

Ground zero: Ontology, recognition, and the elusiveness of care in American eating disorders treatment

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Abstract

This paper reflects upon questions of ontological contingency when the stark, visceral reality of a person's relentless self-destruction unfolds within institutional mechanisms that systematically withhold certain kinds of care. I consider these issues through the lens of "manipulation" as it is elaborated within an American eating disorders treatment center, where the notion of manipulation does particular kinds of affective and pragmatic work. Specifically, it serves to render clients as, paradoxically, both hyper-agentic and "agentically challenged" in ways that legitimate the withholding of their recognition as full subjects and therefore deserving of care. I propose that the ontological perspectives of the treatment center are ill-equipped for accounting for such dynamics and, in fact, carry certain risks when employed in the consideration of psychiatric conditions where they can even become coopted in unintended ways. This carries special importance when working with people whose ontological status is, in a very real (and not just theoretical) sense, teetering on the brink of the void.

Keywords

agency, care, eating disorders, manipulation, ontology

"I relapsed, Rebecca." Anita¹ slouched on the couch in the Cedar Grove eating disorders clinic, as if it took too much effort to hold herself upright. I had met Anita the previous summer, when she was in treatment at Cedar Grove for the first time. Now she was back. Looking at me forlornly, she slowly moved aside the long grey-blue sweater that had been wrapped around her body. I swallowed hard, trying not to show my reaction. Even through her leggings I could see the full outline of Anita's pelvic bones. Her stomach was so shrunken in that she almost

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seemed to disappear into the couch. Her ribs jutted forward as if straining to break free of their skin. After 20 years of working in the field of eating disorders I have seen many people with anorexia before, and I am quite accustomed to the sight of the physical manifestations of extreme starvation. But something about seeing Anita that day yanked me out of my habituated orientation as if I'd been doused with a bucket of ice water. I saw anew what this illness does to people, what it takes from them, the shell that is left behind.

My gaze met hers. "Rebecca, I'm sorry," she said, and her eyes filled with tears. "I tried to stay healthy, I really did," her voice pleading for me to believe her. "I don't know what happened. I didn't mean for it to get this bad." I sat down on the couch next to her and held her hand while she wept.

Talking about this incident later that afternoon with Claire, one of the clinic therapists, I gave voice to my feelings about seeing Anita back in treatment and expressed my concern for her wellbeing. To my surprise, Claire let out a snort and rolled her eyes: "Oh *please*," she said. "Don't you see what she was doing? She was totally *manipulating* you, trying to get you to feel *sorry* for her because she's so sick. You can't validate that. It's exactly what she wants."

I found this comment perplexing, and the more I thought about it, the thornier the issue appeared. There was no question that Anita was—literally—deathly ill. But Claire maintained that the fact that Anita wanted (needed?) acknowledgement of her suffering, *and* that she seemed to solicit it so directly, was part of that very same illness. In such a scenario, explicitly *not* acknowledging her suffering was therefore seen to constitute some sort of care. Under what conditions, I wondered, does "care" come to mean the explicit *withholding* of a response to suffering? And what might this tell us about how illness experiences are shaped within different material and affective realities?

Critical care

I come at these issues through and engagement with the "fraught politics of care" (Martin, Myers, & Viseu, 2015, p. 3) and the "ambivalent rhetorics and practices taken up in its name" (Martin et al., 2015, p. 6). That is, I am interested in how the practices, ideologies, and affective enactments of care in the eating disorders clinic materialize ambiguous, contradictory, and morally laden understandings about which lives are worthy of material investment and care, and which lives are, instead, ungrievable (Butler, 2010).

What do we mean when we talk about "care"?

Care is a slippery term (Lavis et al. 2015). At first glance, the concept of care is deceptively banal, evoking a feel-good sense of tending to another's needs, or an affective orientation of selfless compassion and empathy. But "care" is both more complex (and darker) than our everyday associations suggest. Whatever else it may be about, care is, at heart, about power. Not only does the very idea of care suggest

the pragmatic power to materially affect the wellbeing of another; it also positions people in relationships of control and dependency. In this way, caring “organizes, classifies and disciplines bodies,” becoming a means of governance “shot through with asymmetrical power relations” (Martin et al., 2015, p. 3) that pulse with the potential for both resistance and exploitation. Accordingly, enactments of care—how people care, how people talk about care, how people assess “good” versus “bad” care, how people receive (or reject) care—materialize and moralize relatedness, revealing profound social and cultural beliefs about intimacy, dependency, the meanings of harm, and the imperatives of the “good.”

This “thick vision of care” (Puig de la Bellacasa, 2012, p. 197) as telescoping broader cultural and social values about interpersonal relatedness anchors a growing transdisciplinary interest in care, from cultural studies to science and technology studies (STS) to sociology to anthropology. Across disciplines, the focus has recently extended from a broad concern with care as a feminist ethic to engagements with care as a way of understanding entanglements of politics, power, practice, and affective experience in everyday life.

Anthropologists, in particular, have argued for the grounding of discussions of care within ethnographic specificities and a consideration of how “care” moves within and between social, political, moral, and affective domains. The “anthropology of care” is the ethnographic study of such care practices in domains including community mental health practice (Brodwin, 2013), elder care (Buch, 2013; Kleinman, 2009; Rodriguez, 2014), reparations for state violence (Han, 2012), suicide (Stevenson, 2014), food and eating (Abbots, Lavis, & Attala, 2015; Harbers, Mol, & Stollmeyer, 2002; Yates-Doerr & Carney, 2015), cancer (Livingston, 2012), diabetes (Mol, 2008), and war injury (Wool, 2015; Wool & Messinger, 2012), among others. The current development of an anthropology of care can be traced along two broad axes (Buch, 2014): care as a diffuse but significant form of power (e.g., James, 2008; Ticktin, 2011) and the moral and affective dimensions of everyday interpersonal care practices (e.g., Heinemann, 2014; Russ, 2005).

This literature has much to offer to the study of eating disorders and the provision of eating disorders treatment (Eli, 2014a; Lester, 2014; Musolino, Warin, Wade, & Gilchrist, 2015). Specifically, it is in the interweaving of these two dimensions—the political and the affective—that we can begin to make sense of under what circumstances the *withholding* of “care” can be justified, not only as legitimate under certain circumstances, but as itself a caring response.

Studying the entanglements of care

Over the course of 7 years (2002–2009), I conducted ethnographic research at Cedar Grove, a private eating disorders clinic in a suburb of a mid-sized city in the American Midwest. The clinic treats anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED) and other specified feeding or eating disorder (OSFED; American Psychiatric Association, 2013). The clinic provides three different levels of care: 24-hour residential care, partial-day programs, and outpatient

programs. Patients (as they are called at the clinic) receive comprehensive psychiatric, medical, and psychological assessments prior to admission, and the specifics of a patient's treatment plan depend on these factors as well as the precipitating events surrounding the development of the eating disorder and a patient's progress while in the program. Cedar Grove has become one of the premier treatment centers for eating disorders in the United States, particularly known for its top-notch medical care and its use of evidence-based best practices in treatment. Patients come from all over the United States for treatment, sometimes waiting weeks on a waiting list to get in.

In addition to standard ethnographic activities (attending and participating in group therapy sessions, client meals, group outings, treatment team meetings, team trainings, supervisions, and hundreds of hours of simply hanging out in the clinic) and in-depth interviewing of clients, families, and staff, I also completed (during 2006 and 2007) a 2-year clinical practicum at Cedar Grove in the course of receiving my Master of Social Work degree. During that time I was responsible for running three group therapy sessions per week and carrying an ongoing case load of four clients, which entailed conducting an initial intake, developing treatment plans and documenting progress, holding three 50-minute individual therapy sessions with each client per week, communicating with clients' insurance companies to obtain benefits for treatment, charting about clients' experiences in treatment, developing a discharge plan, and communicating with clients' families and outpatient treatment team to coordinate care. I continued to work at Cedar Grove as a psychotherapist for an additional 3,000 hours (during 2007–2009) to obtain my independent licensure, where my duties were the same as during my internship.

During these various developments in my role at Cedar Grove I worked closely with my university's Institutional Review Board (IRB) to ensure that proper research protections were in place, and I also took extra steps to ensure that participants' privacy and rights were protected. For example, after 2007, as an intern and then a therapist working at the clinic, I was covered by the clinic's Health Insurance Portability and Accountability Act (HIPAA) policy and its own "Consent for Research" document that clients signed when entering care. I was therefore legally permitted to talk to any patients in the clinic and to access patient information and files without separate consents as long as this was done in the routine course of treatment. Nevertheless, I obtained additional informed consents from participants in order to be certain that they understood my research interests and intents, and clients were given the option of electing not to participate in my research without any negative consequences for their care at the clinic. Consents for participant-observation were sought by presenting the aims and scope of the research project in "community group" at regular and frequent intervals as well as through individual conversations with clients who may have been admitted in between such discussions. Clients were asked not to consent immediately, but were encouraged to discuss the project and any and all concerns with their individual therapists before deciding if they wished to participate. I then followed up individually with clients to ascertain their willingness to be part of the

participant-observation portion of the research (indicated by verbal consent, which was recorded in field notes) and to assess their interest in participating in interviews, for which separate, signed consents were obtained. Staff members were approached at staff meetings and through a document placed in the staff log book outlining the research and likewise were asked individually if they consented to be included in the participant-observation. All but two patients (approximately 200 over the course of several years) and all staff (approximately 45 individuals) agreed, separately from the clinic's "Consent to Research" document, to be part of the participant-observation portion of the research. Of these, 75 consented to additional one-on-one interactions and interviews as part of the research project.

Eating disorders, managed care, and moral responsibility

Claire's perspective on Anita's "manipulation" finds its logic in the American managed mental healthcare system and the way eating disorders are figured within it. Managed care is first and foremost an economic model; a system of organizing and rationing health care services within a capitalist system where market forces determine both the cost and value of those services. Built on a rational-choice model of human action with profitability as the ultimate good, managed care is predicated on the standardization of a product (health care) across domains, a regulation of the provision of that product, and a rationing of the supply of the product in order to maximize economic profit and minimize loss (Baily, 2003; Goldman, 1995; Gostin, 2000; Mulligan, 2014). Managed care is predicated on offering manualized treatments—standardized by diagnosis—that can be tested in randomized controlled trials and optimized for efficacy. This is a far cry from more traditional forms of psychodynamic practice that rely on the largely immeasurable and unreplicable nuances of human interaction. To cultivate these new regimes of care, managed care organizations (MCOs), such as Blue Cross, Aetna, United Healthcare, and so forth, contract with hospitals and providers to offer services to subscribers at reduced costs; Donald (2001) has called this "the Wal-Marting of American psychiatry."

The transition to managed care has had particular effects on the treatment of eating disorders in the United States. Despite the fact that eating disorders are the deadliest of all psychiatric conditions (Arcelus, Mitchell, Wales, & Nielsen, 2011), and are more common than autism and more fatal than breast cancer (Hoek & van Hoeken, 2003; Smink, van Hoeken, & Hoek, 2012), they are among the least covered conditions in terms of American managed care health insurance (Golden et al., 2003). Insurance companies specifically dislike authorizing care for eating disorders because, as one case manager told me:

Clients generally don't really want to get better. They don't follow treatment recommendations or they subvert treatment all together, and relapse is so high. Why throw good money after bad? Better to cut the strings and have them take responsibility for getting better.

When I mused to the case manager that perhaps the rate of relapse was so high because people weren't getting adequate treatment in the first place, she scoffed. "I don't think so. Oftentimes it's a game for them. If they really wanted to get better, they would." We see in this case manager's response how eating disorders are configured as a choice rather than as complex illnesses that require specialized interventions, and a person's continued struggle is read as a belligerent refusal to get well.

People with eating disorders are therefore seen to be particularly high-risk patients in terms of insurance companies' bottom lines. Only a small fraction of insurance plans currently provide for the basic minimum treatments for eating disorders recommended by the American Psychiatric Association for these conditions (Fox, McManus, & Reichman, 2003; Horgan et al., 2016; Striegel-Moore, Leslie, Petrill, Garvin, & Rosenheck, 2000). Individuals are regularly discharged below minimum weight recommendations, without necessary behavioral stabilization or support, or without adequate transition assistance back to the community (Vandereycken, 2003). Those insurance plans that do authorize coverage often do so in direct contradiction to accepted medical guidelines of practice, authorizing care that is limited, partial, and in some cases deadly (Steinhausen, 2009; Sullivan, 1995).

Double agents: Brokering care

Clinicians at Cedar Grove spend much of their time, then, trying to obtain treatment that insurance companies generally do not want to fund, for patients who often reject it, but who may desperately need it (see also Cohen, Marecek, & Gillham, 2006). Under such conditions, they must become what Angell (1993) calls "double agents," constantly negotiating between the requirements outlined by insurance providers and locally derived understandings of what is needed for optimal client care. This can be extraordinarily taxing. As Monica, a Cedar Grove therapist explained it:

Dealing with insurance companies is by far the worst part of my job. You have to fight the insurance companies to get [patients] in, then fight to keep them in long enough for it to do any good. And when you finally get the patient approved for more days you turn around and they refuse a meal or something and you're like, "Nooo! There's no way insurance is going to go for that!" That sounds terrible, but it's true. You start to think like that. I mean, the patient is sick, right? That's why she's here, because she struggles with eating and can't do it on her own. But you start to think about it all in terms of insurance and "How is insurance going to react?" Because, honestly, insurance doesn't care. They don't care what might be going on for that person. They only care that the patient was "noncompliant with her meal plan." So you just wait for the next shoe to drop.

This grim situation produces daily challenges for clinicians at Cedar Grove, who often find themselves torn between affectively investing in clients as part of

therapeutic interventions—caring for them in all senses of the word—and maintaining enough distance so that failure, relapse, or insurance-mandated discharge does not create burn out. “It’s hard,” Maggie, another therapist, told me:

Brutal, actually. We are a therapeutic environment. That’s what we do here. We heal through relationship. But this disease can be so difficult, just so difficult to deal with on a daily basis. That’s why most people don’t want to work with this population. You can give everything and just have it thrown back in your face, or else someone is doing well but insurance discharges them before they’re ready and they relapse. It can really drain you if you’re not careful.

Clinicians, then, are called upon to use their affective skills with clients—empathy, concern, attention, practices of attending to clients’ needs—as the core of the care they give, while at the same time recognizing that access to treatment is precarious, eating disorders are tenacious, and clients may not want to—or be able to—get well. Caring may lead nowhere, or even to death. In such a situation, understandings of illness that allow for—and even require—the withholding of responsiveness to clients’ expressed needs can become especially persuasive as a way of managing the tension between care and detachment. In other words, figuring the client as always already “resistant” structures the affective atmosphere of treatment in profound ways, conditioning clinicians and insurance providers to view clients’ struggles not as symptoms, but as willful noncompliance that delegitimizes them as subjects of care.

This precarious positioning of eating disorders treatment in the American managed care setting makes clinicians’ affective investment in clients—their concern, their empathy, their attending-to, their emotional attunement—feel both critically important and potentially dangerous. To manage this tension, clinicians rely on a variety of strategies that allow a withholding of care, while also construing this as an ethical and even therapeutic act. In so doing, structures of care, conditioned by economic and political structures beyond the clinic, become folded into ontologies of illness—understandings of what constitutes the very nature of a condition—in ways that, at least in the case of eating disorders, reinscribe the very practices of restricting, withholding, and denying basic needs that treatment is supposed to heal. Thus, “care” for eating disorders comes to be characterized by practices of deprivation, which are framed as therapeutic acts.

Affective engagements, “halo features,” and ontologies of eating disorders

This ontological “folding in” is an interpersonal process. Diagnostic criteria constitute just one component of how clinicians think about and see what is “wrong” with the patient. Equally as important are the kinds of affective responses clinicians have to different patients and what they believe this tells them about a patient’s

ongoing struggles. “You get a feel for people after you do this job for a while,” Denise, a therapist, told me:

There are many different flavors of eating disorders. Not just anorexia versus bulimia: no two people with anorexia are exactly alike. They may have similar issues in some ways but [the issues] are deeply embedded in how they *are* in the world. It’s not just about food. The food reflects how they manage themselves interpersonally. It’s really about relationships.

In other words, clinicians believed their affective and interpersonal engagements with clients would tell them at least as much about what the client’s struggles are as would observing disordered eating behaviors or measuring changes in weight or lab results. But the American managed health care system privileges behavioral factors and biometric data in eating diagnosis and treatment, which have a direct effect on whether or not treatment is allowed to continue. This produces a situation where clinicians feel their interpersonal relationships with clients to be both critically important and structurally devalued, and their affective investments in clients to be both vitally necessary and personally and professionally risky.

To navigate demands that they be both emotionally available *to* clients yet to remain emotionally protected *from* them, clinicians drew on their own personal reactions to clients—what we might variously call “countertransference,” “clinical intuition,” “expertise,” or “gut feelings”—in sorting through ethical dilemmas. Critical to this process was what I call “halo features,” those features—like manipulation, difficulty with interpersonal boundaries, or a focus on control—at the margins of official diagnostic criteria, which are not themselves part of clinical definitions but which nevertheless constitute part of the accepted “clinical picture” of a condition. These “halo features” allow clinicians a degree of flexibility in where they draw the boundaries of “pathology” for a given client in a given situation, enabling them to lump certain things together as part of the illness while excluding others, as they see fit in a given case. Whether and how clinicians do this depends on the particular interpersonal relationships at play as well as the circumstances involved. Importantly, halo features are identified in and through a therapist’s own intersubjective sense of the client and the situation. In the case of eating disorders, halo features allow clinicians to regulate emotional closeness and distance with clients while figuring such responses as caring acts dictated by the nature of the illness itself.

In answering the question of how the withholding of a response to Anita’s suffering could be construed as “care,” then, I consider the interpersonal constitution of eating disorders as “matters of concern” (Latour, 2004) within a setting where “care” is meted out based on insurance companies’ perceptions of clients’ investments in health (Lester, in press). Eating disorders, in this view, do not exist *within* people, but emerge *between* people. They are not the property of individual psyches, but are continually conjured as “things” in the contexts of shifting interpersonal, structural, and material relationships within which they do very

particular kinds of work. Indeed, how an eating disorder is manifested in a given interaction—what is included as materially important and what is excluded as unrelated (and by whom); how the pieces are thought to interact and hang together; what is thought to cause them; what effects they are believed to have; and how they should be treated—varies not only from person to person but from context to context. What delineates the boundaries of “an eating disorder” and what constitutes its phenomenology are negotiated anew in each and every interaction and in different situational and material circumstances. The question of what constitutes the “thingness” of an “eating disorder,” then, is a relational one, not a psychological or physiological one, although body and mind are deeply involved. Ontologically speaking, the thing termed “eating disorder” unfolds as an interpersonal process.²

Psychiatric care, ontological struggles, and the politics of recognition

Understandings of care, then, are inextricable from questions of illness ontology, the “what is” of what is wrong with the patient (Mol, 2003). But ontologies of psychiatric illness carry a unique set of concerns. The conditions targeted in psychiatric practice cannot be decisively located in blood smears or x-rays films, or laboratory values, but emerge within the ephemera of subjective experience, the only access to which is mediated by the (supposedly impaired and therefore unreliable) patient him- or herself.

When patients’ perceptual, rational, emotional, and/or behavioral capacities are thought to be impaired as part of the illness in question, patients become systematically delegitimated as reliable agents of knowledge through a “looping effect” of the ontological process itself (Hacking, 1986); that is, the ontology of illness inscribes a notion of the patient as an adulterated agent. In such cases, patients essentially become objects similar to other materialities, rather than subjects whose perceptions matter in the enactment of an illness. Clinicians learn to read clients’ interpersonal engagements not as expressing legitimate subject positions but as further data to be fitted into a diagnostic paradigm. Despite what clients may try to assert about their own intentions or experience, clinicians’ own feelings towards clients become especially critical to these unfolding ontological enactments, as they shape how clinicians read ambiguous situations for clues about clients’ diagnosable conditions. In effect, clients become exiled from their own experience in ways that, at least in the case of an eating disorder, can mimic the features of the illness itself (Williams, King, & Fox, 2015). Not only are multiple “worlds” generated through psychiatric practice, then, but some of those worlds are ontologically delegitimized through that very practice.

Ontological delegitimation is pronounced in the case of eating disorders, where patients are frequently perceived as not only incapable of accurate reality testing but as being deliberately manipulative, or playing on others’ emotional investments in order to obtain desired ends (cf. Ramjan, 2003). Characterizations of clients’ behavior as “manipulation” in the managed care context—where access to

treatment is precarious and unpredictable—does particular kinds of affective and pragmatic work. Specifically, it serves to render clients as, paradoxically, both hyper-agentic and “agentically challenged” in ways that legitimate the withholding of their recognition as full subjects and therefore as subjects deserving of care. This makes the selective *withdrawal* of attention and effort into a locally meaningful therapeutic act. Ethical care for eating disorders, then, emerges and takes shape in the clinic through a “struggling out” (Rhodes, 2004) of differing ontological claims among differently legitimated actors, in ways that become materialized in everyday practices and interactions.

It is clear, for example, that Claire and I had different understandings about where to draw the lines around “Anita” and “anorexia.” For me (and, I believe, for Anita), “anorexia” was something Anita and I were both reflecting on; present in the sense of being extant in Anita’s lived experience sitting on the couch, but existing *in the interaction* as the relatively distanced object of our discussion. For Claire, on the other hand, “anorexia” was actively structuring the very terms of Anita’s and my relating, which therefore justified her characterization of Anita’s claims to empathy as part of her illness itself.

In other words, in clinical settings, some people’s realities are considered more “true” than others, and in psychiatric conditions in particular, the issue of ontology can loop back onto itself, becoming part of local power dynamics. This requires us to maintain special attention on how ontological processes intersect with such notions as rationality and agency in different contexts. I submit that this paradoxical rendering of care (that withholding care is a form of care) mirrors the paradoxical construction of Anita’s agency as both ubiquitous and impossible.

In thinking about how the withholding of responsiveness to Anita could be construed as care, then, we need to understand the practices by which people become authorized (or not) as legitimate agents and the ways in which different worlds come into dynamic—and uneven—engagement in the constitution of the “what is” of an eating disorder. One mechanism of this is attributions of “manipulation.”

Manipulation

Claire’s admonition that I should not have responded to Anita’s expressed suffering hinges on the notion that eating disorder clients are notoriously manipulative. In clinical terms, “manipulation” can mean many things, but can broadly be defined as using subtlety, dishonesty, deceit, and/or other strategies of persuasion to attempt to get someone to act or feel a certain way without them being aware of what is happening (Bowers, 2003). Manipulation is usually considered to be a hallmark of a personality disorder, a feature of one’s “character” rather than an occasional strategy. In such cases, manipulation is thought to be an expression of who one *is*, not just what one *does*, and is thought to structure interpersonal relationships in certain ways. Specifically, it leads to viewing the “manipulator” as an illegitimate agent.

Anthropologist Lorna Rhodes (2004) describes how expectations of manipulation become an organizing principle in an American maximum security prison, where “running a game” and “knowing the game” characterize all social interactions. Guards were so distrustful of prisoners, in fact, that, “unless [a prisoner] is floridly psychotic he has the near impossible task of proving that he is not manipulating” (2004, p. 169). This problematic was confirmed by a prison guard who observed “A person is not a liar because he lies, but he lies because he is a liar” (2004, p. 171). In other words, there was no way for a prisoner to prove he was not lying, since he was viewed as a liar no matter what he said or did. Rhodes argues that, taken to its logical limits, this perspective precludes the very possibility of a “real” or truthful self as a stable locus of experience and center of initiative, and instead figures the “self” as always already a performance, mask, and strategy. In this way, the notion of “manipulation” articulates both a metaphysics of the person and a practical theory of human agency that juxtaposes external behavior and a perceived internal authenticity (or the lack thereof), as well as involving moral evaluations about the relative health or pathology of these uses of self (see Lester, 2009, for further discussion).

Rhodes’ (2004) description of the institutional dynamics of the prison resonates strongly with what I observed at Cedar Grove. I wish, however, to be very clear. The clinicians at Cedar Grove are compassionate and caring professionals who genuinely want to help patients get well. As in most mental health settings, they sometimes struggle with issues of workplace stress and occasional burnout, but this in no way characterizes the general atmosphere of the place. When clinicians characterize patients as “manipulative,” then, it generally stems not simply from cynicism, hostility, or disregard (though these may be present in some degree) but from a very particular and mindfully thought-out way of relating to clients who are interpreted as “agentially challenged” (as one clinic psychiatrist described it) in fundamental ways. That is, clinicians at Cedar Grove understand eating disorder clients to have developed pathological strategies for getting their needs met, such that personal agency is refracted through interpretive and behavioral lenses that distort and contort it into destructive patterns. For this reason, “gratifying” a directly expressed need of a client is almost always considered to be bending to a form of manipulation, and therefore to be avoided.

This view of eating disorder patients is by no means unique to Cedar Grove. In the clinical world, eating disordered patients in general are thought to be characteristically manipulative and are frequently portrayed in the literature as secretive, dishonest, sneaky, sly, and gamey (Lester, 2009). Such assessments often sit at odds with clients’ own experiences (Warin, 2009), yet have profound practical implications for the trajectory of treatment. Specifically, viewing clients as manipulative legitimates a relational strategy in which the *nonacknowledgement* of clients’ claims to authenticity can be construed as optimal care. A second brief ethnographic example can help illuminate these dynamics.

Heather

One day, Heather (a patient at Cedar Grove) seemed to be in a particularly good mood. “I just feel really good,” she told me when I asked her about it. “I feel really on top of things. I’ve got my plan in place and I’m ready to move on.” Heather was talking about her discharge plan, in which a client stipulates her goals for recovery and her specific life plans after discharge. Usually it is completed the week prior to discharge, once the end of treatment is in sight. Heather, however, had only been at the clinic for 2 weeks and was facing a stay of 2 months. Although she knew it was premature to be working on her plan, Heather told me she wanted to show the treatment team that she was taking her recovery seriously and was thinking realistically about the challenges ahead.

The next time I saw Heather, she was distraught. She sat on her bed and hugged her knees, tucking them under her chin. She sobbed quietly as she told me about how the treatment team had not only rejected her discharge plan but had told her she would likely stay an extra month past the original estimate. She seemed devastated. “I just don’t understand,” she told me. “I just wanted to show them I’m trying to be responsible and take my recovery seriously, and I feel like I’m being punished.”

After the interview, I spoke with Jim, Heather’s therapist, and asked about the treatment team’s decision. “Yes, Heather did submit a very complete and detailed discharge plan,” he told me; “Very complete. In fact, we thought it was a bit obsessive.” When I asked for clarification Jim said,

It seemed like she was trying too hard to please us, which is one of her issues. To be seen as a ‘good girl,’ and to get what she wants through the back door. A kind of manipulative thing. And that’s at the heart of her eating disorder. So we didn’t want to gratify that.

Here, again, we have two very different interpretations of the same set of events and, more specifically, different understandings of how to think about Heather’s agency vis-à-vis both her outward actions and her inner experiences. Underlying this disjuncture is the proposition that the treatment team is ultimately better able to discern the truth of Heather’s actions than is Heather herself; that her outward behaviors speak a truth about her inner experience that even Heather may not be aware of or might categorically reject.

While it is certainly the case that people may not be directly conscious of their motivations for behaving a certain way, it seems that something more complicated is going on here in terms of practical theories of self. Heather understood her writing of her discharge plan as an exercise in personal agency and as a concrete demonstration to the treatment team that she was fully and willingly engaged in the recovery process. For her, intention and action were aligned and consistent, and her outward behaviors articulated her inner dispositions in a fairly direct way. The clinicians, on the other hand, understood Heather’s personal agency to be eclipsed by her eating

disorder. They understood the discharge plan as evidence of how far removed from authentic agentic action she really was. For them, Heather's "real" (albeit unconscious) intention was to manipulate the treatment team into thinking of her as a model patient. Although this intention aligned with the action of writing the discharge plan, in their view Heather's behaviors distorted and misrepresented her real intentions, thereby rendering the action itself inauthentic and evidence of pathology.

Manipulation, ontology, and recognition

So how might we think about Heather's noncompliant compliance, and Anita's nonagentic agency? And what does this tell us about care, ontology, and illness?

Anita's moving aside her sweater and Heather's creation of a discharge plan were constitutive acts. They created certain realities. The therapists, clients, and anthropologist all had different interpretations of what those realities were, but we all agreed that *something* changed in those moments. Ultimately, if paradoxically, for the clinicians, Anita's and Heather's apparent ability to instrumentally use their eating disorders to achieve certain aims was evidence of the fact that they were, in actuality, fully immersed in their disease.

In this regard, we might say that the concept of "manipulation" requires the attribution of a certain kind of agency to the actor as one who not only surveys and understands the social landscape but can engineer (or attempt to engineer) the construction of a certain kind of truth. Yet, at the same time, as in the case of both Heather and Anita, this "hyper-agency" is read in the clinic as evidence of a lack of *legitimate* agency, as it is thought to indicate that patients are under the sway of their illness. Patients, then, are constituted as always already manipulative such that the exercise of "healthy" agency, even when they are compliant with treatment expectations, is deemed a logical impossibility. Ironically, under such conditions, clients often have little recourse aside from learning to inhabit the "manipulative" stance accorded to them at the outset. Indeed, Heather had to strategically alter her enthusiasm for preparing for discharge in order to better approximate what the clinicians expected of her and to hopefully secure an earlier release date. Anita had to learn to not solicit empathy and concern quite so directly but instead to try eke it out with no one being the wiser. In such situations, then, the only "healthy" agency a patient can exhibit is one that mirrors expectations of subterfuge, while denying the acknowledgement of the patients' needs as deserving of recognition.

If, to paraphrase Rhodes' (2004) prison guard, Heather's and Anita's behavior is construed as manipulative in large part precisely *because* they're seen as manipulators, then it becomes difficult for the clinical team to *ever* perceive them as acting authentically, regardless of Anita's or Heather's intentions. In a context where authenticity is understood as foundational to psychological health, this puts clients like Heather and Anita, as well as the clinicians themselves, in a tricky spot in terms of how to evaluate when or if clients are "getting better" and how to respond clinically as a result.

What is important about this in terms of ontological understandings of illness is that the client herself is both erased as an agent in these dynamics while at the same time being figured as powerfully agentic and therefore dangerous. In other words, in enactments of illness, not all agents are created equal, especially when issues of agency are themselves considered diagnostic of the condition of concern, and where regimes of care hinge on understandings of agency that become foreclosed.

Beyond theory: The elusiveness of care

Care in the eating disorders clinic is both central and elusive, both an organizing principle and an ever-receding horizon. It is, on the one hand, what the clinic is there to *do*: to care for people with eating disorders by attending to their medical, psychological, and social needs. At the same time, however, the resources to provide that care are not ultimately held by the clinic itself but are gate kept by managed care companies who, as the name implies, *manage care*, ultimately deciding who will receive care and who will not, under what conditions, and of what that care will consist. In the managed care framework, the fewer resources one needs, the better a patient one is seen to be, a stance that perilously mirrors eating disorders themselves (Lester, 2014). Worse yet, sometimes what a managed care company proscribes as “care” (e.g., moving a client to a lower level of care against treatment recommendations) is interpreted by the clinicians or clients as unhelpful or even counterproductive. The concept of “care,” then, operates across several domains simultaneously, sometimes folding back on itself to produce oblique expressions or even cause harm. This is what Martin et al. call care’s “darker side: its lack of innocence and the violence committed in its name” (2015, p. 627).

Beyond issues of theory, then, it matters in a material way whether Anita and Heather are deemed manipulators or not. In both cases, managed care companies reviewed their treatment progress on a semiweekly basis, assessing the degree to which they were proceeding along expected recovery trajectories. If they were not making satisfactory progress, their treatment coverage could be terminated. Critical to this expected progress, according the Cedar Grove treatment plan document, was evidence that the patient “has insight into her illness and how it functions in her interpersonal relationships.” Manipulative behavior was considered to be categorical evidence that clients were *not* reaching this goal. Clinicians, ultimately, were the arbiters of this issue, and had to weigh what they observed in daily practice against what they knew of a patient, inferring what they thought her motivation might be in any given situation. If a patient was seen to be chronically manipulative, with little insight into her “manipulative behaviors,” she could be forced out of treatment, either by the termination of insurance benefits or by the clinic asking her to leave. The logics of care in this setting, then, perpetuate a paradoxical rending of clients’ agency that, in turn, constitutes care as a continually shifting, mutable, and elusive goal.

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Notes

1. All names are pseudonyms.
2. Much of the anthropological research on eating disorders over the past decade has grappled, either explicitly or implicitly, with ontological questions (e.g., Anderson-Fye, 2004; Becker, 2007; Eli, 2014b; Gooldin, 2008; Gremillion, 2003; Lester 2007, 2009, 2014; Pike & Borovoy, 2004; Shohet, 2007; Warin, 2009). In each of these cases, we see how scholars explicitly and intentionally trouble assumptions about what constitutes eating disorders, reconsidering them as not only culturally and socially, but *interpersonally* enacted through practices of diagnosis, treatment, and daily living.

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