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Self-governance, psychotherapy, and the subject of managed care:

Internal Family Systems therapy and the multiple self in a US eating-disorders treatment center

ABSTRACT

"The self" has seen a surprising resurgence in recent anthropological theorizing, revitalizing interest in whether and how it can be studied ethnographically. These issues are brought to the fore by a newly popular psychotherapy technique, Internal Family Systems therapy (IFS), as practiced in a US eating-disorders clinic. There, clinicians and clients negotiate tensions between this model's understanding of a multiple, refracted self and managed-care companies' insistence on personal responsibility. In considering the moral and pragmatic work of IFS in the clinic, a new critical anthropology of selfhood illuminates the vectors through which economic and political commitments become imbricated in the self. They do so in ways that resist both psychologism and subjectivism while holding them in productive—albeit sometimes troubling—tension. [*eating disorders, managed care, anorexia, self, neoliberalism, psychotherapy, United States*]

Internal Family Systems therapy (IFS), a psychotherapy technique developed in the 1980s by psychologist Richard Schwartz, is increasingly popular in the United States for treating personality disorders, mood disorders, and eating disorders. The theory behind IFS is unusual among US therapies in that it envisions "the self" as a dynamic, evolving, adapting, and open system of subpersonalities or "parts" that operate in ever-changing relationships with one another and the outside world. The self in IFS is not a singular or bounded thing but, rather, a *process* that emerges from a complex of internal relationships among constantly changing "parts." Agency, accordingly, is not localized within a fixed, singular core but is distributed and mutable, shifting among different subpersonalities depending on the setting, circumstances, and interactions at hand. This figuring of the self and agency has profound implications for how IFS practitioners understand and treat psychopathology.

Three aspects of IFS merit anthropological attention. First, the model's recent surge in popularity in the United States might tell us something about the clinicians and clients to whom it appeals, especially in the context of health-care policy reform. Second, the process of becoming an IFS therapist (which is both lengthy and expensive) speaks to the convergence of structures of care and structures of finance, as therapists are obliged to become "therapreneurs"—continually pursuing additional trainings, new certifications, and new specializations so that they can offer more marketable niche treatments. Third, the everyday practice of IFS foregrounds questions about how selves are locally enacted and understood within competing models of moral responsibility.

Engaging with IFS, I ask two sets of questions: ethnographic and theoretical. The ethnographic questions are, how do tensions between the IFS model of distributed agency and the managed-care emphasis on personal responsibility unfurl in everyday practice? What might these tensions tell us about how economic processes shape understandings of psychiatric

distress? And what might they tell us about how both clinicians and clients innovate and work around constraints in the system? The theoretical questions are, can we place the self at the center of ethnographic inquiry? Under what circumstances, and for what kinds of questions, might focusing on the self be not only desirable but also necessary? In bringing these ethnographic and theoretical questions together, I seek to bridge points of disagreement between those anthropologists who explicitly engage the self as an ethnographic analytic and those who view such engagements as epistemologically problematic.

Black boxes and sensual surfaces: Theorizing the self

Historically, the term *self* in US anthropological scholarship has been used, following Western philosophical traditions, to denote a person's essential being, a center of agency and intentionality, and the subject of one's existence (Hallowell 1955). Beginning in the 1970s, however, many cultural anthropologists turned away from discussing the self, explicitly rejecting such questions as outside the purview of anthropological inquiry (Geertz 1973). A primary reasoning for this was that the self cannot be directly observed and therefore cannot be studied ethnographically. But more than this, theoretical trends in anthropology problematized the very concept of the self as a very specific and even "peculiar" (Geertz 1984, 126) cultural convention unique to late modernity in the industrialized West. The very idea of a self, from this perspective, is an illusion, generated by interpellated discourses (Althusser 1971), habituated through everyday practice (Bourdieu 1977), created for the purposes of domination (Foucault 2006), or spawned as an ambivalent effect of power (Butler 1997). According to these views, those who purport to study the self as something real and knowable naively replicate Western cultural assumptions about human experience, and their findings are therefore epistemologically suspect.

Simply rejecting the self out of hand, however, produces a challenge of a different order: namely, where to stake claims about why people do what they do. Even those anthropologists who reject the self as a legitimate domain of anthropological study write about such issues as identity, belief, cultural change, violence, political power, imagination, agency, sexuality, gender, subjectivity, race, and neoliberalism, to name just a few. The ethnographic study of any of these topics involves, at the very least, working propositions about how cultural beliefs and values affect human experience and behavior, and how people perceive themselves in relationship to others and to the world. Although such propositions are not always explicitly identified as part of the analysis, how one thinks about, talks about, and theorizes them is critical. Often, this is the connective tissue that holds arguments together. When this

"how" and "why" of human behavior is not explicitly theorized, normative Western assumptions about self tend to accrue, and truisms about cognition, affect, intentionality, agency, and motivation often do this implicit theoretical work, replicating unmarked Western categories of the self even as scholars deliberately reject discussions of self as irrelevant (Lester 2011b).

Such challenges regarding whether and how to talk about the self are particularly evident in the emergent literature on neoliberal selfhood, in which a great deal of slippage occurs between the concepts of neoliberal subject and neoliberal self (e.g., Leshkovich 2014; Muehlebach 2013; Prentice 2012; Orta 2013). Although left undefined, *self* in these works seems to be figured as the action arm of neoliberal subjects in the human social world (Freeman 2014; Gershon 2011) in ways that are self-evident, though how and why this comes to be the case is left unexplored. Such slippages are not unique to these works and are ubiquitous in recent anthropological writing, which tends to link notions of the subject and the self, belying an implicit theorizing of self-making that requires more careful attention.

How, then, to talk about the self without assuming either a deep interior or a flattened surface, while allowing for aspects of either or both? I propose building on Deborah Battaglia's (1995) vision of *a critical anthropology of selfhood* in which the "proper subject is neither the self (as experienced) nor the 'self' (as culturally figured), but the *problematics of self-action*" (Battaglia 1995, 2; italics in the original). What I add to Battaglia's earlier project is that I am interested in the self as an *enactment*, in Annemarie Mol's (2002) sense of the term, that is, as constituted through practices, including embodied, dialogical, imaginative, interpersonal, and institutional practices. Such practices require one to reflexively engage with the question of who one is (and who one is *to others*) in the world. This differs from poststructuralist views of self, since it does not hinge on denying that there exists a core self. It also differs from traditional psychological theories, since it does not hinge on affirming that a core self *does* exist. This truth game is not of interest. Rather, a critical anthropology of selfhood, as I develop it here, focuses on how specific lived truths of self—however locally construed—emerge within the practices by which people come to know those truths. To understand how the self is lived, we must understand reflexive practices as both epistemological and ontological activities. In other words, researchers should not ask if there is a real self but should rather endeavor to identify the specific practices through which local understandings of self come to be experienced as real.¹

A critical anthropology of selfhood, then, accepts the lived reality of local understandings of selfhood without insisting on an essentialist view of self. Consistent with this approach, however, it does not disallow a "core self" as part of the lived reality of "self" for some people in

some contexts. From this perspective, we can study the self ethnographically, *even though* we cannot view it directly and *even though* the idea of an essential core self is but one culturally specific notion among many for describing human experience. What becomes interesting, then—and the focus of ethnographic study—is how reflexive practices generate affective currencies between lived experiences and local understandings of self, and the specific processes through which those currencies circulate and attain meaning.

IFS in US clinical eating-disorder practice offers a particularly apt opportunity for elucidating this approach. As I discuss in more detail below, the IFS model enables clinicians to make health-care decisions in an economic context where they are often prevented from delivering optimal care (Cohen 2006). Specifically, it opens ways for conceptualizing patients' moral responsibility that are not predicated on the rational-actor proposition enfolded in dominant psychiatric conceptualizations of health (Gaines 1992; Hacking 1986).² This is particularly useful in treating patients with eating disorders, who often appear conflicted about whether they want to get well (Vitousek, Watson, and Wilson 1998).

Yet despite the pragmatic advantages of IFS in cultivating a new "moral topography of self" (Taylor 1992, 111), the focus on the multiplicity of the self inadvertently primes the IFS model for co-optation by managed-care priorities. It thus functions as what Nikolas Rose terms a "consumption technology," in which individuals learn to narrativize their lives through ethics and techniques that together make "a virtuous liaison of happiness and profit" (1999, 86). The catalyst for this co-optation, I propose, is the resonance between managed-care economic models of the desirable consumer-subject and IFS's implicit morality of self-governance of self-multiplicity (Bondi 2005). As we will see, in a for-profit managed-care environment, successful recovery may be at least as much about helping clients develop appropriate economic subjectivities as about addressing serious mental-health concerns. In considering how this happens, we see how IFS offers an ethnographic instance of how economic policies of free-market consumerism, deregulation, and privatization become imbricated in the lived experiences of self in ways that not only resonate ideologically with orientations of personal "responsibilization" (Rose 1999) but also become deeply meaningful for individual actors. In this way, we can begin to bridge the epistemological and conceptual divides that characterize anthropological views regarding the self.

The clinical context

Cedar Grove is a nationally renowned private eating-disorders clinic in the US Midwest.³ Opened in 2001, the clinic treats anorexia nervosa, bulimia nervosa, binge

eating disorder, and other specific feeding and eating disorders (American Psychiatric Association 2013). It offers 24-hour residential care, partial-day programs, and outpatient programs. When I conducted my research, it had 12 residential beds and could accommodate 30 day-treatment and outpatient clients. Patients receive comprehensive psychiatric, medical, and psychological assessments before being admitted, and the specifics of a patient's treatment plan depend on the assessments as well as on the eating disorder's precipitating events and a patient's progress while in the program.

I conducted ethnographic fieldwork at Cedar Grove over a seven-year period, from 2002 to 2009. I attended and participated in group-therapy sessions, client meals, group outings, treatment-team meetings, team trainings, and supervisions, spent hundreds of hours of simply hanging out in the clinic, and interviewed clients, families, and staff. In addition to these standard ethnographic activities, I completed (during 2006 and 2007) a two-year clinical practicum at Cedar Grove in the course of receiving my master's degree in social work. During that time, I was responsible for running three weekly group-therapy sessions and carrying a full caseload of four residential-treatment clients. Working with these clients entailed conducting an intake assessment, 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, recording entries in medical charts 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 2007–9) to obtain my independent licensure, and my duties during that period 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 to ensure that proper research protocols were in place.

How can you be the right kind of patient when you're the wrong kind of sick?

Hope is hard to come by when treating eating disorders. They are the deadliest of all psychiatric conditions (Arcelus et al. 2011) and are more common than autism and more fatal than breast cancer (Smink, Van Hoeken, and Hoek 2012). Yet eating disorders also are the least covered in US managed-care health insurance companies, which see them as exceptionally bad for their bottom lines because they are expensive to treat and have high rates of relapse (Golden et al. 2003). Only a small fraction of insurance plans provide for the basic minimum eating-disorder treatments recommended by the American Psychiatric Association

(Fox, McManus, and Reichman 2003; Striegel-Moore et al. 2000), and patients are regularly discharged below minimum-weight recommendations, without necessary behavioral stabilization or support, or without adequate help to transition back to the community (Vandereycken 2003). These problems remain entrenched after the implementation in 2010 of the Affordable Care Act (colloquially known as Obamacare): a 2015 study found that 21 percent of insurance plans categorically excluded eating disorders from coverage, compared with only 5.9 percent that excluded autism and none that excluded drug and alcohol treatment (Horgan et al. 2015). Perhaps not surprisingly given this spotty care, eating disorders have an extremely high rate of relapse, reinforcing the perception that these conditions—and the people who develop them—resist treatment (Steinhausen 2009).

How insurance providers perceive patients affects what kind of coverage the patients receive. With the expansion of for-profit managed care in the United States in the 1990s, insurance companies developed a powerful, vested economic interest in minimizing the benefits used, regardless of how necessary or cost effective (Mulligan 2014). In short, the industry regulating the release of benefits is also the industry that profits most from withholding them. Under such priorities, insurance companies cultivate the “responsibilization” of the patient in a very particular way (Rose 1999). In this model, “good patients” (Lorber 1975) are those who are predictable, seek good health, and participate in their own recovery. They act to maximize health and minimize harm. They want to get better. They follow recommendations. They can get well. These patients are what we might call the “right” kind of sick in the managed-care framework—they are considered good investments of health-care funding. In the context of eating-disorders treatment, this means insurance companies look for clear evidence of progress in a patient’s capacity for self-governance and pro-health behaviors, as indicated by such things as regular and significant weight gain and compliance with program rules. In other words, patients’ capacity to act with “right intention”—their moral agency as manifested in these outcomes—is considered the barometer of whether they deserve further care and the release of additional benefits to pay for treatment.⁴ “Bad” or “difficult” patients are a different story. They may not want to get better. They might not comply with health-care providers’ directions, and they might even do things to exacerbate their conditions (Hahn 2001; Jackson and Kroenke 1999). These patients are the “wrong” kind of sick; they are poor economic investments. Health-care benefits, even if they exist, should not be “wasted” on such patients (Mulligan 2014).

For the US insurance industry, people with psychiatric concerns are, almost by definition, the “wrong” kind of sick (Haas et al. 2005). They frequently act in

unpredictable ways, may harm themselves, insist they are the messiah, or hoard animals. They might refuse to take their medications or accuse caregivers of trying to hurt them (Lester 2014). In fact, being flagrantly unpredictable and “irrational” is often a central part of what distinguishes them as ill (Luhmann 2000). Such concerns are pronounced with regard to eating-disorder patients, whom clinicians widely regard as among the most difficult populations to work with. This leads to a serious dilemma: how can you be the right kind of patient if you are the wrong kind of sick?

Given these conditions, clinicians at Cedar Grove must become what Marcia Angell calls “double agents” (1993, 279), constantly negotiating between the requirements outlined by insurance providers and locally derived understandings of what is needed for optimal client care. Clinicians spend much of their time trying to obtain treatment that insurance companies generally do not want to fund, for patients who often do not want it but who may desperately need it (Cohen, Marecek, and Gillham 2006). As Claire, 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.

Perhaps not surprisingly, job burnout among these professionals is exceptionally high (Warren et al. 2012).

In the context of for-profit managed care, then, eating-disorder patients are not only the wrong kind of sick but are also seen as bad patients (Giovanni et al. 2013; Kaplan and Garfinkel 1999). Becoming the right kind of patient when one has an eating disorder is almost a logical impossibility until treatment is effective and one is no longer a patient at all. This poses serious problems when patients’ perceived motivations for health have a gatekeeper effect in enabling or restricting their access to care (Lester 2009).

Shelly, for example, was 27 years old when she came to Cedar Grove for the third time. She was known to be a “highly difficult patient”; the past two times she had been at Cedar Grove, Shelly came to the clinic stating she wanted to get better but then proceeded to subvert the program

at every turn. She hid food so she would not have to eat it at mealtimes, only to binge on it and purge in the middle of the night. She hoarded artificial sweeteners (taken in large doses, they can have a laxative effect) and snuck in diet pills and laxatives in the lining of her makeup case. She found an area just out of view of the nurses' station where she could do jumping jacks without being seen. Although Cedar Grove clinicians recognized these behaviors as indicating that Shelly needed *more* treatment (not less), they were forced to discharge her after two weeks because her insurance company would not release any further benefits because of her "noncompliance."

How do clinicians understand their work with clients like Shelly? In brokering between managed-care company expectations and the lived reality of eating disorders, clinicians at Cedar Grove struggled to find ways of holding two truths about patients simultaneously: patients really are doing the very best they can to get better, *and* they are desperately clinging to their eating disorders and will fight recovery every step of the way. It was here that IFS seemed to become a useful tool within the clinic, albeit with unintended consequences. Specifically, IFS offers a way of thinking about patients' moral agency that enables clinicians to navigate the paradox about mental illness inherent in the managed-care system: how can you be the right kind of patient if you are the wrong kind of sick?

IFS: Multiple selves, systems theories, and society of the mind

Given Cedar Grove's emphasis on treatment practices that are state-of-the-art, evidence-based, and biomedically focused, I was surprised when I attended my first IFS group during my second month of fieldwork. I had never heard of IFS before, and as the therapist presented the outline of the model to the patients, I found myself perplexed. The IFS approach differed from everything I had seen or heard so far at the clinic, which until then had involved mostly discussions of weight changes, meal plans, and lab results. IFS is concerned with none of those things and, in fact, seemed to operate in a completely different discursive and pragmatic universe from the quantitative metrics of recovery I had until then observed. It even seemed at odds with the standard understandings of the mind in US psychiatry.

IFS

IFS understands the mind as a system of different subpersonalities, each with its own history, emotions, cognitions, and ways of interacting with the world. IFS calls these subpersonalities "parts"—"inner people of different ages, temperaments, talents, and desires, who together form an internal family or tribe" that organizes itself in the same ways other human systems do, and "reflects the

organization of the systems around them" (Schwartz 1995, 57). IFS holds that we each have an indeterminable number of these parts, which have developed out of idiosyncratic life experiences to help us adjust to and cope with different circumstances and events. These parts remain in our "self-systems" as functional clusters of thoughts, behaviors, affects, and abilities. This view, Schwartz says,

transports us from the conception of the human mind as a single unit to seeing it as a system of interacting minds. . . . [Once we make this shift,] the mind . . . becomes just a human system at one level, embedded within the human systems at many other levels. It can be understood with the same systemic principles and changed with the same systemic techniques. (1995, 17)

The task then becomes how to understand this inner society of mind as such a human system.

IFS acknowledges that most people do not experience themselves as systems of moving parts, but instead (at least in the postindustrial West) as mostly integrated and unitary, most of the time. This sense of integration—what is commonly called "the self"—is an illusion, according to IFS. It is a functional fantasy. It enables us to move through the world with some degree of coherence and organization, but it belies the fact that agency, moral responsibility, and interpersonal positioning continually shift among our inner parts rather than resting in any one place.⁵

IFS and distributed agency: Locating moral responsibility

If IFS understands the self as a system of subpersonalities that constantly shift and interact, where does IFS locate agency, or moral responsibility for one's actions? If the self is a distributed network of complex agents, who is in charge? This is critical for understanding how IFS helps clinicians figure eating-disorder clients as the right kind of patients even though they are the wrong kind of sick. This is no easy feat. How can someone demonstrate an intention to get well if she continues to hurt herself? It is here that IFS offers clinicians a way to reconcile complex issues of agency within the flattened agentive space of the managed-care system (Lester 2011a).

To understand this, we need to take a closer look at how IFS envisions "health." A healthy self-system in IFS is one in homeostasis, but this is different in critical ways from the notion of the "stable self" in US psychological models in that it can be accomplished in any number of ways through constantly shifting patterns of interactions among parts. The focus is not on maintaining the same parts in the same configurations, but rather on the *quality of communication and cooperation among the parts* at any given time. This is accomplished, according to IFS, by accessing energy available to all of us in the form of pure consciousness, called Self (capitalized and without the definite

article), which is quite different from standard Western understandings of the term.

Rather than standing as the core of one's unique individual identity, Self in IFS is more akin to the Buddhist concept of *anatta*, or "nonself," and is characterized precisely by a loss of boundaries and self-identification. Self in IFS is not a "part" but rather the absence of parts. All people have Self, the fundamental human spark with which we are all born. Schwartz describes Self as "both an individual and a state of consciousness, in the same way that quantum physics has demonstrated that light is both a particle and a wave. . . . It is the same Self, but in different states" (1995, 38). When in the wave state, Schwartz says, our waves can overlap with other people's waves, creating "a sense of ultimate commonality and compassion" (38).

The goal in IFS therapy is not to eradicate parts or to become pure Self but, rather, to become what is called Self-led, which means that Self can productively harness the energies of the parts and strategically invoke them in life. As Schwartz explained it in a training workshop for IFS therapists, Self functions in similar ways as the conductor of an orchestra, with the parts as the instrumental sections. In a given situation, Self might call on more strings, or more brass, or more drums, depending on what is needed. Or Self might quiet down one section so another can be heard. Self regulates tempo and tone and ensures that the orchestral performance—the lived experience of self—is collaborative, intelligible, and effective.

But sometimes parts can take over. In situations of perceived danger, parts "come forward" to manage the system, sometimes assuming extreme or overdeveloped roles:

It may be useful to compare a person's Self and parts to the functioning of a country. As another country threatens to attack, the president [Self] is moved to a special place of safety. . . . Civilians are sent to shelters, and the military [parts] takes over. If through the crisis the president stays calm, and provides the strength and comfort that leads to a satisfactory resolution of the crisis, then the trauma may increase the people's trust in their leader. If, however, the president cannot prevent the devastation of the country, the president loses credibility, and military leaders are likely to remain in power to protect and manage the country. (Schwartz 1995, 45)

According to IFS, this threat response, in which Self is taken out of the lead, can produce all sorts of conditions that we call psychiatric illnesses, including eating disorders.

IFS is clearly a cultural model of self in an explicit and direct way. Because IFS cannot be separated from the social, cultural, and economic meanings within which it emerged and within which it is clinically employed, it becomes an important source of ethnographic data. That is, rather than

dismissing "the self" of IFS as irrelevant to contemporary anthropological theorizing, it becomes richly instructive. How this model of self works in practical and pragmatic ways at Cedar Grove further illustrates this perspective.

Me, myself, and Ed

At Cedar Grove, clients learn through IFS to identify their eating disorder as a part or, rather, as an identifiable subsystem of other parts that hang together in something called an eating disorder. As a way of helping clients conceptualize this subsystem, clinicians personify it and give it a name: Ed. Ed, gendered male, is himself composed of many other parts—these may be self-critical parts, competitive parts, or parts that need approval or acceptance. Ed might have restricting, bingeing, exercising, or self-destructive parts. Ed can work to maintain homeostasis in the system by helping to regulate strong affect, and this is one of the main reasons it is believed that Ed has taken over leadership of a system in crisis.

But Ed becomes increasingly complicit in generating that dysregulation as well as alleviating it, thereby gaining more and more power. Clients learn to think of Ed as a partner in an abusive relationship (Schaefer and Rutledge 2003), and it is here that Ed's "masculinity" becomes especially relevant. He is portrayed as controlling and possessive, as wanting, clients learn, to dictate their every thought and action. He feeds you a constant string of lies to keep you dependent on him, they are told. He tells you that you are ugly and worthless and that you cannot exist without him, wearing you down so you cling ever more dependently to him. He punishes you if you stray, barraging you with abusive messages about how bad and disgusting and horrible you are. Above all, they learn, Ed is powerful, resilient, and entrenched. And he expects to be obeyed. In return, he promises acceptance and love and, above all, safety.

This framing of Ed as a part (with his own parts) within clients' self-systems complicates understandings of agency and moral responsibility for behaviors such as bingeing, purging, compulsive exercise, or calorie restriction. IFS stresses that it is not really the client herself (or, perhaps more accurately, not her Self) who does these things; it is her eating-disorder part. Ed drives them to yell, sulk, lie, or say they wished they could die. Clients learn that Ed is the one who has caused them to isolate themselves from friends, obsessively calculate calories, and cruise pro-anorexia websites. He is the one who pushes them to obsessively check their bodies in the mirror every morning for any sign of weight gain, to run for 10 miles every evening before hitting the gym for another two hours. He is the one who lures them to the scale for a verdict on their worth. Within treatment, Ed is the one who pushes people (like Shelly) to hide food, purge in secret, or do jumping jacks in the bathroom to burn extra calories. Ed makes people

mistrust the dietitian, keep secrets from their therapists, and feel jealous of the new patient who is so thin and weak she needs a wheelchair. Ed tells people to leave treatment because he misses them and loves them and is waiting for them with open arms.

In recovery through IFS, clients must first learn to distinguish Ed's agency from their own.⁶ Then they must gradually persuade him to relinquish power and to "step back" so Self can assume its role as rightful leader. This cannot be achieved by a coup. Clients are taught that they must persuade Ed to step back willingly. In other words, they have to cultivate an inner relationship with him that reverses the dynamics of power in the system and hopefully leads the client toward health.⁷

To better illustrate this process, I turn now to an account of an IFS group-therapy session at Cedar Grove, one of many dozens I attended (after obtaining consent) during the course of my research. I took detailed field notes directly after the group presented here and asked key participants to review my rendering for accuracy.

Encountering Ed: IFS in action

This group-therapy session used a technique known as "sculpting," aimed at helping clients externalize their inner states by enacting them visually. In sculpting, one client asks others in the group to act as stand-ins for various important people (father, mother, siblings, etc.) as well as key parts of the client's self-system. The group facilitator assists the client in talking to these different characters and exploring her relationships with them. In this way, clients learn to observe and interact with their internal psychological processes and their various parts as if they were interlocutors who were just as "real" (and complex) as the people in their lives.

To begin the group, Karen, the group therapist, gathered everyone into a large circle in the center of the room and asked for volunteers for the sculpting activity. After a few moments of awkward silence, Jill raised her hand. "Great!" said Karen. "Thank you, Jill. Now, let's start identifying your parts." Picking up a stack of index cards, a roll of tape, and a black marker that she had brought with her, Karen turned to Jill. "OK. We're going to sculpt your inner system. What we want to do is to get as accurate a representation as possible of what it *feels* like to be you, what your *experience* is. OK? There's no right or wrong here. *You* are going to tell us what it should look like. Now, where do you want to start?"

This last question was slightly disingenuous; Karen had premade an index card that said "ED" in bold black marker, and it was right on top of the pile. "I guess I'll start with Ed?" Jill said somewhat tentatively. "OK," said Karen. "Who would you like to play Ed?" Jill looked around the group, brow furrowed in thought. "Ummm . . . Molly?" Jill said.

Molly moved into the center of the circle with Jill and Karen. Karen taped the card labeled "ED" to Molly's chest.

"OK, Jill," said Karen, "where do you want to put Ed?" "Where do I *want* to put him?" asked Jill, perplexed. "I mean, where is he right now in your experience?" Karen clarified. "Like, does it feel like he's right up next to you, or maybe a few steps away? Is he in front of you facing you, or maybe behind you? It's really up to you. Again, there's no right or wrong. It's just how it best represents what it feels like inside."

"He would be right in front of me," said Jill. "Facing me." "OK," said Karen. Turning to Molly, she said, "Ed, you come here and stand right in front of Jill. As close as the two of you feel comfortable." Ed sidestepped over to stand about a foot away from Jill and looked directly at her. Jill appeared nervous and uncomfortable and avoided eye contact.

"Now, what kinds of things does Ed say to you?" Karen asked Jill. "He tells me I'm ugly and fat and disgusting. He tells me I'm selfish and lazy," Jill replied. "He says no one will ever love me. But if I'm thin, at least people won't be totally grossed out by me."

"Ed, now I want you to say those things to Jill. And remember, you're not you, you're Ed. So say them as if you're Ed."

"You're ugly and fat and disgusting!" Ed snarled. "You're selfish and you're lazy. No one is *ever* going to love you. At least if you're thin people won't be totally grossed out by you."

Jill visibly shuddered and looked pleadingly at Karen. "Did that sound about right?" Karen asked. "Oh yeah," said Jill. "Does it need to be louder, softer? Anything different?" "No," said Jill, "that was pretty much right on."

"OK," said Karen. "Who else is in this system? Who else should we put in here today?"

Jill identified her parents, who were pressuring her to leave treatment and go back to college, as well as a Good Girl part and a Hopelessness part. Once everyone was in place, Karen asked Jill to take a moment and sense if the sculpture felt right, if it mapped on well to her internal experience. "It does," said Jill, "except I think Good Girl and Hopelessness move around a lot. Sometimes they're right there behind Ed, kind of supporting him and beefing him up, but sometimes they're behind me, kind of next to my parents. And sometimes they're right up next to me, maybe on the sides or something."

"OK," said Karen. "Well, let's try putting the sculpture in motion, and you can always make changes as we go, OK?" Jill nodded. "So when I say go, I want each of you to speak the lines of your part and to move and act just as Jill told you to. Got it? OK. Go."

Jill's sculpture came alive. Her Parents, Ed, Good Girl, and Hopelessness began speaking their lines, all at the same time. Hopelessness and Good Girl slowly moved around as

they spoke, just as Jill described. For about 60 seconds, we all experienced part of Jill's inner world along with her. It was clamorous, and confusing and the negative messages seemed to hammer Jill from all sides. During the enactment, Jill went from turning her attention to one or the other parts to closing her eyes and sobbing softly. Clients observing the activity were riveted. Many had tears in their eyes.

Karen called a stop to the enactment. She checked in with Jill, asking her if that felt like it had captured something of her experience. "Oh, yeah," said Jill. "Wow. I didn't realize all of that was going on at the same time, but it is. It felt really suffocating, like it was all coming at me from the front, the back, the sides. And all of it was about how I'm not good enough, how I'm bad, how I'm unworthy. Wow. That's intense."

Karen asked all of Jill's parts except Ed to step way back, to the edge of the circle. Facing each other, Jill and Ed still avoided eye contact. "So now we're going to give you a chance to say something back, Jill," said Karen. She asked Ed move in even closer to Jill, to stand over her in a menacing way, almost directly in front of her, and to repeat the words Jill had indicated: "You're ugly and fat and disgusting! You're selfish and you're lazy! No one is *ever* going to love you! Why would they? At least if you're thin people won't be totally grossed out by you." As Ed spoke these words to her, Jill's eyes dropped and her head bowed. She curved in her shoulders. Karen asked Jill how she felt. The exchange went as follows:

Jill: Hopeless

Karen: Right, we know about Hopelessness. What else?

J: I feel like maybe he's right.

K: Yes, that's Good Girl, the one who wants to do things right and be accepted. What else?

J: Like I'm not worth anything.

K: What else?

J: I don't know.

K: Yes, you do. What else?

J: I don't *know*! [*becoming more on edge*]

K: You *do* know! How do you feel that Ed has made you feel so worthless? How do you feel that he's telling you you're ugly and disgusting?

J: [*mumbling*] I hate it.

K: Say more.

J: I *hate* it. I *hate* feeling so bad about myself all the time, like I'm not worth anything, like I'm gross and disgusting and unlovable. I hate feeling like I have to work so hard just to not be repulsive to people, just to be *normal*. It's exhausting and I hate it.

K: That's right! [*Steps a bit closer to Jill so she was just behind her left shoulder, facing Ed together with her.*] Ed, tell Jill again what you said before, that she's ugly and disgusting.

Ed: You're ugly and disgusting!

K: Jill, what do you have to say to that? What do you want to say to Ed?

J: [*silence*]

K: [*to Ed*] Say it again.

Ed: You're ugly and disgusting!

J: [*pausing for a second, then looking right into Ed's eyes*] I hate you.

This group illustrates an early stage in the IFS process called unblending, which aims to help the patient accept the idea of the multiplicity of the self and to identify her parts and their functions. Getting angry with Ed is an important step, but the goal is for clients eventually to move from this antagonistic relationship with Ed to one of understanding and compassion. Clients are taught that they must learn how to relate to Ed so they can understand what, despite his destructive methods, he had been trying to do for them, for the self-system. Only then can they gradually ask him to yield control.

As I learned more about IFS, I began to see the subtle ways this refashioning of "the self" as a system of interacting parts was not just employed in therapy sessions but integrated into everyday interactions in the clinic. For example, one day when a patient named Carla argued with the dietitian about an increase in her meal plan, she was told that it was "not you, but your eating disorder talking." The stronger Carla insisted that, no, she was legitimately upset about a meal change (which she said violated the agreed-on treatment plan in her chart), the more adamant staff became that it was clearly her eating disorder that was in control. Similarly, when Bethany became panicky because of a change in the timing of the afternoon walk, she was told that it was her eating disorder—not really *her*—who was thrown into such states of anxiety, and that *she* could be flexible, even if her eating disorder could not. At the same time, therapies and everyday interactions also focused on what Ed does *for* a client, what functions Ed serves in their everyday lives. When someone's "eating disorder was talking," clients were encouraged to look at what constructive purpose it was serving, even as it was also making their lives more difficult. Were they trying to avoid conflict? Manage difficult emotions? Communicate something? The therapeutic task was then to help the client find other ways of dealing with the issues Ed had taken on as his job so that Ed could "step back" and let Self take the lead.

Dialogical interiority and the self as a dynamic social system

Building on the “dialogical self theory” of Hubert Hermans and Giancarlo Dimaggio (2004), I call this internal diversification and restructuring in IFS practice the cultivation of a “dialogic interiority”—a rendering of one’s self as constituted in and through ongoing (and shifting) dialogues between two or more internally experienced aspects of the subject. This reorientation of inner experience proposes (and also generates) the self as epiphenomenal, arising from a buzzing, dynamic *network of internal relationships* rather than as any sort of identifiable, stable, or even especially predictable state of being. In this sense, developing dialogic interiority shifts clients’ understandings not only of the *structure* of self (multiple vs. singular) but also, more fundamentally, their understanding of what self *is*. Interior experience is reconceptualized as always already diversified and intrarelatational. In other words, IFS entails specific techniques for not only observing or articulating internal dialogue but also for restructuring it, thereby reconfiguring the relationships within one’s internal system.

This is where the perspective of a critical anthropology of selfhood becomes pivotal. If, as in IFS, “the self” is reconceptualized not as a “thing” but as *a set of relationships among different aspects of experience* that can be narrated and externalized, the self is no longer invisible to ethnographic investigation and can be directly engaged as a social system akin to others. Anthropological theories of making meaning, constructing knowledge, dialogics, and relationships of power can be brought to bear in understanding “the self” as it emerges as a practice, rather than bracketing the self as an inaccessible deep interior. This engagement with the self as a set of dynamic relationships is critically important for understanding how broader cultural values about power, governance, and moral responsibility become entangled with the practice of IFS.

Priming the subject: Accommodating agency

As we have seen, the practice of IFS at Cedar Grove proceeds within a context—US managed mental-health care—that is far from value-neutral and incentivizes the cultivation of “good patients” who are rational, predictable, and oriented toward health. Accordingly, questions of agency and choice come to the fore. Specifically, I am interested not only in how political and psychological subjectification might proceed in tandem (Bondi 2005; Fassin and Rechtman 2009; Foucault 2006; Henriques et al. 1998; Kirmayer 2007), but also in how the incitement to multiplicity in IFS refracts this subjectification, so that there is at least a temporary division of the subject, and one aspect reflects on the other(s). This refraction complicates models of agency predicated on the assumption of a unified, singular actor.

Here, I find Janice Boddy’s (1989) early work on practitioners of the Zār cult in Sudan to be useful. Both IFS work and Zār possession entail identifying a force other than the person herself who has co-opted a person’s will and bends her behavior to fit its own needs and wants. Both provide a language for talking about the relationship between the person and this entity and a framework for understanding a path to healing. And both hinge on the notion that volition is complex, situational, and contested.

Boddy describes a setting in which mostly married, mostly middle-aged women break with the everyday world of female subordination by becoming possessed by powerful spirits that cause them to act in scandalous ways. Boddy considers how these competing figurations of women’s agency (everyday understandings that locate them as inferior and subordinate to men, and the parallel world of the spirits in which they are powerful and even threatening) can—and do—coexist. It is precisely *because* of this doubling of agency that the women can experience Zār practice as transformative. It allows them to creatively engage with and work through competing models of who they are and who they should be and to come to a largely individualized solution, concretized in each woman’s relationship with her possessing spirit. Boddy proposes the notion of “accommodating agency” as a way of conceptualizing this process. Women learn how to live *with* their possessing spirits, to even collaborate with them. In so doing, they can paradoxically inhabit contradictory value systems as they carve out for themselves ways of being in the world otherwise foreclosed to them.

I find this line of analysis useful for thinking about the practical utility of IFS at Cedar Grove. Through the work with IFS, clients at Cedar Grove are encouraged to develop a form of accommodating agency. Just as Boddy’s informants had to learn to be possessed, clients at Cedar Grove must learn how to live *in relationship* with Ed. And Ed is thought to never entirely go away. Clients must learn how to live in an accommodating relationship with him for the rest of their lives. But not just any relationship.

Self-governance, neoliberalism, and the subject of managed care

In IFS, there is clearly a “right” way to organize one’s inner system, with wise Self at the helm and the parts—with all their disagreements, polarizations, coalitions, and back-room deals—agreeing to work toward the common good of the system. In a vision of pluralism and deliberative democracy similar to that of John Rawls (2005), parts are encouraged to articulate their grievances and concerns to other parts and with Self in a dialogue that everyone can agree is fair, even if not everyone likes the outcome. Parts are then

expected to uphold their side of this social contract. In return, Self ensures that parts have the emotional and energetic resources they need to function and that they will be equipped to protect themselves against the intrusion of danger. It is, in other words, a neoliberal ideal par excellence (Gershon 2011).

The political resonances of the IFS model are not lost on its founder, who explicitly likens the IFS model of internal systems to a pluralistic view of society. "Pluralism," Schwartz writes, "involves an attempt to hold unity and diversity in balance, to value the many within the one, to resolve conflict without imposing synthesis or expelling groups, and to celebrate difference. Multiplicity of the mind," he continues, "involves this kind of pluralism" (1995, 15). It is taken as a given that such forms of governance are "naturally" healthy and optimizing.

Within this framework, clients' emergent experiences of mastery and agency in treatment are considered legitimate only when they emerge from a process of deliberative consensus among parts. Clients learn to reorient to their inner worlds as a sort of mini-congress, where various parts, each with their own diverse interests and motives, learn to work together for the good of the whole person. As Self becomes the leader, a client becomes more compliant with the treatment team, aligning with them against Ed. She becomes more predictable because her impulsive parts are brought under the governance of Self. And because Self is always already an expression of health, clients who are Self-led are by definition proactively engaged in their own recovery.

In the context of managed mental-health care, then, IFS offers clinicians at Cedar Grove a strategy for "rendering subjectivity calculable" (Rose 1990, 7). It does so by providing a model of the pluralistic subject in which patients can be both the "wrong kind of sick" and the "right kind of patient." As clients become more proficient at using the IFS model to understand their eating disorders, they emerge as simultaneously agentive and nonagentive, powerful and vulnerable, singular and multiple, but in a way that they can learn to coordinate and direct. As they demonstrate that they are capable of developing an accommodating agency in relation to Ed, then, they signal that they are working toward this form of internal governance, and these changes are supported and rewarded through the provision of further health-care benefits.⁸

For example, Karen, the therapist in the group-therapy session described above, was thrilled with Jill's participation in the group, not only for the potential therapeutic value but also for the practical utility of obtaining additional treatment days from Jill's insurance company. "This is great," she told me a few days after the group.

This is something really concrete I can take to [the insurance company] to say, "See—she really is trying.

She's working hard. Her weights don't show it yet, but she's doing the work and using treatment." I'll tell them about the part at the end for sure. They like to hear about patients getting pissed at their eating disorder. It makes them believe they're motivated to get better.

In "successful" treatment with IFS, then, there is a convergence of how clients learn to experience their inner lives and managed-care companies' understandings of moral selves deserving of care. As this happens, patients and clinicians learn the parameters of acceptable and unacceptable forms of internal orientations and are guided toward those that coincide with the rational patient-actor model consistent with predictable profit margins. One key danger of the IFS model as it is elaborated within the managed-care system is that it risks being co-opted by economic models of the liberal, rational subject predicated on the ideals of deliberative process and individual choice. By reframing clients' experiences of mastery and agency as only legitimate when they are the outcome of negotiation, consensus, and collaborative action among parts, this process in its fruition approximates the liberal, rational subject favored by managed care. In this regard, it may be that "recovery" from eating disorders through IFS is as much about socializing clients to become appropriate subjects of the managed-care economic model as it is about healing the eating disorder itself.

Returning to the proposition of a critical anthropology of selfhood, we can see how, in the case of IFS, a fine-grained look at practices of self-making can illuminate the vectors by which broad social, economic, and political processes come to shape individual experience in profound ways. It is in the enactment (Mol 2002) of self that subjectivities acquire personal significance, sometimes felicitously, sometimes with a great deal of "friction" (Tsing 2005). The textures of such engagements are critically important for the anthropological critique of neoliberalism, in which the relationship between "the subject" and "the self" is often left undertheorized beyond the self emerging as a gloss for the agentive or embodied dimensions of subjectivity. Understanding how these conditions of possibility give rise to various forms of selfhood on the ground and within the day-to-day messiness of the real world requires special attention to the micropactices through which neoliberal ideologies and structures become entangled with deeply human experiences of becoming. This allows us to talk about "the self" without essentializing it as either a universal psychic structure or dismissing it as lurking in the unknowable black box of interiority. It instead mobilizes the self as an ethnographic ally.

My goal here is to steer cultural engagements with questions of "the self" beyond a focus on structure (e.g., is the self singular or multiple?) and toward questions of process and relationship *within* local understandings of

selfhood. In other words, the question is less “*what* is the self” in a given context, but “*how* is the self?” Viewing the problem this way, we can bring what anthropology has learned about social power, strategies of governance, and conditions of emergence into our discussions of how selves are locally construed and experienced in order to understand how they become deeply meaningful and motivating for people. In this regard, a critical anthropology of selfhood goes to the heart of contemporary ethnographic enterprise, in that it seeks to understand how social life happens in the in-between, how it emerges in the spaces within existing structures where dynamic relationships, exchanges, tensions, articulations, and emergences occur. As we have seen in this discussion of IFS, when we refocus our attention on the in-between, we find ourselves not simply surveying the topography of a rigid structure but pushing past its edges, engaging with the ongoing, generative processes through which the work of culture and the work of being cocreate one another.

Notes

Acknowledgments. I am grateful to the staff and clients of Cedar Grove and to Dr. Richard Schwartz for their collaboration in the research process and their feedback on earlier drafts. Many thanks to the *AE* reviewers and *AE* editorial staff for their careful and constructive comments.

1. We have good models in our discipline of how to address these concerns. For example, most anthropologists would agree that, like “self,” both race and gender are social constructs involving interpellated discourses, habituated dispositions, and ideological sites of power-work that are linked to but not wholly defined by observable characteristics. Most would also agree that, even though they are not “real,” change over time, and have no ultimate “truth,” race and gender are lived social realities for people that directly affect their daily lives in ways that are culturally informed and culturally meaningful. They are, therefore, not only appropriate topics of ethnographic study but are, in fact, unusually rich ones.

2. The clinic, which I call Cedar Grove, refers to people seeking mental-health services as patients. Other mental-health providers refer to them as clients or consumers. I use these terms interchangeably.

3. All names of institutions and people are pseudonyms.

4. If agency can broadly be defined as “the socioculturally mediated capacity to act” (Ahearn 2001), we might say that *moral* agency is the capacity to act according to locally held values of right and wrong, or as “the subjective work produced by agents to conduct themselves in accordance with their inquiry about what a good life is” (Fassin 2012, 412). For an excellent overview and discussion of anthropological views on moral agency, see Csordas 2013.

5. As a therapy model, IFS has become wildly successful over the past decade, with thousands of trained IFS practitioners now working across the globe.

6. Ed’s masculinity becomes useful here in distancing the eating disorder from the self. Ed as male sits in notable contrast to feminized personifications of eating disorders commonly found on pro-anorexia or pro-bulimia communities, where “Ana” and “Mia” are often portrayed as friends, goddesses, or harsh mistresses to be appeased. I do not know of any studies that examine these gendered constructions of “Ed,” “Ana,” and “Mia” among the growing

population of males with eating disorders, though this would seem to be an important line of inquiry.

7. A number of anthropologists have engaged with questions of selfhood in eating disorders from a variety of different perspectives (e.g., Eli 2014; Gooldin 2008; Gremillion 2003; Warin 2009). My argument differs from these works by critically engaging models of selfhood within the specific economic and political field of US managed-mental health care as a technology of responsabilization within particular neoliberal priorities.

8. A similar irony about agency emerges in the increasingly popular family-based treatment (FBT) for treating anorexia in adolescents. In FBT, parents assume the role of controlling and monitoring the adolescent’s food, much as a treatment team would do in a treatment center. An adolescent demonstrates her developing capacity for independence by complying with a regime predicated on the notion that she is incapable of self-care.

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