialization alongside the manufacturing of corresponding goods, services, and knowledge [32]. Today, the idea of a "healthy lifestyle" is central to neoliberal societies and may be accurately described as a *habitus*.

In his description of *habitus*, Bourdieu [33] notes that it provides a cognitive map of the individual's social world and the appropriate dispositions or actions to take in particular situations; he also asserts that food and the body are cultural and social constructs. There is symbolic violence embedded in subtle practices such as eating, dressing, and bodily care practices that align with cultural habits and social class and reflect power relations [33]. Building on the concept of *habitus*, one might ask: Is it acceptable to be obese, but not anorexic? From a biomedical standpoint, which condition entails greater harm and risk? If we are allowed to force-feed an anorexic, should we also perform weight-loss surgery against the will of someone who is obese?

People with anorexia almost always require care, yet most do not seek help for their disordered eating behaviors. However, aren't those suffering from eating habits deemed technically harmful—such as diabetics who consume excessive sugar, obese individuals with hypertension who regularly indulge in alcohol and fatty foods, or dialysis patients who consume large amounts of animal protein—expected to seek help as well?

Looking at the issue from the perspective of individuals with anorexia helps us understand why they do not view their behaviors as problematic and therefore do not seek assistance. If disordered eating is experienced as a form of care in itself, then seeking other types of health care becomes unjustified. It is essential to understand how the complexities of health and care contribute to resistance to both coming out and seeking professional support [33]. Food and medication restriction among people with anorexia resonates with broader discussions about its symbolic meaning in various ethnographic contexts. What this suggests is that, in some cases, the symbolic meaning must be discerned, and that the cultural meaning of biomedical intervention cannot be understood apart from the patient's relationship to life and health as a valued and meaningful goal. It is necessary to interpret noncompliance through the lens of moral self-governance rather than as a rejection of or resistance to treatment [34].

Assessing competence in individuals diagnosed with anorexia nervosa is also problematic, as these individuals are generally capable of making decisions in most areas of their lives, except when it comes to body weight, and they often perform well on standard competence evaluations. How, then, can we determine whether a person with anorexia is competent to consent to or refuse treatment, and whether involuntary treatment respects the patient's autonomy? Some argue that individuals with anorexia nervosa lack the competence to make decisions regarding body image and eating, and that involuntary treatment is therefore justifiable. Others advocate for evaluating the behavior of individuals with anorexia nervosa on a case-by-case basis, assessing treatment refusals individually, as multiple factors influence their decision-making capacity.

Beliefs and values regarding the meaning of body fat, low self-esteem, and the perceived benefits that anorexia nervosa may provide all impact decisions to consent to or refuse treatment. However, the difficulty in assessing competence based on beliefs and values lies in the fact that there are numerous examples in everyday life of people engaging in risky behaviors without external intervention, such as mountain climbing, skydiving, or participating in ultramarathons and such.

When it comes to values, there is danger in binding them to competence; doing so risks pathologizing and discriminating against individuals who hold values that differ from those of professionals or from societal norms [35-37]. Given the limited success of treatment for severe anorexia nervosa, the ethical justification for overriding a patient's autonomy in the name of best interest becomes questionable. There is also the issue of whether treatment efficacy alone can justify overriding treatment refusals. This question is particularly contentious in cases where the patient has chronic anorexia nervosa and faces imminent risk of death if professional intervention does not take place[38].

Individuals with chronic anorexia may be incapable of making competent decisions about food intake but still capable of making informed decisions about their quality of life. They may be able to assess what life with anorexia nervosa entails and thus be in a position to determine whether the burden of prolonged treatment is worth enduring. Anorexia nervosa cannot be equated with a debilitating, chronic, or terminal illness, since it is a reversible condition and death from it is preventable. Therefore, if treatment refusal by competent individuals with anorexia nervosa is to be respected, the justification for doing so cannot rest on the chronic nature of the disorder. On the contrary, such decisions can only be upheld based on respect for the individual's autonomy.

Autonomy, beneficence, and non-maleficence in anorexia

The balance between "respect for autonomy," "beneficence," and "non-maleficence" varies depending on how one interprets the patient's competence to refuse care and whether low treatment efficacy is considered a justification for limiting or enforcing involuntary care. Moreover, whether anorexia nervosa can be considered a chronic illness is a critical question in these evaluations, making it possible to argue that when a patient is deemed incompetent to make decisions about nutritional intake, they may still be capable of providing informed consent to withdraw from treatment—based on their treatment history and quality of life with and without further intervention.

However, the difficulty of accepting a patient's decision to discontinue treatment must be acknowledged, particularly in light of uncertainty surrounding treatment effectiveness. Still, the right of patients to refuse treatment—even when such refusal will inevitably lead to death, and thus constitutes a "right to die"—is defended based on respect for their competence and relief from suffering caused by the illness. This requires consideration of treatment futility and the distinctions that must be made between "treatable" and "untreatable" patients[39]. The question of an anorexic person's "right to die" cannot be separated from the broader debate, now straining social and legal norms, around the "right to euthanasia or assisted suicide."

It is an almost universal legal principle that individuals deemed competent have the right to make autonomous decisions, including decisions about whether to eat or not, even if those decisions result in death. The State may only intervene when a person cannot decide for themselves. On the other hand, when a person lacks capacity, there is a duty to make decisions that are in their best interest. The first question, then, is whether the person is capable or not. The second, which only arises if they do not, is what decision best serves their interests. In discussing the question of compulsory treatment, we must ask: is anorexia nervosa a conscious choice, or a serious illness? Some argue that life-saving compulsory treatment, when used as a last resort, can at times be considered compassionate and justified.

Patients' resistance to treatment cannot be explained by a single cause; they adopt multiple, shifting, ambiguous, and even contradictory perspectives regarding their diagnosis, the prospect of change, and treatment itself[39]. This construction of the "disordered eating patient" renders them powerless, as there is no space in which they can speak for themselves. It should therefore be considered that what is labeled "resistance to treatment" may, in fact, be resistance to the disempowerment that comes with being assigned the role of "eating disorder patient."

Although one could argue that "respect for autonomy" requires honoring the decisions of autonomous individuals at any stage of treatment, this issue is complicated in the case of individuals diagnosed with anorexia nervosa, since it is not always clear whether their refusal of treatment reflects autonomous decision-making. The difficulty in assessing autonomy in individuals diagnosed with anorexia lies in the fact that they often perceive the disorder as intrinsic to their identity[39].

But the question of compulsory treatment extends beyond anorexia. Is it justifiable to treat a person with substance dependence against their will? Or a hypertensive patient who refuses medication and dietary changes? Or a person with diabetes who is noncompliant with treatment? Should elderly individuals who decline COVID-19 vaccination be vaccinated against their will? Or those who would rather die than receive blood products? Or individuals who choose to treat bacterial pneumonia with Bach flower remedies instead of antibiotics? Do these people lose their autonomy simply for not following prevailing medical directives, for resisting what biopower prescribes? In reality, even voluntary treatment already contains elements that may be perceived as coercive, especially when physicians emphasize the negative consequences of noncompliance and strongly assert what must be done according to medical authority.

On the other hand, it is ethically and clinically very difficult to stand by and do nothing while someone dies from refusing to eat. This recalls the biblical precept: give food to the hungry and drink to the thirsty. It may be that mere eating is enough to survive, but is that truly in the best interest of the anorexic person? When it comes to risk factors for compulsory treatment, high symptom severity is associated with a greater likelihood of involuntary intervention. What seems clear is that it is not the use of detention itself that matters most to patients, but how that intervention is carried out [39].

The ethical discussion surrounding the treatment of anorexia offers no easy answers, which is precisely why it must be critically examined and problematized, rather than resolved through standardized, rigid alternatives. As has been suggested, the principles of bioethics, like in other ethical dilemmas, may diverge, leaving the physician with no basis for decision-making other than personal judgment and careful evaluation—a situation that is not uncommon in many other clinical contexts.

One possible approach to the dilemmas raised would be to understand the patient as a subject (though this will not be explored in depth here). The concept of the subject carries various definitions in philosophy, psychoanalysis, and law, but regardless of the framework, it represents a fundamental dimension of the decision-making process—one that lies outside the biomedical model and should be taken into account in clinical reasoning. Authenticity, which entails respect for the subject, is central to how we ought to live; the goal of our lives is to be true to ourselves, that is, to the core of our subjectivity.

People with anorexia nervosa frequently raise questions of authenticity. Are their behaviors, experiences, and choices to be regarded as authentic (as part of their "real self") or inauthentic (as expressions of anorexia)? This leads to an ethical question: if certain choices are deemed inauthentic, is it ethical to override them? Undeniably, people with anorexia are those with direct experience: they are in the position to articulate why thinness and lightness matter to them, what these ideals symbolize, and why fatness is perceived as threatening.

Values such as self-control, perfectionism, bodily mastery, and willpower may help explain the intense fear of fatness and the relentless pursuit of thinness. To understand anorexia, the phenomenon must be examined in all its dimensions; we must question not only our assumptions about anorexia but also the values that underlie it, and be willing to investigate the continuity between the set of values that inspire the pursuit of lightness and those that shape our responses to thinness [39].

Final considerations

The reflections presented here, when applied to clinical practice, can be summarized by the expression "modest tenacity," a phrase coined by Vialettes [40] to guide the management of anorexia nervosa cases. According to the author, modesty is warranted due to our limited understanding of the disorder's mechanisms, the uncertainty regarding treatment effectiveness, disappointing success rates, and the inability to predict outcomes. He also points to the existence of a logic developed by patients that differs from the logic rooted in medical knowledge, which, according to the author [40], calls for tolerance on the part of healthcare professionals; he emphasizes, however, that such tolerance does not necessarily entail leniency toward what he refers to as a death wish. From this, a dialectical approach to the care of individuals with anorexia emerges—one in which the perspectives of both the sufferer and the caregiver must be actively engaged.

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