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Eating Disorders and Bioethics: Reflections on treatment approaches and therapeutic relationships in support of Human Dignity

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Abstract

Eating Disorders (EDs), including problems e.g. Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder, represent a significant global public health problem. They are most prevalent in Western countries and among young people, particularly among females. The evidence shows an increase in their incidence over the past few decades and a possible rise following the COVID-19 pandemic, with a consequent growing impact on public health and society [1,2]. Furthermore, subclinical and undiagnosed cases - which are not included in official surveillance registries, when existing - appear to be common, suggesting that the problem is underestimated.

The psychopathology of EDs is complex and deeply affects the Person who suffers from them, impairing health and quality of life.

As about the treatment, the NICE guidelines serve as the primary international reference for the treatment of ED. They recommend the use of CBT-ED (Cognitive Behavioral Therapy for Eating Disorders). Such approach includes so called CBT-E, which focuses on resolving a specific psychopathological core in order to restore balance to the self-perception domains of the Person, thereby overcoming an excessive preoccupation with weight, body shape, and food control. The therapeutic relationship is crucial: it requires mutual trust, empathy, and active listening.

In this clinical setting, it is important to assess both the therapeutic relational and bioethical implications of care, with a focus on the Person and respect for their identity, autonomy, freedom, and ontological dignity.

Keywords

Bioethics, Eating Disorders, Doctor-Patient relationship, Personalism, human dignity

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Introduction

Bioethical reflection on EDs treatment is a complex field. Here, the ethical principles of clinical practice - i.e., autonomy, beneficence, non-maleficence, and justice - may come into conflict with one another. In particular, this can occur when impairments to physical and psychological health call into question Person's decision-making capacity itself.

Then, one of the key issues concerns the relationship between the autonomy of the Person and the need for clinical intervention. The principle of autonomy implies that every individual has the right to make informed decisions regarding their own body and medical care. However, in some cases, when a Person suffers from severe or extreme ED, their judgment may be severely impaired by psychopathology. So, refusal of treatment may not always be the expression of a free and informed choice, but rather the result of a cognitive distortion linked to body image and weight perception [3]. In such circumstances, absolute respect for autonomy risks resulting in therapeutic neglect, with potentially serious or even life-threatening consequences.

This scenario raises the ethically sensitive issue of so-called involuntary treatment. The guidelines of the American Psychiatric Association (2025) acknowledge that, in life-threatening situations, coercive intervention may be justified. However, such treatment must be time-limited and accompanied by a constant effort to re-establish the Person's consent. Then, involuntary treatment raises profound ethical and moral questions: when and to what extent is it permissible to restrict individual freedom to safeguard life? Furthermore, how can we prevent such practices from becoming paternalistic or detrimental to the Person's dignity? Therefore, the justification for involuntary treatment should be based on a rigorous assessment of decision-making capacity and the proportionality of the intervention, always prioritizing the least restrictive alternatives and avoiding disproportionate or risky choices.

The available scientific data acknowledge the validity of therapeutic approaches that are dialogical, collaborative, and always respectful of the Person's freedom. Therefore, whenever possible, it is important to choose these treatment approaches, particularly CBT-E (or, where appropriate, Family-Based Treatment). CBT-E (Enhanced Cognitive Behaviour Therapy) [4] shifts from a "disease model" to a "psychological model": it does not "treat a disease" but rather helps the Person actively and collaboratively overcome a disorder that impairs their psychosocial functioning, health, and quality of life. From a bioethical perspective, this aligns particularly well with the framework of Personalist Bioethics.

Medicine, through medical acts, deals with people who have dignity, history, relationships, and rights. Any clinical decision has moral implications. Physician is not a sterile executor of protocols, but a moral agent called upon to harmoniously integrate technical competence, human sensitivity and relational empathy, professional deontology and Bioethics. Authentic medical act requires prudence, respect for Patient autonomy and protection of life and its dignity. These characteristics are of paramount importance in the therapeutic relationship when treating EDs, as the Person suffering from them is affected physically, emotionally, psychologically, and relationally by the problem, its perpetuating mechanisms, and its consequences.

Professional Ethics are central to everyday clinical practice. It is not enough for a Doctor to know guidelines: honesty, compassion, justice, and responsibility should also be demonstrated. The Physician-Patient relationship is based on trust, and that trust is sustained by the moral integrity of the professional. In a context often marked by economic pressures, increasing technologization, and the risk of defensive medicine, the centrality of Bioethics becomes even more decisive. So, Personalist Bioethics responds to the medical need for professional Ethics, placing the Person at the center in his/her integrity as an autonomous relational subject endowed with ontological dignity. It allows for the establishment of an empathetic and respectful Physician-Patient relationship, capable of guiding and defending life. These considerations are of great importance in the context of EDs treatment.

DICUSSION

Personalism [5] is a bioethical system characterized by some key aspects, like: centrality and wholeness of the Person, principles of responsibility, solidarity and subsidiarity, dignity of life. Its roots lie in 20th-century philosophical Personalism, greatly influenced by Thomism. The central idea is that human being, considered as a unitary subject endowed with inalienable ontological dignity, constitutes the fundamental criterion of every bioethical evaluation. From a Thomist perspective, human dignity does not derive from accidental or contingent qualities such as efficiency, functional autonomy, or social recognition. It is rooted in the very *being* of the person. This has fundamental ethical consequences: if dignity depends on being and not on performance, then every Person possesses it inalienably, regardless of health, development, cognitive abilities, or any other subjective characteristic. Today, Personalist Bioethics attempts to respond to contemporary bioethical challenges based on a unified and dignified conception of the human Person, integrating philosophical reflection, anthropology, and clinical practice.

As about the medical act, it differs from many other professional practices. In fact, it is not simply a technical intervention aimed at solving a biological problem, but an encounter between people, in which a vulnerable individual entrusts their health and life to the competence and responsibility of another. This dimension of trust makes medical practice intrinsically ethical: it involves not only scientific knowledge, but also moral issues.

There are different theoretical models which define Physician-Patient relationship. Let us recall the “paternalistic” model, in which Patient is passive and Physician decides everything, the “informative” model, in which Physician provides all the information and Patient's autonomy is exasperated, the “interpretive” model, in which Physician helps Patient understanding their values as a consultant, and the “deliberative” model, in which Physician and Patient discuss together which health-related values are most appropriate and ethical in the specific case [6]. These models are also accompanied by the more recent thesis of “Bureaucratic Parsimony” [7], in which clinical decisions are influenced by insurance, guidelines, administrative constraints, or similar factors, for the economic management of the system, requiring a focus on efficiency and cost containment and reducing the freedom of both Physician and Patient. The risk in this last case is that bureaucratic and economic structures will take over the whole relationship.

Instead, only by making Patients feel that the healthcare system is stable and provides high-quality service, and by making Doctors feel that they have adequate professional conditions and a sustainable workload, it becomes more realistic to build a positive Physician-Patient relationship. Such relationship should focus on the authentic good of the Patient, considered as a Person suffering from a specific problem. Before being a pure medical relationship, it should be approached as a meeting between two people, and therefore between two different universes of humanity. By practicing the principle of *people first* [8], the focus of discussion should be on the whole Person and their good and not on the organic pathology - as if it could be excised from the entirety of the human being who suffers from it. So, we can not *talk about* an Eating Disorder, but we have to *talk with a Person who is suffering from* an Eating Disorder. The Patient is, first and foremost, a Person, and therefore a human being endowed with autonomy and full ontological dignity, never just a physical body. This presupposes a comprehensive approach to the individual, without mechanistic reductionism.

So, the therapeutic relationship is a meeting between two consciousnesses, which are expressed in a complementarity of situations: one makes themselves available professionally, the other asks for professional help. It is necessary to achieve a dynamic balance that does not exaggerate the decision-making power of the Physician (which would result in a paternalistic approach) and does not exaggerate only the autonomy of the Patient (which would result in a rejection of the medical expertise). Every single decision should be made prudently, ethically, and with the utmost understanding possible. The language used in the Physician-Patient relationship should be adapted to the second one's cognitive and cultural abilities, in a clear and understandable manner, without rushing and without any manipulation.

Historical development of Medicine has influenced the Doctor-Patient relationship and their autonomies. From the modern age, the development of Medicine as a Science emphasized the technical possibilities and the progress of knowledge, making available opportunities and resources unimaginable before then. Momentum of rational culture canceled previous “magic” or superstitious visions, leading to what Max Weber defines as “*Entzauberung der Welt*” (“disenchant-ment of the world”) [9]. Within this context, in the medical field the Doctor became the one who was supposed to be the only source of judgment, on the basis of his scientific competence. Such kind of model is no longer acceptable, respecting now Patient’s autonomy, freedom and self-determination.

However, the opposite risk is to shift all attention to the Patient, relegating the Doctor to a mere performer of inquiries received. In this way, the Doctor-Patient relationship would become pure performance. In addition, an interpersonal relationship would no longer be created, but just an impersonal contract. An ambiguous risk is the granting of an absolute individualistic freedom and radical autonomy, which can absolutize the choices, compromise the Doctor-Patient relationship and turn into a danger to human dignity. Thus, a disinterested permissiveness may turn into moral and ethical disregard. On the contrary, for a good clinical path, an interhuman relationship of dialogue and trust between Doctor and Patient is needed. In such relationship, the Doctor should take care of the Patient integrally: if we reduce the disease to the symptom, and the sick to the sickness, we lose unit. In this case it may be possible to *cure*, but it becomes impossible to *care*.

By applying the theoretical considerations mentioned above to the medical field of EDs, we can therefore assume that a key challenge lies in establishing a proper therapeutic relationship. Healthcare professionals (Doctors, Psychotherapists, Dietitians, Physical therapists) should be empathetic and approachable, yet firm and not overly accommodating. In clinical practice, an empathetic and collaborative approach fosters the development of a therapeutic alliance, and at the same time an approach that is also firm and structured ensures proper adherence to therapeutic protocol and helps manage resistance [10].

An other crucial aspect concerns informed consent [11,12]. In EDs, obtaining genuinely informed consent can be particularly challenging, especially in adolescents, in cases involving psychiatric comorbidities, or in severe disorders that impair decision-making capacity. However, the consent process should not be viewed as a purely formal act, but rather as an ongoing process of communication and therapeutic relationship-building. It is necessary to adapt the manner of providing information to the Person's age, culture, language and level of understanding. In the case of minors, family involvement becomes essential, but it introduces further ethical complexities related to confidentiality and the balance between the minor's rights and parental responsibility.

The principle of beneficence, i.e., the duty to act in the best interests of the Person, intersects with the principle of non-maleficence, i.e., the duty to do no harm. In EDs, this balance can be particularly delicate: interventions such as force-feeding or involuntary hospitalization can be life- saving, but they can also be experienced as traumatic. Therefore, such practices should be accompanied by an empathetic and respectful approach that acknowledges the Person's subjective suffering and seeks to minimize the negative impact of the intervention. A bioethical framework that integrates the aesthetic and existential dimensions of EDs could be adopted, because such disorders cannot be reduced to mere biological problems, but have to be understood in their identity-related complexity [13]. They risk being misunderstood if they are labeled merely as a neurobiological disorder, to address with therapeutic and medical approaches that aim solely at weight correction - even more if choosing coercive approaches.

An other particularly significant issue is the definition of the boundaries between health and disease in the field of EDs. Indeed, ethical questions arise regarding the medicalization of eating behaviors that might be considered socially acceptable. For example, the growing cultural focus on food quality could lead to pathological conditions that are difficult to distinguish from healthy lifestyles [12]. In general, Bioethics urges us to critically reflect on diagnostic criteria and the risk of labeling harmless behaviors that reflect cultural or personal values as diseases. However, since the line between health and illness is blurred, there is also a risk of misdiagnosis: on particular, we note cases of "atypical" EDs, in which a Person's quality of life and overall health are compromised, despite a normal weight and the absence of other biomedical abnormalities. Consequently, there may be cases of false diagnoses of ED (where too much attention is focused on non-harmful behaviors) and cases of missed diagnoses of ED [15] (where too little attention is paid to harmful behaviors). Let us recall that contemporary society appears vivacious, dynamics and rich in multicultural instances. There are no single "unitary" cultures, typical of past historical periods.

Finally, the principle of justice emphasizes equity in access to care. EDs are often associated with significant barriers: e.g., social stigma, lack of specialized services, and socioeconomic inequalities. Many Patients do not receive adequate or timely treatment, with negative consequences for long-term outcomes and direct implications for distributive justice [16]. From a bioethical perspective, this highlights the need to promote health policies that guarantee equitable and universal access to care, along with prevention and awareness-raising initiatives targeting both healthcare personnel and the general population.

CONCLUSION

Daily medical practice in clinical nutrition for EDs is characterized by complex decisions, often made under conditions of uncertainty or pressure. In these situations, the moral conscience of the professional is an essential guiding principle. Medical practice is a service to the Patient as a Person suffering from a complex disease: a service that combines science and conscience, competence and humanity, technique and moral responsibility.

Personalist Bioethics focuses on the Person and their well-being, as a unified and relational subject, autonomous and endowed with inalienable dignity. It upholds solidarity as an ethical and social principle whereby each

Person is responsible for the welfare of others. This solidarity stems from the recognition of shared dignity: since everyone shares the same personal nature, each Person is called to promote the welfare of others. This generates care for the most vulnerable and active co-responsibility in the pursuit of the common good and of the integral development of each Person. Subsidiarity, on the other hand, protects the freedom and initiative of individuals and intermediate communities, respecting the Person as a subject capable of initiative and responsibility. Together with solidarity, it guarantees a social order in which the Person is at the center, supported by the community but never flattened into it.

The focus of attention, even in medical act and supported and recognized by the moral professionalism of the Physician, is always on the Person as a unique and complex human being. The aim is to achieve the greatest possible good, respecting their autonomy, supporting their dignity, and defending life.
The relational dimension of care in EDs plays a central role not only clinically but also ethically. Respect for the Person's dignity, the establishment of a therapeutic alliance, and the recognition of the Person's individuality are essential elements. In this sense, Bioethics does not merely provide abstract rules but offers an interpretive framework that helps professionals navigate complex and often challenging situations.

Ethicality also includes the respect of Patient's autonomy. The Doctor should explain to him/her each time all the different achievable options. Explanation has to be understandable and clear, without any omission or manipulation. Then, the choice should be made jointly, in a dialogue that has as its highest goal the maximum good of the Person. Probably this good can be achieved only if both autonomies and roles are fully respected, those of the Patient and those of the Doctor. A choice that is too unbalanced on Patient's will, whatever the cost, might be improper. Likewise, the imposition of Doctor's decision might be improper, too. Finding the proper balance between autonomies and competencies in the Doctor-Patient relationship is a contemporary challenge. Bioethics is called upon to answer, offering respectful reflections, always open to dialogue and looking for the possible good for anyone.

In conclusion, Bioethics in the treatment of EDs is a dynamic and interdisciplinary field. Clinical decisions should take into account not only scientific evidence (always essential for practicing Evidence-Based Medicine) but also the values, rights, and dignity of the individual. The ethical challenges related to autonomy, consent, coercive treatment, and equity require a reflective, serious, multidisciplinary, and context-sensitive approach. Medical expertise should be integrated with ethical, psychological, and philosophical considerations. Only through such integration is it possible to ensure care that is also ethically justified and respectful of human ontological dignity and complexity. Both the improvement of the bioethical skills of Doctors and the concrete availability of experts Bioethics consultants [17] could provide valuable support to therapists treating EDs, especially in very severe and complex cases.

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