Medical Paternalism, Anorexia Nervosa, and the Problem of Pathological Values

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Amanda Evans
University of Pittsburgh

Abstract: Concerns over medical paternalism are especially salient when there exists a conflict of values between patient and clinician. This is particularly relevant for psychiatry, the field of medicine for which the phenomenon of conflicting values is most present and for which the specter of medical paternalism looms large. Few cases are as glaring as that of anorexia nervosa (AN), a disorder that is considered to be egosyntonic (meaning its symptoms are reflectively endorsed by the patient) and maintained by the presence of pathological values. One might think, given this, that an approach to medicine that foregrounds the role of values in clinical encounters would be particularly well suited to address the problem of medical paternalism in treating AN. As it happens, this is precisely the goal of values-based medicine, an approach to medicine that prioritizes the integration of patients' unique values into the aims of treatment and that has been touted as being particularly applicable to psychiatric conditions such as AN. Although this strategy may initially appear promising, in this paper I will argue that the directive to incorporate patient values (as dictated by values-based medicine) cannot do the work of mitigating medical paternalism in the treatment of egosyntonic disorders such as AN. Rather than chalking this up as a failure due to AN being a particularly challenging case, I will instead conclude that the failure of values-based medicine in this context cuts to the heart of the limitations of rectifying medical paternalism within psychiatry as it currently exists.

0. Introduction

Psychiatry often finds itself at the forefront of bioethical concerns over medical paternalism[1]. This is particularly true when it comes to the treatment of anorexia nervosa (AN), a disorder that can serve as uniquely insightful case study when theorizing about just and unjust paternalist interventions in medicine. Part of AN's uniqueness stems from the fact that it is an *egosyntonic* disorder (Gregertsen et al. 2017, O'Hara 2015). In clinical psychopathology, a disorder is considered egosyntonic (as opposed to *egodystonic*) when the symptoms which constitute the condition are reflectively endorsed by the patient and cohere with her considered goals and values.

The fact that anorexic patients experience their disorder egosyntonically increases the risk of unjustified paternalism in AN treatment, given that the clinical aims of treating a given mental disorder will necessarily be at odds with the persistence

[1] Medical paternalism occurs when a clinician (or other medical authority) acts in a way that usurps the patient's autonomy in the interest of the patient's (perceived) benefit (Cf. Groll 2014 for further discussion).

of the disorder's core symptoms. Since anorexic patients tend to relate to their symptoms egosyntonically, it follows that the aims of their clinicians will likewise be at odds with these patients' goals and values. To make matters more complex, the demographic data of this clinical population, which is made up of predominantly young women as well as gender and sexual minorities (Smink et al. 2012, Nagata et al. 2021), increases the risk of unjust paternalism colored by sexism, ageism, and various other forms of epistemic injustice (Radden 2021).

In the wake of a growing movement in the philosophy of psychiatry to take seriously the perspectives of the pathologized and incorporate them into the aims of psychiatry as a science (e.g., Washington 2018, Knox 2022), it has become increasingly popular to suggest that we can avoid some of the paternalistic[2] worries associated with the treatment of AN by incorporating patient values in the context of a pluralistic value framework (Stanghellini and Mancini 2017, Fulford 2020, Stanghellini and Fulford 2021, Stanghellini et al. 2021, Jaiprakash et al. 2024). According to such proposals, the values of patients with AN must be integrated into the aims of treatment so as to avoid a purely top-down therapeutic structure that is in the business of enforcing certain (clinically approved) values over those held by the patient. The theoretical roots of this approach to the problem of psychiatric paternalism can be found in values-based medicine, which is specifically designed to address the problem of conflicting values in medicine between patient and clinician (Fulford 2004, 2008).

Although this approach may initially appear promising, in this paper I will argue that it cannot accomplish what it sets out to do. More carefully, I will argue that any proposal which tries to address the problem of medical paternalism in the context of treating an egosyntonic disorder such as AN by way of incorporating patient values will result in one of two outcomes. That is, it will ultimately re-introduce the sort of paternalism such a such a move is designed to avoid, or else it will result in clinical consequences that will run afoul of ethical codes of conduct for clinicians.

[2] In this paper I will speak of "paternalism" as a shorthand for "unjustified paternalism". The arguments to follow ought to be applicable regardless of one's preferred theory of paternalism, so long as one allows that some instances of paternalistic intervention in medicine appear to be particularly problematic and in need of interrogation.

To that end, the paper will proceed as follows. In §1, I will elucidate the concept of pathological values in the context of AN, and I will motivate the claim that we cannot properly assess the problem of paternalism in AN treatment without first acknowledging these pathological values as an inextricable piece of the puzzle. Then, in §2, I will provide the necessary background on values-based medicine as developed by Fulford and colleagues. With this necessary context in hand, I will introduce the target of my critique, namely the proposal to incorporate patient values into AN treatment as a means to avoid paternalism. In §3, I will work through the available interpretations of such a proposal, and I will demonstrate that each of these results in one of the two outcomes described above. I will then conclude with some remarks on the irreconcilable nature of medical paternalism in psychiatry (at least, as it currently exists) in the context of egosyntonic disorders.

1. The significance of pathologized values

The public conception of AN tends to be misleadingly simplistic, thanks in part to media depictions that coalesce into the image of a waifish (usually white, usually upper-middleclass) young woman who simply "doesn't eat". This superficial image, however, belies the philosophical richness of the condition. To be certain, extreme caloric restriction does play an important role in the conception of AN, particularly in relation to its diagnosis. It is important to recognize, however, that food restriction is only one behavioral symptom of the disorder, whereas many of the philosophically pertinent aspects of AN lie much deeper in the etiology and maintenance of the condition. Recent philosophical scholarship has made clear that one cannot begin to properly understand AN without appreciating that the external behavioral symptoms of AN (i.e., excessive caloric restriction and other compensatory behaviors aimed at weight loss) are the manifestations of deeper abnormalities involving, e.g., one's experience of agency (Evans 2023), one's self (Osler 2021), and one's emotions (Arnaud et al. 2023, Varga and Steglich-Petersen 2023).

Most relevant to the matter at hand is the fact that philosophers of psychiatry have argued that AN must be understood not just as a set of pathological behaviors but as a condition that is partly constituted by a set of *pathological values*. These values

(which I will refer to as "anorexic values" for ease of exposition) are described by Radden (2021) as follows:

> Quite typically expressed by patients are two values that will serve as [primary examples]: the *paramount importance of being thin*, even to the extent of preferring to risk death rather than gaining weight, and the view that *self-starvation is a sign of achievement* (p. 143, emphasis in original).

Along these same lines, Giordano (2005) argues that individuals with AN tend to attach ethical significance to the behaviors and values that make up the disorder itself. Even more strikingly, Charland and colleagues have argued that AN ought to be seen as a pathological passion in the historical sense of the word (Charland et al. 2013), while Stanghellini and Mancini (2017) go so far as to compare AN to a kind of religion.

To be clear, the purpose of bringing to light the distinctive presence of anorexic values is not to suggest that they are all that is needed in order to understand AN. Indeed, it is now becoming increasingly common for theorists to hold that any satisfactory account of the disorder will almost certainly need to be multifaceted in nature (Cf. Gadsby 2023). And, although the influences of body dysmorphia and Western beauty standards have arguably been overblown in cultural depictions of AN, they almost certainly play *some* role in the pathogenesis and the maintenance of the disorder. Given that the present concern is that of anorexia's uniquely fraught relation to medical paternalism, however, my focus will be on anorexic values from here on out.

What we are faced with, then, is a disorder that is inextricably tied to a set of values that are in direct conflict with the aims of eating disorder recovery treatment. To add to the ethically fraught nature of this case, the subset of the population most likely to comprise this pathologized group (i.e., young women and other gender minorities) is one that is already subject to outsized paternalism in medicine as well as epistemic and hermeneutical injustice (Cf. Knox 2022, Tekin 2022). Moreover, as a matter of actual clinical practice, individuals diagnosed with AN can be subjected to coercive treatment measures even in the absence of formal (i.e., court-mandated) treatment orders (Tan et al. 2010). This is particularly concerning given the fact that anorexic patients are regularly deemed to possess decisional capacity and are competent according to the relevant legal and clinical standards in both the U.S. and the U.K. (Radden 2021, Tan et al. 2007).

Given this context, AN's unique status vis-à-vis the conversation surrounding medical paternalism should be readily apparent. Regardless of the distinction one wishes to employ between justified and unjustified paternalistic intervention in psychiatry, the fact that any such intervention on behalf of a typical AN patient would go against her considered values is highly problematic. The very fact that anorexic values are described as pathological in and of themselves renders this outcome effectively unavoidable. And, the situation is made worse by the fact that anorexic values tend to be deeply connected to the individual's understanding of herself.

Indeed, we ought to be especially wary of any paternalistic intervention for which the disagreement between the paternalist and the paternalized involves contents that are significantly interwoven into the paternalized subject's self-understanding (Groll 2014, see also Washington 2018). In arguing for this point, Groll (2014) considers the classic bioethical stock example of a Jehovah's witness patient who refuses a blood transfusion on the basis of his faith. According to Groll, a paternalist intervention against such a patient would be morally problematic in part because the disagreement in question—viz., whether accepting blood transfusions bars one from the afterlife—occupies a central place in the patient's self-understanding and identity. As it happens, there is a significant overlap between Groll's Jehovah's Witness patient and the AN case. That is, to subject either type of patient to life-saving treatment against their will would amount to acting contrary to a legally competent adult's longstanding and deeply held commitments and values (be it beliefs about the preconditions of the afterlife or beliefs about the worthwhileness of maintaining a certain degree of thinness). And, crucially, the relevant disagreement in both instances is a decidedly normative disagreement concerning what is worth living and dying for, to put it somewhat colorfully.

To be clear: One *may* be tempted to suggest that anorexic values, in virtue of their being pathological, are not the sort of thing that needs to be honored in medical practice. To thoroughly respond to this worry would take us beyond the present scope, although it is important to recognize that the labeling of "pathological" in the context of anorexic values is itself a product of the psychiatric structure that is currently being interrogated on paternalist grounds. For present purposes, however, I do not need to establish that any class of values should or should not be respected in a psychiatric context. This is because my focus is not on the status of anorexic values themselves but

on a type of proposal that aims to remedy the clinical conflict of values just described. With this important caveat in hand, let us now turn to the potential solution that will serve as my object of critique from here on out.

2. Values-based medicine to the rescue?

I have argued that the presence of pathological (i.e., anorexic) values poses a particularly challenging problem for AN treatment in the context of avoiding medical paternalism. One might think, given this, that an approach to medicine that foregrounds the role of values in clinical encounters would be particularly well suited to address this concern. As it happens, the field of values-based medicine[3] as popularized by Bill Fulford and colleagues promises to do just that—even and especially in hard psychiatric cases such as AN treatment (e.g., Fulford 2004, Stanghellini and Fulford 2018, Stanghellini and Fulford 2020, Fulford 2020). While I am sympathetic to and am generally optimistic about the potential of values-based practice as a whole, I do not think it is capable of helping us out of the predicament described above. In the following section, I will demonstrate why the core proposal of values-based medicine in the context of AN treatment is structurally unable to address the problem of paternalism in light of pathological AN values. Before that, however, it will be illustrative to trace the theoretical underpinnings of what will become my primary target.

Values-based medicine is touted as a balancing partner to evidence-based medicine in the context of clinician-patient interactions. Just as evidence-based medicine provides a framework for how clinicians ought to assess and develop treatment plans in light of "complex and conflicting" evidence, values-based medicine purports to do the same for clinical situations involving "complex and conflicting" values (Fulford 2021, see also Fulford 2008). As an illustration of how values-based medicine can be utilized in clinical practice, Fulford highlights anecdotes drawn from real clinical encounters such as that of Mrs. Jones, an elderly gardener with arthritic knee pain (Fulford 2020, 2021). In this vignette, we are told that Mrs. Jones's doctor

[3] In the literature one finds reference to both "values-based medicine" and "values-based practice". Since the two are seldom disambiguated and are often used interchangeably, I will be following suit.

astutely gathered that Mrs. Jones was more concerned about her decreased mobility (which was inhibiting her gardening) than the pain the arthritis was causing. By incorporating this input using the tools of values-based medicine, the doctor opted to forego knee surgery (which would have otherwise been the preferred treatment according to evidence-based medicine) in favor of an alternative treatment regimen that would better maximize knee mobility (at the expense of some pain reduction). In such a context, the promise and allure of values-based practice is clear and persuasive: The patient's unique value ordering (in which mobility was valued over pain reduction) was incorporated into the aims of her treatment, and this in turn resulted in a positive and effective clinical outcome.

Patient preferences for arthritic knee treatment outcomes are, of course, rather far afield from the sort of psychiatric dilemmas values-based medicine advertises itself as being particularly well suited for. How, then, does values-based practice shake out in these more challenging psychiatric contexts? One of the more promising psychiatric case studies in this literature centers on Diane, an artist with bipolar disorder who came to her psychiatrist looking to treat symptoms of hypomania (Fulford 2004, 2008). We are told that Diane was first prescribed lithium, which is the standard treatment regimen for managing manic symptoms. Once on the lithium, however, it became clear to Diane that her ability to create art was suffering. She explained to her doctor that she was no longer able to "see colors", by which she meant that the felt emotional intensity that had previously been attached to her perception of colors had been dulled by the lithium (Fulford 2004, p. 210). Given the negative effect this was having on her creative process, Diane decided to stop taking the lithium. When she eventually informed her doctor about this decision, we are told that the doctor, though initially surprised, was able to understand Diane's decision to stop taking her prescribed medication in light of her values—art was, after all, deeply important to Diane in addition to being her livelihood.

Thus, through the collaborative process of values-based practice, Diane and her psychiatrist were able to arrive at a compromise. Diane was permitted to stay off of the lithium on the condition that she work out a plan with a trusted friend who would prompt her to obtain short-term neuroleptic medication the next time said friend noticed that Diane was becoming hypomanic. This medication would help to treat the

worst of Diane's symptoms in a shorter-term, as-needed basis without dulling her experiences of color. With the help of open and honest communication between patient and clinician, then, the two parties were able to arrive at a clinical outcome that respected Diane's priorities as a professional artist while also ensuring that her acute symptoms of hypomania could be managed in the future.

Values-based medicine, as I have said, is specifically designed to address potential value conflicts that arise between patient and clinician (or, more accurately, between a given patient and the medical system broadly construed). It is only when values are in conflict, after all, that they become salient, which is something that advocates of values-based practice are right to point out (Fulford 2004). In order to recognize the central issue with values-based medicine (and its practical output of values-based practice) as it pertains to egosyntonic disorders such as AN, however, we must first attend to the relative *shallowness* of value conflict that is operant in cases such as Diane's. In this case, we might say that both Diane and her physician shared the value of <REDUCTION OF HYPOMANIC SYMPTOMS>[4]. Thus, the "conflict" between the two parties only arose due to the fact that Diane's value ordering also included <BEING ABLE TO CREATE GOOD ART>, which superseded the former in importance. Notice, however, that the two parties still shared a substantive value that amounted to a willingness to have her condition treated on Diane's part. Furthermore, in the end a compromise was reached that did not ultimately conflict with <REDUCTION OF HYPOMANIC SYMPTOMS> *or* <BEING ABLE TO CREATE GOOD ART>. Properly examined, then, Diane's case is one of only a relatively superficial conflict in values. And, the case of Mrs. Jones's knee is even more superficial in this regard.

It is important to highlight the nature of the purported value conflict that is operant when values-based practice appears to be successful, as in the cases of Mrs. Jones and Diane, as this will allow us to appreciate the ways in which the AN case differs. It must also be stressed that Fulford, Stanghellini, and colleagues specifically promote values-based practice as an effective antidote to the problems that arise in the treatment of AN. Indeed, it is used as a central case study for values-based practice in Stanghellini and Mancini (2017), Fulford and Stanghellini (2018), Fulford (2020), and

[4] I adopt this notation to more expeditiously refer to the contents of particular values.

Stanghellini and Fulford (2020). According to these accounts, the values-based medicine-informed solution to the problem of conflicting values in AN treatment is a concerted and collaborative effort to *integrate* the perspectives and values of anorexic patients into the therapeutic process.

Building on these same ideas beyond the specific context of values-based practice, Stanghellini et al. advocate for both "value acknowledgment" and "value pluralism" in the therapeutic process in order for the clinician to embark on a "sense-searching journey" with the AN patient "without prepackaged answers" (2021, p. 753), thereby mitigating "paternalistic moralism" (Ibid., p. 751). And, in a recent commentary that aims to critique and build on these ideas, Jaiprakash et al. advocate for "the inclusion of patient perspectives" in AN treatment in order to "avoid the pitfalls of paternalism" (2024, p. 1). For the purposes of this paper, I would like to glean two things from these recent developments. First, the common thread among these assertions amounts to a directive to incorporate the perspectives and unique values of anorexic patients into the goals and aims of treatment. In the interest of zeroing in on the object of my critique, then, I will henceforth refer to this particular *structure* of a solution to the problem of conflicting values in AN treatment as the Value Incorporation Proposal or the VIP. Second, although the VIP's theoretical underpinnings are to be found in values-based medicine as described above, one can promote a version of the VIP without making explicit reference to values-based practice (e.g., Stanghellini et al. 2021, Stanghellini and Mancini 2021, and Jaiprakash et al. 2024). For this reason, my focus for the remainder of this paper will be on the VIP in particular, although one should not lose sight of the fact that the theoretical predecessor of the VIP is to be found in values-based medicine and its practical application of values-based practice.

3. Interrogating the Value Incorporation Proposal

In the previous section, I provided a brief background of values-based medicine and its recommendations for addressing the problem of paternalism in the context of treating AN. I then zeroed in on a *form*[5] of solution found in the literature and

[5] By referring to the Value Incorporation Proposal as a form or a structure of solution, I am intending to make clear that "the VIP" does not refer to any particular instance of such a proposal. After all, what is

designated it as the Value Incorporation Proposal or VIP. In this section, I will draw out and examine the available interpretations of what such a proposal might amount to in practice. I will ultimately conclude that any solution to medical paternalism in AN treatment that structurally resembles the VIP will either result in the same kind of paternalism it was designed to avoid, or else lead to clinical consequences many will find unacceptable (and, in most jurisdictions, would violate professional and legal codes).

To be begin, let us first examine what a directive to incorporate patient values in this context ultimately boils down to. On one reading, the VIP amounts to nothing more than a call for clinicians to genuinely listen to what their patients have to say regarding their relationship to their AN diagnosis. While there are undoubtedly clinicians who would benefit from this sort of reminder, I doubt this is what VIP advocates have in mind. After all, genuine interest in one's patients should already be expected of practitioners, even if many fail to meet this basic standard. Since VIP advocates speak of the proposal in terms of something that must be *changed* in how we theorize about and treat AN, I take it that this "weak" interpretation cannot be what they have in mind.

What, then, is actually being proposed when an author recommends that clinicians incorporate AN patient perspectives into the aims of treatment? It appears we must take seriously the "incorporation" bit of the VIP acronym. That is, we must take the directive to incorporate patients' goals and values *into the goals of treatment* at face value. At this point, it will be useful to work through the potential outcomes of incorporating patient values when these values are in direct conflict with those of the clinician (or what is sometimes referred to as a "therapeutic collision") (Stanghellini et al. 2021, Jaiprakash et al. 2024). For ease of exposition, I will refer to a hypothetical AN patient, "A", and her clinician, "C". To begin, we must bracket off any cases in which the apparent clash of values between A and C turns out, upon further inspection, to be merely superficial (à la Mrs. Jones and Diane). If, that is, ordinary therapeutic protocol would cause A to realize that she does not actually value thinness or other anorexic values more than her health, then this would not be a relevant instance of a therapeutic collision.

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meant by "incorporation" in this context can be filled in and spelled out in various ways. Regardless of the particular details, however, the core issues of a solution that boils down to being an instance of the VIP will remain constant.

What we are left with, then, are those instances in which there is a bona fide conflict between A's considered goals and values and the considered goals and values of AN treatment as practiced by C. It is here that proponents of the VIP must show that it can avoid or at least diminish the incidence of objectionable paternalism (which, recall, can involve forced treatment of legally competent adults). How does the VIP fare? It seems to me that there are two ways in which C might heed the directive of the VIP in treating A when faced with genuine therapeutic collision:

> *Option 1:* C interprets the VIP as a therapeutic emphasis on discussing A's anorexic values with an eye toward *changing* said values. Thus, C treats A with the goal of altering either the contents of A's values and/or the relative prioritization of A's anorexic values in relation to her other values.
>
> *Option 2:* C interprets the VIP as a therapeutic emphasis on discussing A's anorexic values *without* the goal of altering the contents of A's anorexic values or of changing A's relative value prioritizations.

Laid out in this manner, it becomes easier to see that one of the natural interpretations of the VIP (*Option 1*) amounts to the intentional manipulation of values from a position of power on the part of the clinician. Although there is much debate as to when, if ever, clinicians can justifiably engage in soft manipulation (or "nudges") for the benefit of their patients, recall that the VIP is meant to be an *antidote* to paternalism—not a means of substituting one form of paternalism for another. Furthermore, any account of the ethics of paternalist manipulation ought to be especially squeamish when it is the patient's sincerely held, longstanding values that are being manipulated.

Given this, the practitioner sympathetic to the VIP may be inclined toward *Option 2* over *Option 1* if faced with the choice. On the face of it, after all, *Option 2* boasts more of the egalitarian and pluralist sentiment that can be seen in the literature on values-based medicine and in the various iterations of the VIP. However, committing to *Option 2* is in many ways more radical than it might initially seem. This is because clinicians are bound by a duty of care and are therefore required to not take part in anything that might be seen as increasing mortality—they have vowed, after all, to "do no harm" (Miles 2004). Allowing a Jehovah's Witness patient to refuse a blood transfusion, to harken back to Groll's example, is one thing. Actively engaging in the

therapeutic process when some subset of the goals and values espoused by this process are contrary to the patient's wellbeing[6] is another thing altogether.

At this point, it is likely that the VIP advocate will take issue with my framing of the available therapeutic interpretations of the VIP. It might be objected, for instance, that C's intention can simply be to practice proper and thorough therapy that is directed, in part, at inquiring into A's values. Then, given suitable time and the right therapeutic relationship, it may be thought that A will come to see that her overarching values of the good life are ultimately incompatible with her anorexic values. I will call this the Teleological Objection, since it relies on the assumption (reminiscent of a sort of psychological teleology) that, with sufficient therapeutic intervention, all (or all but the most severely ill) individuals will ultimately move away from what is considered psychopathological and toward relative non-pathology or wellness.

Unfortunately for the VIP advocate hoping to leverage the Teleological Objection, however, an objection along these lines seems to presuppose (quite incorrectly, given what we know about AN) that anorexic values are sufficiently malleable in such a way that this strategy could be reasonably supposed to lead to the desired outcome in some clinically significant number of cases. In other words, the Teleological Objection amounts to something like an unjustifiably optimistic prediction of how the contents of A's values would shake out if C were to treat A by discussing A's values in a way that was *entirely neutral* with respect to C's desired clinical outcome. It is important to stress that this is an empirical question that certainly cannot be assumed on a sort of faith or optimism in the natural tendencies of human psychology. More to the point, we have significant empirical reason to believe that the opposite of this teleological assumption is the case—*especially* in chronic and severe AN patients (Charland et al. 2013, Radden 2021 and 2022, Hay et al. 2012). Notably, it is precisely this clinical subgroup that the VIP is designed to target, given that patients with a shorter duration or a less severe level of illness already tend to have better clinical outcomes with standard "treatment as usual" approaches (Guarda 2008).

[6] That is, contrary to the patient's wellbeing from the standpoint of the medical system—again see Washington (2018) for further discussion.

Furthermore, unpacking the Teleological Objection in this way helps to bring out the paternalistically manipulative undercurrent running through both it as well as the VIP itself. Although the VIP (and, consequently, much of the related work in values-based medicine) *purports* to be committed to a form of value pluralism, I suspect that many VIP advocates would be less committed to the idea of value incorporation if it did not in fact lead to any changes in either the contents or the relative value orderings of patients with anorexic values. This is in line with the fact that many AN researchers already seem to presuppose something like the Teleological Objection when trying to integrate patient values into extant therapy methods. Acceptance and commitment therapy (ACT), for instance, is an offshoot of cognitive behavioral therapy (CBT) that has recently garnered increased attention in AN research. Indeed, Jaiprakash et al. (2024), specifically promote ACT as a way to achieve patient value incorporation in AN treatment. Fogelkvist et al. (2020) describe ACT as a therapy in which "…patients are prompted to *clarify their values*. This aims at increasing vitality and motivation to behavioral change" (p. 156, emphasis in original). The move from "clarifying" one's values to behavioral change (which, in this context, would mean acting *contrary* to anorexic values) is just a restatement of the Teleological Objection in different terms. And, as Louis Charland and colleagues (2013) and Jennifer Radden (2022) have emphasized, we cannot simply assume or hope that the anorexic values of chronic and severe AN patients will be so mutable *even in* the face of explicit clinical manipulation of values, let alone without.

4. Conclusion

In this paper I have considered an initially attractive solution to the problem of medical paternalism in the treatment of AN, and I have drawn out the ways in which it falls short of its intended goal. Although the conclusion of this paper is largely negative, I believe it is just as important in this arena to gain clarity on what we ought *not* devote our theoretical, experimental, and financial resources to. If values-based medicine and its practical output, the VIP, cannot deliver on their promises, then we must turn our attention to newer and, perhaps, more radical solutions.

Indeed, this discussion brings into glaring focus the reality that there is almost certainly no quick or relatively straightforward fix for the problem of medical paternalism in psychiatry, *especially* when it comes to AN and the other egosyntonic mental disorders. In this paper I have focused exclusively on anorexia nervosa as the representative of the egosyntonic disorders, in part because its distinctive and relatively consistent phenotype allows for a clearer analysis of the limitations of the VIP. Zooming out, however, it should be noted that these limitations would also extend to the personality disorders, which are often egosyntonic (Hart et al. 2018). Furthermore, some conditions that are not typically categorized as egosyntonic, such as schizophrenia, can involve symptoms (e.g., auditory verbal hallucinations) which are egosyntonic for some individuals (Rosen et al. 2015, see also The Hearing Voices Movement (Higgs 2020)). For these other egosyntonic symptoms and disorders, the inclusion of patient perspectives (as is dictated by the VIP) will similarly be unable to mitigate medical paternalism so long as the disorder (or symptom) itself remains pathologized. Whether (or to what extent) such conditions and symptoms *should* be pathologized is, of course, the difficult question that must ultimately be answered in each instance.

As for where we ought to go from here, I believe Bennett Knox's (2022) discussion of how to avoid mere "lip service" (p. 261) in incorporating the perspectives of the pathologized is instructive. Furthermore, Radden's (2022) reflections on the shaky scientific status of the pathologization of AN raise important issues that have yet to be properly addressed in the literature. With the tools currently at psychiatry's disposal, it may well be the case that the desire to avoid paternalism is irreconcilable with the treatment of egosyntonic mental disorders. Where we go from here may be far less clear, but this does not diminish the value of dissipating the allure of what turned out to be a false theoretical hope.

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