

## How Do I Code for Black Fingernail Polish? Finding the Missing Adolescent in Managed Mental Health Care

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**Abstract** In this article, I examine clinical dilemmas in treating adolescents with eating disorders under the U.S. managed healthcare system. Managed care is built on a rational choice model of human behavior with little room for considering developmental processes. In this model, adolescents figure as little more than failed adults. This poses significant problems: if treatment providers prioritize developmental issues over quantifiable behavioral milestones, they risk jeopardizing continued coverage for their clients. If they prioritize quantifiable behavioral change without attending to underlying developmental concerns, they risk not affecting lasting change. Through a case study of a client in treatment for an eating disorder, I illustrate how this dilemma frames everyday encounters and negatively impacts client care, while at the same time missing developmentally meaningful opportunities for healing. An outline for a proposed applied psychiatric anthropology is presented, together with specific recommendations for adolescent mental health policy, research, and practice. [applied psychiatric anthropology, mental health, managed care, adolescence, eating disorders]

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Managed care is currently the dominant mechanism for health service delivery in the United States. 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 to maximize economic profit and minimize loss. To do this, managed care organizations such as Blue Cross, Aetna, and UnitedHealthcare contract with hospitals and providers to offer services to subscribers at reduced costs; what Donald (2001:427) calls “the Wal-Marting of American psychiatry.” Clinicians often find themselves torn between following protocols that ensure continued coverage, versus providing what they feel would be the best care practices for that client (Feldman with Novack and Gracely 1998; Hall and Berenson 1998; Ulrich et al. 2006; Weinstein 2001). In this article, I consider some of the special challenges this creates for adolescents in treatment for a mental health condition.

Why focus on adolescent mental health treatment? I do so with both theoretical and practical aims in mind. First, both “adolescence” and “mental illness” operate at the margins of our current health care regime that privileges (and works to constitute) a particular kind of subject-agent: the healthy, rational, autonomous adult (Lester 2009).<sup>1</sup> Examining policies and practices about adolescent mental health can thereby throw into relief the (il)logics of this system and the ideological and practical gaps it produces.

But considering adolescent mental health care in the United States is of far more import than mere ideological exercise. Studies have shown that half of all lifetime cases of mental illness begin by age 14 (Kessler et al. 2005). Twenty percent of U.S. children and adolescents have a diagnosable mental or emotional illness (U.S. Department of Health and Human Services 1999), yet a full 80 percent go without needed treatment (Kataoka et al. 2002). In addition to ethnicity and insurance status as complicating factors, discriminatory coverage, such as limiting the number of inpatient and outpatient visits for this age group, and higher copays and deductibles for children and adolescents render it difficult even for those with insurance who do seek treatment to receive adequate care (Hughes and Luft 1998). On top of such structural barriers to care, these estimated 12 million youth with a psychiatric disorder (six million with serious psychiatric conditions) are in a transition from adolescence to adulthood, a life stage characterized by rapid and profound changes in biology and self-experience.<sup>2</sup> They are therefore struggling with the regular developmental challenges most adolescents face while also trying to manage the day-to-day difficulties of living with a mental illness.

### **Managed Care and Developmental Processes**

The structure, philosophy, and delivery of managed mental health care render attending to developmental concerns highly problematic. In her ethnography of U.S. psychiatrists-in-training, Luhrmann (2000) considers the emergent subject of managed care as enabled by the bifurcation of contemporary psychiatry into “biomedical” and “psychodynamic” approaches as a legacy of the Cartesian division between body and mind. She argues that managed care and biological approaches are aligned, because both rely on similar understandings of mental “disease” as something separable from the person him or herself. This leads, she says, to ways of evaluating of human suffering that sit in stark contrast with those enfolded in more psychodynamic or developmental approaches. We might say, then, that managed care approaches and developmental approaches constitute contrasting subjects of care.

The subject (regardless of age) of managed mental health care is generally evaluated according to adult standards, is assumed to be operating with a rational choice orientation to the world, and is presumed to be relatively stable across contexts (Lester 2009). Mental illness is generally viewed by managed care companies as episodic cognitive-behavioral dysfunctions essentially resolved once the symptoms abate (Belkin 2003; Luhrmann 2000). Interventions, then, are largely behaviorally focused and time limited, and clinicians are figured as little more than technicians who implement evidence-based practices (Belkin 2003). In this model, adolescents figure as little more than failed rational adults. The result, as Maryann Davis notes, is that treatments are often “guided more by bureaucratic constraints than by young people’s developmental needs” (2003:496).

Viewed from a more developmental perspective, however, adolescents are in the middle of a difficult, but temporary, life stage, characterized by uncertainty, change, and self-exploration. They are undergoing changes in every area of biopsychosocial development, including

cognitive, emotional, sexual, moral, and identity formation (e.g., Damon and Lerner 2008). Mental illness from this perspective is inseparable from this broader developmental process, as a whole-person condition, rather than as a discrete, isolable disease.<sup>3</sup> Interventions built on developmental frameworks tend to be grounded in interpersonal connections, with therapists figured as specialists who act as mentors through the recovery process (e.g., Heyman et al. 2007).

The contrasts between these ways of figuring the subject of care in adolescent mental health treatment—as failed rational adult or as developing person-in-transition—pose significant challenges for mental health practitioners (Rosenberg and DeMaso 2008). If they prioritize developmental issues over quantifiable behavioral milestones, they risk jeopardizing continued coverage for their clients. Yet if they prioritize quantifiable behavioral change without attending to underlying developmental concerns, they risk not affecting lasting change. They may even feel they are setting their clients up for failure. And this may be true (M. Davis 2003).

## **Toward an Applied Psychiatric Anthropology**

Attending to the real-life consequences of the marginalization of both mental health and developmental concerns in the U.S. health care environment has urgent implications that reach far beyond anthropology's tradition of nondirective study. It calls for what I term an *applied psychiatric anthropology* that bridges research, policy, and engaged clinical practice. Applied psychiatric anthropology, as I introduce it here, is a person-centered approach (Levy and Hollan 1998) integrated with a critical systems perspective (Graham 1999) that is concerned with alleviating psychic distress and optimizing locally meaningful forms of care. It requires a thorough knowledge and facility with local clinical diagnoses, terms, policies, institutional structures, and treatment techniques as well as proficiency in ethnographic methods, including (but not limited to) participant-observation, person-centered interviewing, discourse analysis, network analysis, case study techniques, phenomenology, and grounded theory. As an integration of (1) anthropological theory and methods with (2) active clinical mental health practice and (3) critically engaged policy advocacy, applied psychiatric anthropology builds on critical medical anthropology's concern with identifying and critiquing knowledge/power structures in the generation of medical truths (e.g., Scheper-Hughes 1993; Biehl 2005, 2007; Bourgois and Schonberg 2009) and clinical ethnography's focus on the mutual application of ethnographic and psychiatric frameworks (Herdt 1999; Levy and Hollan 1998; Luhrmann 2004). It extends these projects by linking research and practice to policy advocacy and political action. This is arguably a controversial positioning within academic anthropology, but one that is in step with other trends within our field such as critically engaged anthropology, applied anthropology, and public anthropology (e.g., D. Davis 2003; Rylko-Bauer et al. 2006; Sanjek 2004). What makes applied psychiatric anthropology different from these other endeavors is that it focus specifically on issues pertaining to mental health and illness and requires expertise in local clinical systems and practices.

The movement of some areas of anthropology toward more proactive public engagements reflects ethical debates within the broader discipline. As anthropologists, we often bear witness to terrible suffering—to basic needs denied, broken lives untended, inequities, and violence unvindicated. What are the implications of our work beyond the academy? What kinds of impacts can we have—or not—in the structural systems that constrain and condition people's lives? What is our role as witnesses to inequity and suffering? Our disciplinary tradition offers us some scaffolding for dealing with such quandaries by urging cultural relativism and nondirective research. But anthropologists have found this increasingly unsatisfactory and have strained against injunctions to remain dispassionate observers of the grassroots struggles of the people we work with. Yet how, exactly, to become involved—to what extent, in what ways, and to what ends—remains an open question. The task of translating anthropology's often confounding tendencies (things are always more complicated than they seem) into policymakers' bullet-point fact sheets is no easy feat, and requires a concerted reskilling among scholars interested in this sort of practice I offer the following case study as a preliminary example of why such linkages and translations are so critical and how they might be forged.

### **Case Example: Carly**

My ethnographic work over the past 15 years has focused primarily on adolescent girls and young women in crisis and in pursuit of healing (Lester 2005, 2007, 2009; Zayas et al. 2005). I am particularly interested in how individuals engage with institutional processes that purport to “cure” them. In addition to being an anthropologist, I am a licensed clinician and work primarily with eating disorder clients. Over the past seven years I have been involved in ethnographic research and clinical work at a private eating disorder clinic in the U.S. Midwest, which I call Cedar Grove. It was there that I met Carly.

Carly was 19 years old the summer I met her. She is petite at 5'2” with long blonde hair, brown eyes, and a pronounced southern accent. She had come to Cedar Grove from a small southern town where she had moved back home with her mother and maternal grandparents after having dropped out of college. Carly became a therapy client of mine and,<sup>4</sup> as we worked together over the next year and a half, I watched her variously struggle, improve, relapse, and try again. As I write this, she is in a full relapse. The outcome of her story is as yet unclear.

Carly traced the origins of her eating disorder to conflicts with girlfriends during her senior year in high school. She had been friends with the same circle of girls since preschool, but she said that when she began earning awards and scholarships and serving as student council president, they had “turned against her” and wanted to “bring her down.” As is common among many U.S. adolescent girls, this tectonic shift in allegiances was spread with a veneer of civility and niceness that adds layers of complexity to every interaction. In keeping up the appearances of friendships, Carly ate lunch with this group of girls every day and endured (as she represents it) a mounting litany of subtle barbs and backhanded compliments and

jokes at her expense. She began to find it physically hard to eat. “I would just sit there with my lunch and I would stare at it,” she told me. “I had this horrible gnawing feeling in my stomach, like an animal was eating me from the inside or something. It was awful. And I just couldn’t eat. I literally couldn’t.” Carly began to lose weight. She dropped about 15 pounds in two months, which was dramatic on her petite frame. She loved the changes in her body and began to consciously restrict her intake to lose more weight. Teachers and coaches and parents of friends began to express concern. Carly’s mother took her to see a gastroenterologist. They could find nothing wrong.

The following fall, significantly underweight, Carly went off to college at a large southern state school. She participated in sorority rush and was invited to join the most prestigious sorority on campus. She relished the sorority girl persona and, even while in inpatient treatment, continued to wear T-shirts and shorts and flip-flops sporting her sorority letters and would doodle her sorority insignia during group therapies. At school, Carly’s weight kept dropping and her energy and motivation plummeted. She started having trouble getting to classes. She barely finished the fall semester before dropping out of school and moving back home. She continued to lose weight. Five pounds more. Seven pounds more. Ten pounds. By the spring, Carly’s mother had taken her to every doctor and every specialist within a 200-mile radius. Doctors began using words like “anorexia” and “psychiatric.” Finally, Carly’s mother became alarmed enough to seek out eating disorder treatment. “Nothing else had worked,” she told me, “and I was just at the end of my rope. I hoped that maybe y’all could fix her.” By the time she arrived at Cedar Grove, Carly weighed just 64 pounds and easily met the criteria for anorexia nervosa.

In addition to her low weight, Carly’s treatment was complicated in unexpected ways. First, Carly and her mom colluded in something like a shared hypochondriasis or an attenuated form of Munchausen’s. Beginning when Carly was a baby, and continuing through the time I met her, her mom took her to doctors and specialists regularly—sometimes as often as four or five times per week—for a variety of concerns: muscle pain, constipation, headaches, vague malaise. Although there was never any indication that Carly or her mom created these medical conditions (as is the case in Munchausen’s and Munchausen’s by proxy), it remains the case that Carly had dozens of tests, examinations, and procedures in her lifetime, without anything serious ever turning up. By the time she arrived at Cedar Grove, Carly had become proficient at medicalizing any sort of distress and reported feeling comforted and cared for in hospital and clinic settings. Her engagement with treatment, therefore, was multilayered.

Additionally, Carly and her mom were palpably enmeshed, even more so than is thought to be common among eating disorder clients (Dare et al. 1994). Most notably, they both spoke in the plural “we” when referring to themselves, even when alone (e.g., Carly might say something like, “We think I should make an appointment with Dr. Davis for tomorrow.” Mom might say something like, “We had a hard time sleeping last night”). Carly had great difficulty thinking or acting outside of reference to her mother.

Through the course of months of intensive therapy, Carly was gradually able to understand her anorexia as, at least in part, keeping her dependent on mom by taking adulthood off the table. Interestingly, though, Carly did not simply want to remain a child—she is very bright and has clear education and career ambitions. She tried to resolve this, we discovered, through a fairly ingenious process of essentially becoming geriatric at age 19. Because of her anorexia she had full osteoporosis. She had digestive problems that required daily medications. She had difficulties with her joints. Her hair was falling out. In short, she had the body of a 70-year-old woman. Through her illness, then, Carly did not necessarily want to stop developing all together; she just wanted to leapfrog over the adult stage, which, based on what she saw with her mom, entailed endless caretaking and self-sacrifice in the service of others.

Carly was torn, then, in terms of self-actualization. On the one hand, being different from others was dangerous; it brought rejection from her peers and threatened her intimacy with her mother. On the other hand, being “special,” at least in terms of being sick, kept others close to her and concerned for her well-being. The question of how to forge an independent identity outside of the sick role, however, completely confounded Carly.

## Case Discussion

If we look at Carly’s case, we can see how the markers of recovery scrutinized by most managed mental health plans (incl. Carly’s)—things like labs and vitals, weight gain, compliance with treatment, and discharge planning—would give a very limited picture of her situation. As it turns out, despite being on a very high calorie meal plan (over 4,000 calories per day) Carly gained weight extremely slowly, perhaps one-half to one pound per week, rather than the two to three pounds required by her insurance. Her blood work and vitals were fairly stable, which was actually a bad thing in terms of treatment because it meant that her insurance was more likely to discharge her sooner. Carly appeared very engaged in treatment and discharge planning, though rarely followed through on her commitments outside of the treatment context. In other words, from the point of view of her insurance company, Carly’s was “failing” treatment.

But Cedar Grove clinicians saw real recovery for Carly as entailing more than just weight gain and compliance.<sup>5</sup> For them, it also involved a process of identify clarification. They followed her weight and vitals and labs closely, but also were attuned to the subtle changes they saw occurring in Carly’s relationship with her mom: Was Carly able to state her needs directly to her mom in family session? Does Carly allow herself to become frustrated with her mom? Is mom getting better with setting clear limits, and upholding them? How well did Carly manage her anxiety while mom was away? Cedar Grove clinicians viewed changes in these areas, no matter how small, as Carly’s attempts to launch, to separate from her natal family, and to begin to build her own life. They had been aborted attempts to date, but they were viewed as attempts at something healthy nonetheless.

## Black Fingernail Polish

Then, one day, something happened. In therapy, Carly was working on recognizing the narrow scope of experience she allowed herself, and how she had tried to contort herself in infinite ways to fit others' expectations of her: Sorority girl. Dutiful daughter. Good Christian. Southern Belle. Carly had absolutely no idea what she really wanted for herself, but she knew how to follow the rules of these roles so that she could feel safe.

Imagine my surprise, then, when Carly—sorority girl, pastel-wearing, ribbon tied around her ponytail Carly—came into session one day sporting black fingernail polish. I noticed it right away, but didn't remark on it. She brought it up. "Rebecca, I don't know what got into me!" she said with her eyes wide, holding out her hands for me to see:

I stopped at Walgreens on the way back to the hotel, and all I could think about was black fingernail polish! Oh my gosh! I walked up and down that aisle like 5 times, trying to decide if I should buy it. I even made myself go over to the other side of the store and pick up the other things I needed. I planned to head straight for the check out, but before I knew it, there I was again! Back in front of that nail polish! So I grabbed one and quickly paid for it. When I got back to the hotel, I set it on the bedside table and just stared at it for about an hour. Should I? Shouldn't I? Finally, I decided to just do it. It felt so good!! I really like it! When I talked to my mom on the phone that night I told her about it and she FREAKED! "Carly!" she said. "What's gotten into you?!?" "I don't know, mom!" I told her, but I said I liked it and was leaving it on. I'll probably have to take it off before she comes back here next week. But oh well. I can enjoy it until then!

I made an observation about how great it was that she was exploring new ways of expressing herself. "Well," she said with a hint of a smile. "Not *completely* new. I *did* get the kind with sparkles in it."

This seemingly minor incident was the single most encouraging thing I had seen from Carly in the time I had known her. This was a young woman who, just months earlier, could not even conceive of a life or a worldview outside of the one she and her mother had crafted. She was so welded to the southern sorority girl identity that she would not even let herself test other waters. Yet here she was, wearing black fingernail polish, and enjoying it. To me, and to the other clinicians at Cedar Grove, this indicated that something, indeed, was shifting for Carly and that she was taking small—infinately small—steps toward discovering her own sense of self.

This is not, however, the kind of information insurance companies tend to find particularly relevant. "It's not enough," the insurance case manager told me when I tried to advocate for further coverage by sharing the black fingernail polish story. "It doesn't mean anything if she's not gaining weight." Overall, they felt she was not using treatment effectively and denied further coverage.



## **(Mis)Translations**

In my experience, these kinds of things happen regularly with adolescents in treatment. They make apparently small changes—like being more engaged in group therapy sessions, socializing with the other clients, asking staff for something they need, when before they would have just gone without—that suggest deeper developmental shifts. Yet there is no way to effectively translate these kinds of everyday victories into the language the insurance companies find relevant. Although insurance case managers might be personally heartened by such things, ultimately their decisions are constrained by numbers and diagnostic codes and quantitative thresholds. How does one code for black fingernail polish?

This mismatch regarding indicators of recovery is a problem across the U.S. mental health system, not just in working with eating disorder clients.<sup>6</sup> Because managed mental health operates with an implicit model of rational adulthood as the measure of health, the developmental challenges of adolescent clients are left largely unengaged. Not only does this mean that serious problems may be missed but also, as in Carly's case, that we risk foreclosing points of leverage for change.

## **Anthropology in the Public Realm**

Anthropologists have expertise in understanding human social processes. We are adept at conceptualizing and analyzing group dynamics and we are practiced at understanding how everyday social interactions are deeply inflected with social and cultural meanings far beyond the particular issue at hand. We study how systems work, how change happens, how people and groups make meaning, and how these meanings generate material effects.

One point of engagement for anthropologists, then, is to use our expertise to demonstrate, with the kinds of richly textured accounts that only ethnography can provide, the specific mechanisms through which systemic and structural processes like the ones I've described here not only produce barriers to mental health but can also propagate mental illness. We can use our expertise and experience to offer concrete, grounded recommendations for change; but only if we thoroughly understand and can work productively within local clinical realities. We must approach clinicians, legislators, and other social actors (yes, even managed care executives) with the same kinds of respect and inquisitive openness we would bring to any other field setting. We must be willing to assume, until conclusively demonstrated otherwise, that people are doing the best they can with what they've got.

Orienting to clinical and policy worlds from a stance of engaged curiosity will get us much farther than lobbying incisive critiques from privileged positions of academic superiority. This kind of dialectical movement between understanding and appreciating current systemic and individual conditions that sustain illness, and working toward changes to alleviate psychic distress and optimize care, is the foundation of applied psychiatric anthropology. Specifically, applied psychiatric anthropology attends to the mechanisms through which people and systems interact across domains, what goes wrong, and what might help make it better.



In Carly's case, for example, we can see how a mismatch between markers of recovery (themselves tied to broader social and economic contingencies) led to the early termination of care when she was, in fact, making important developmental strides. This observation would not surprise the Cedar Grove clinicians who deal with this sort of thing everyday and have become resigned to offering suboptimal care. Nor would it surprise the managed care representatives who also know this happens but generally regard it as an unfortunate consequence of a healthcare system that, on the whole, benefits more people than it hurts. Interestingly, Carly's story did surprise many state legislators and policymakers who heard it. Most found it appalling but could not envision a solution that could withstand objections by the insurance company lobby. Applied psychiatric anthropology requires understanding not only each different stakeholder's point of view but also bringing an informed, critical eye to how the relationships among them function (or dysfunction) to produce material effects. This then enables us to pinpoint specific areas of difficulty and to recommend steps to meet those challenges.

In the case of adolescent health, for example, we can identify four broad areas of concern: insurance parity, markers of recovery, service coordination, and family involvement.

First, despite recent advancements in mental health parity, the fact remains that mental health benefits are generally managed separately from medical benefits. And once an illness has been deemed "psychiatric," medical benefits are no longer available for anything deemed to result from a psychiatric issue. This is of particular concern when treating developing adolescents, many of whom need specialized medical attention in the course of mental health treatment. Not getting that care leads to increased risk of long-term health effects and increased severity and chronicity of mental health concerns (e.g., Lee and Jonson-Reid 2009). Given this, clients should be able to access both mental health and medical benefits in the course of treatment, either consecutively or concurrently. Furthermore, coverage, with parity (in terms of financial limits, but also in terms of office visits and treatment days, regardless of the person's age), should be available across the treatment spectrum. In Carly's case, the lack of these supports significantly extended the duration of her illness, as she often had to tack back and forth between medical units (where her food intake was not supervised and she received no psychotherapy support) and the eating disorder clinic.

Second, because those interventions covered by managed care tend to focus on behavioral markers, rather than on developmental process, treatments are often truncated, effectively precluding adequate treatment for adolescents (e.g., Case et al. 2007). We need continued, interdisciplinary research on the long-term trajectories of recovery to help us revise expectations of treatment. This should include building in time for adequate assessments, treatment planning, and discharge coordination. If we at Cedar Grove had been able to provide the managed care company with reliable data supporting our assertions that Carly was making progress despite her lack of weight gain, we might have been better able to argue her case. Because we could not do this, at least not with enough heft to counterbalance the data regarding quantifiable behavioral and medical indicators, our objections to the insurance companies fell flat.

Third, poor service coordination among treatment contexts, family, and community resources also makes effective treatments for adolescents difficult (Wright et al. 2006). Even if they do get adequate care while in treatment, many adolescent clients are discharged back into situations that are not conducive to recovery. Resource coordination after discharge should mean more than simply setting up an outpatient team, which is fairly standard practice. Having an outpatient team in place certainly does not mean that clients will make use of them. This could be for any number of reasons. If adolescents depend on parents for rides to appointments or, as in Carly's case, have to drive long distances for care, the probability of receiving necessary outpatient supports dwindles.<sup>7</sup>

Going off to college, or returning to school after treatment, are also vulnerable junctures, as adolescents must create new treatment teams in new (and possibly unfamiliar) settings, and then try to coordinate information sharing, recommendations, and treatments between teams at school and at home. For adolescents ambivalent about treatment, this can be an opportunity to avoid oversight and follow-through. For those who are invested in treatment, it can be frustrating and obstructive to care.

Still dependent on others, adolescents often have very little recourse for affecting systemic change. As we have seen in the case of Carly, putting parents in charge of adolescents' care is not always in the adolescents' best interest. Nor do most parents, no matter how invested they might be to their child's recovery, have the skills and know-how necessary to manage an interdisciplinary treatment team. As a result, many adolescents—even those who are motivated for recovery—have a very difficult time building successful and sustained outpatient support. Better connections and communications among the various caregivers in an adolescent's life provide a safer and more stable environment for recovery (Ivanova and Israel 2006). A reliable, third-party point person should be responsible for ensuring that all these pieces are assembled, that clients are receiving the services they need, and that different arms of intervention are talking to each other.

And finally, because of cost concerns, managed care companies are increasingly advocating for family-based treatments for adolescents. These approaches seek to transpose inpatient or residential treatment structures and modalities from the hospital or clinic into the family home. In the case of anorexia, for example, Lock and colleagues (2001) advocate training parents to become surrogate treatment staff within the home. Parents are mentored in how to take charge of their child's eating disorder and refeed her back to a healthy weight. They do so by creating a strong parental alliance and focusing treatment entirely on the symptom (their child's food refusal), rather than the underlying issues or concerns that might be driving the behavior. Parents take over all food choices and eating options from the child and (in theory) dispassionately remove any options for her noncompliance. This sort of approach can save the family the cost of residential or inpatient treatment and has shown to have effective short-term outcomes (Loeb et al. 2007).<sup>8</sup>

Although such interventions may certainly sound appealing (and can be successful for some conditions in some circumstances; see O'Leary et al. 2009), in my experience, this approach

as currently executed places too great a burden on families in crisis, while at the same time reinforcing the notion that the pathology exists within the adolescent alone (vs. as an outgrowth of problems in the family system). We must involve families in recovery by helping them “develop capacity,” rather than simply expecting parents to assume the mantle of service providers to their children (Flynn 2005). Think, for example, of the complications that would arise from asking Carly’s mother, as well-meaning as she may be, to be in charge of her recovery. To this end, treatment programs should have access to protected benefits aimed at developing family training and capacity building programs.

## Staking Claims

As we can see in this discussion of Carly’s case, applied psychiatric anthropology requires committing oneself to statements about “better” and “worse” practices and outcomes. This is unusual for anthropology, and it requires a thorough consideration of the kinds of risks we are willing to assume in the course of our work. At the most fundamental level, this means something as simple (and as complicated) as taking a stance. Staking such claims is, of course, easier for those of us who are tenured or well-positioned within our local institutional worlds. It is much less so for those in junior positions, and this is important to remember. But if we take seriously our role of bearing witness to suffering, we cannot just stop there. Anthropologists must be willing to do something with what we see, even at the risk of personal or professional discomfort or insecurity. Applied psychiatric anthropology does not mandate any particular political stance or degree of personal involvement or risk. But it does require that we translate our research into some sort of action in the real world.

This can take any number of forms. To give just one example, in 2008, I testified in front of a Missouri State House Committee on Health Care. I told them much of what is contained in this article and presented them with additional findings from my research about the consequences of managed care restrictions for eating disorders. This testimony was in regard to proposed legislation that would require managed care companies in Missouri to use the American Psychiatric Association guidelines in determining “medical necessity” for eating disorders treatment (rather than developing their own, which they are currently permitted to do). It would also require that insurance companies abide by APA parameters of standards of care for these illnesses, as is standard for other conditions. Representatives of various managed care companies were present at the hearing as well, and provided testimony as to why they should not be required to make these changes. The main argument was that eating disorders are costly to treat and that these changes would create an undue financial burden on the insurance companies. One speaker, apparently unmindful of the irony, then proceeded to note that people could always take second mortgages on their homes to pay for treatment if necessary. That year, no policies were changed.

I was invited back again during the next legislative session and made the rounds to the legislative committees. In addition to requesting the same policy changes as before, this

time the proposed legislation also asked the state to supply funds for the development of an eating disorders prevention curriculum for educators in the state. I recently heard that the resources for the curriculum were approved, but the policy changes were not.

I will continue to advocate for legislative change on insurance coverage for eating disorders in Missouri (and beyond), educating lawmakers and others about the issues at stake and providing my research findings from Carly's case and dozens others like her. Whether my work will contribute to any sort of significant policy change, I don't know. The process is slow, slogging, and often disheartening. What I do know, however, is that my testimonies were the beginning of a conversation, and one way of asserting the legitimacy and value of what we do as ethnographers in the public realm. If nothing else, those legislators and the other people who heard my testimonies now know what ethnography is and what anthropologists do. Since then, I have been contacted by media outlets, local politicians, and community members interested in learning more about anthropology, as well as by mental health facilities looking to involve ethnographers in program development and evaluation. This is, I hope, indicative of a broadening understanding of what anthropology can offer to current debates of wide social import.

To make these kinds of opportunities count, however, anthropologists need to learn to speak the languages of public policy and clinical cultures as well as to productively communicate research questions, methods, and findings in terms that are more easily digestible to the general public. This does not mean we have to relinquish our intellectual pursuits. Rather, it requires that anthropologists develop additional skill sets for translating what we do well (understanding complex social contexts and how people navigate within them) into terms others can readily understand and appreciate. In my experience, legislators and policymakers are, on the whole, well-educated, intelligent people who genuinely wish to serve the public good. They are also saturated with information and are lobbied all day long by people seeking their support and influence for any number of projects, proposals, and initiatives. Similarly, clinicians are generally eager to make their services better, make their patients happier, and improve health outcomes. But they, too, are often stretched to the limit, pulled in multiple directions by patient needs, administrative tasks, emergency calls, and insurance appeals. Until anthropologists become adept at making the 60-second elevator pitch about what we do, why it matters, and how it can specifically benefit someone else, we will be left out of conversations in which we, as purported specialists in human social interaction, have a vested stake.

This sort of cultural translation is not generally part of graduate training in our discipline. In fact, we often spend our graduate school years learning how to make our ideas sound progressively more complex, not less so. Unlearning this style of presentation is challenging. It is more challenging still to learn to code-switch depending on the audience. Certainly, individual anthropologists have been doing this for decades with varying degrees of success. But as a profession, we have been less attentive to how to systematically cultivate these skills as we seek a clearer and more solid public voice. Conferences such as the one that inspired the series of articles developed here provide rich and fruitful opportunities for the very sorts

of interdisciplinary and extramural dialogue needed to help anthropologists stretch past conventional limits, build new alliances, and get to work.<sup>9</sup>

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## Notes

1. Gaines (1992) argues that U.S. psychiatric epistemology that works in concert with managed care priorities, construes this healthy subject as, specifically, Germanic, Protestant, and male.
2. The anthropological literature on adolescence is vast and varied, and broad claims about “adolescent development” must be made with caution. It is clear that social and cultural forces can dramatically shape human developmental trajectories (e.g., Anderson-Fye 2003; Brown and Larson 2002; Whiting et al. 1986). Nevertheless, the hormonal, neurological, and physiological changes that occur during puberty suggest it is reasonable to identify adolescence (as a loosely bounded, socially patterned life process) as a time of profound transition (Erikson 1968; Spear 2003).
3. This perspective is consistent with the ecocultural approach pioneered by John and Beatrice Whiting (1975) and further developed by LeVine (1988), Rogoff (1990), and Weisner (1997, 2002), among others. Ecocultural theory views children’s development as a process of continual, reciprocal interactions between universal human biological substrates and a child’s particular interpersonal, emotional, psychological, physical, and moral environments. Ecocultural theory locates these adaptive processes in everyday forms of activity through which children are scaffolded by others in learning locally valued modes of being.
4. Washington University’s IRB does not require research consent for the use of case study information obtained in the course of providing clinical services (as long as identifying information is changed) because this provision is part of standard treatment contracts. However, as an anthropologist, I felt it was important to do so. I obtained separate signed consents from all clients I worked with at the clinic to use deidentified information from our sessions in teaching, publishing, and other scholarly activities.
5. Carly’s treatment team consisted of myself (as therapist), a psychiatrist, an adolescent medicine specialist, and a dietician, with input from nursing and online staff.
6. Although I do not think this kind of slippage is isolated to eating disorders, I do believe that the fact that Carly had anorexia and not another psychiatric condition was relevant. Schizophrenia, bipolar disorder, major depression, and other mental illnesses that are widely accepted as biological in origin seem to elicit greater accommodations by insurance companies in terms of patient compliance. Compliance and progress are still important, of course, but noncompliance in these more “organic” conditions is more commonly viewed as part of the illness itself as opposed to outright willful resistance. In Carly’s case, even though she was, in fact, largely compliant, her lack of weight gain led the insurance company to doubt her motivation for recovery.
7. She had to drive over an hour in one direction to see her therapist, 45 minutes in another direction to see her dietician, and almost an hour in yet another direction to see her psychiatrist. It is hardly surprising that this was not sustainable for very long.
8. The longer-term outcomes of such interventions on both symptomatology and family function are less clear.
9. New Directions in Policy-Relevant Research on Adolescence: Perspectives from Psychological Anthropology conference, Case Western Reserve University, Cleveland, Ohio, November 7–8, 2008.

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