PROLOGUE

This book is an ethnographic study of a psychiatric program in North America that specializes in the treatment of anorexia nervosa (or anorexia) among adolescent girls. Anorexia is a phenomenon of self-starvation, often coupled with rigorous exercise, occurring primarily among girls and young women. It is notoriously difficult to cure. This difficulty is ordinarily attributed to patients' "pathology" and tenacity, but in this study, I shift the focus of concern to problems with therapeutic practices. In addressing the question of why treatments for anorexia are so fraught with conflict and struggle, I argue that mainstream therapies participate unwittingly in historically specific, dominant cultural discourses of gender, individualism, physical fitness, and family life that help constitute anorexia's conditions of possibility.

The site for this study is a small inpatient unit called Walsh (a pseudonym, as are all names used for participants in the treatment program), located in a major teaching and research hospital in the western part of the United States. I spent time in the outpatient clinic associated with the unit as well, but the inpatient unit is the site for the fullest elaboration of treatment protocols and is the

focus of my analysis. In many ways, Walsh is ideal for this book project. Many medical and mental-health professionals agree that the program at Walsh is cutting edge in the field; conducting research there has allowed me to situate state-of-the-art treatments for anorexia in their social context. In addition, I have been able to analyze both biomedical and psychological approaches to anorexia, because Walsh combines talk therapies (including individual, family, group, and "milieu" therapies) with medical and behaviorist interventions. At the same time, however, my choice of an inpatient unit presented some constraints and dilemmas that I would not have faced had I conducted research in a residential treatment center, or in an outpatient clinic alone. I begin here with a discussion of these institutional constraints. Whereas much of this book explores the effects, and broad contexts, of certain treatment practices on program participants (especially patients and their parents), this prologue locates Walsh as a particular kind of treatment program and also provides a window onto my own position as a social scientist working in a psychiatric setting.

A few months before my fieldwork began, I met with Mark Blevins, the head psychiatrist at Walsh, to discuss my role as a participant-observer on the unit. Mark had authorized my project some time before this meeting, assuring me of his belief that my status as an "outside" researcher—someone who is not a clinician or a clinician in training—would not be a hindrance or even felt as anomalous to the people who worked and lived (temporarily) at Walsh. He had explained that I would be one of a number of adults on the unit (not only clinicians and staff but also researchers) who might come and go, record observations and thoughts, and occasionally sit quietly during a meal, a group therapy session, or a recreational activity. However, I still wanted to talk through in some detail my options for, and the potential effects of, different levels of participation and observation for the range of therapies, activities, meetings, and interventions that go on at Walsh. I knew that I would be spending considerably more time on the unit than most researchers. I also knew that as an anthropologist and a feminist activist, I had some concerns and questions about the impacts of my presence that would not be part and parcel of a research strategy for, say, a psychologist investigating links between anorexia and depression, or

for a medical resident comparing the physical symptoms of pre- and postpubescent anorexic patients.

While I felt sure from my conversations with Mark and others that my project would not disrupt the everyday work practices of clinicians and staff, my remaining, and primary, concern was to avoid increasing or intensifying patients' inevitable experiences of surveillance on the unit (as much as possible)—whether that might result from my note taking, my silence at times when speaking would be out of place, or the mere fact of my presence as an adult at Walsh who would be there consistently but also had the freedom to leave when she wished. By the end of our talk that day, Mark and I both felt reasonably confident that once I explained the overall purposes of my project to participants and obtained consent for interviews and for sitting in on therapy sessions, my presence would not be problematic with regard to exacerbating patients' experiences of being watched. Mark and I did agree that because I was not a medical student, it would not be appropriate for me to be present for patients' routine physical exams or for any invasive medical procedures that might occur while I was there (e.g., the rare tube feeding). I was aware that although medical interventions make up only a small part of proceedings at Walsh, they carry significant meaning, representing a "bottom line" of patient care. One of the constraints of conducting my research on an inpatient unit was that direct observation of this important set of treatment practices could not be a part of my analysis (although I did hear reports about these practices in doctors' rounds). This book focuses on the various "talk therapies," the milieu and group therapies, and the behavior modification program surrounding food intake and weight gain at Walsh. I do not discuss physiological problems and concerns involved in weight restoration. (For discussions of the medical—and, occasionally, biochemical—"management" of anorexia and some complications for therapy and weight gain, see Andersen, Bowers, and Evans 1997; Mehler and Andersen 1999.)

Another constraint was my identity as a "soft" scientist in a context that is legitimized largely through appeals to "hard" science. There were, at times, benefits to my positioning as a somewhat "naive observer"; for example, I could comfortably ask mental-health professionals, patients, and parents alike to describe and explain unit practices in their own words. However, because I am a disciplinary "outsider," many clinicians and staff in particular saw me as a scholar whose views

and methods are inherently less significant than those of psychiatry and biomedicine for understanding and addressing anorexia. This positioning is, of course, tied to institutional and financial arrangements that extend well beyond the beliefs and careers of individual practitioners at Walsh. The unit has developed a prestigious reputation through networking and publications in biomedical and psychiatric venues, and insurance companies constantly reinforce these connections, requiring for reimbursement an account of patients' progress in biomedical terms. While many clinicians and staff were quite interested in my work, no one seriously considered the idea that my study might contribute to changes in treatment approaches. In my meeting with Mark about my participant-observation on the unit, I mentioned the influence of feminist therapies and theories on my project. Mark smiled and said, "We'll show you what anorexia is *really* about."

Mark also commented that day, laughing and ribbing me verbally a bit, that it seemed to him I would be examining the "culture" of the unit, as constituted by the people who work there, as if it were "an exotic tribe." I was to hear this idea a number of times from clinicians and staff during my fieldwork. Here Mark and others were speaking to my "insider" status as an anthropologist who would render strange some of the taken-for-granted beliefs and practices of her own society. But they were also speaking to disciplinary relations of power: because anthropologists have traditionally studied less-powerful "others" (and sometimes represented these "other cultures" as bounded and exotic entities), it was amusing to imagine that I could turn an anthropological gaze onto a powerful group of people—amusing, in part, because of my status as a "soft" scientist in this context.

But if the head psychiatrist could find my position as a social scientist at Walsh amusing, the medical director of the unit—a younger psychiatrist named Bob Peters, who was new to the unit and under Mark's supervision—was quite openly unsettled by my unique role in the treatment program (unlike most researchers there, whose work was attached to a larger project under the direction of a psychiatrist, pediatrician, or psychologist, I was operating independently). I met with Bob before my fieldwork was to begin, and he let me know that Mark had agreed to give him the authority to make decisions about the parameters of my research activities. Bob's tone was clear when he added that there could well be a significant delay in my getting started: I was to respect unit hierarchy, which, in my case, now stopped with him. For

about four weeks, my fieldwork consisted of a one-hour lunch once a week with Bob, who tried to discourage the project and emphasized his role as (in his words) "captain" of the "ship" that is Walsh. Bob's discomfort was not about the content of my work; rather, it spoke to differentials of power on the unit—between a junior and senior psychiatrist, for whom my presence at Walsh had different implications, and among a range of clinicians and staff in relation to Bob. The dilemmas I was to face in negotiating my place within the hierarchical structure of an inpatient environment thus began with access to the unit and continued throughout my fieldwork.

Of course, these dilemmas and positionings were constitutive of my research topics and methods. How are unit boundaries and hierarchies constructed and maintained? How could I, a feminist anthropologist interested in supporting particular changes in treatment practices, best represent the psychiatric status quo—along with the points of conflict, innovations, and resistances in its midst—when my (inter)disciplinary affiliations render me "soft" for many of the people with the institutional power to help effect change? What was I to do with the fact that, during the course of my fieldwork, I found myself aligned with, and supported by, some patients, parents, clinicians, and staff more than others? How could I keep from writing about participants in the program, in ways that inscribe another version of power relations that exist on the unit—for example, would some readers be left with the idea that patients are "cases" for, or "objects" of, social scientific analysis in addition to biomedical and psychiatric analyses?

I wrestled with these questions during my entire research project and also in the process of writing. I never fully resolved them. They remained active for me when I interacted with and observed program participants, when their dilemmas and knowledges shaped and shifted my own, and while I considered the possible effects of my representations in this book for a number of different audiences. In her study of the social impact of amniocentesis, Rayna Rapp (1999) states that the ethics of her work included "a constant assessment of the limited benefits and possible harm" her research might afford or do (22). I too have found that these assessments have been constant and ongoing, informing a range of considerations: smaller ones such as my decision to get to know patients before eating meals with them (and to refrain from taking notes during mealtimes—the forms of surveillance and note taking that already exist in this context are particularly fraught for patients), as

well as larger considerations, such as formulating descriptions of medical power that capture both its contradictions and its seemingly totalizing effects.

On the latter topic, I received feedback via e-mail (in March 2002) from a clinician at Walsh indicating that my critical accounts of clinicians' beliefs and actions seem viable and also sufficiently complex to her. This person was the only program participant to provide me with feedback (for this purpose, an earlier version of my manuscript was made available at Walsh in 1996, as well as to interested patients who had been discharged); I am sure that others on the unit would disagree with her opinion. But I am pleased that many of my arguments seem reasonable to a relatively powerful person there.

The treatment modalities described in this book are similar to those found in most hospital-based programs, and in many outpatient and residential programs as well, in the United States (and perhaps elsewhere) today. A multidimensional treatment approach has become de rigueur for eating disorders during the past fifteen years or so and almost always combines some form of behavior modification (surrounding the goal of weight gain) with milieu and group therapies, individual therapy, and family therapy. However, there is some variation across the country in the specific content of, and the interrelationships among, these therapies. In addition, quite "alternative" treatments are available as well, mostly outside of inpatient treatment settings. Although they are not the focus of this book, some of these alternatives have emerged through a critical questioning of dominant treatment paradigms that resonates with aspects of my own analysis. I discuss one such alternative—"narrative therapy"—in the epilogue. I mention a few more here as a way to frame my own project.

Although developing and sustaining an alternative practice is of course never easy, individual and family therapists probably have the most room to vary their approaches from the norm, even on inpatient units. For some time now, a number of feminist psychotherapists and family therapists have challenged powerful cultural assumptions that predominate at Walsh and elsewhere: namely, that people who are healthy have "separated and individuated" from their families of origin (particularly from their mothers), and that autonomous individualism is the linchpin of psychological maturity (Gilligan 1982; Miller 1976;

Walters et al. 1988). What is more, many feminist therapists who work with "eating-disordered" clients believe that these assumptions are constitutive of the problems facing young women and girls who are in extreme conflict negotiating independence along with competing demands: for example, demands for self-sacrifice and nurturing others, along with pressures to shape their bodies in ways that reflect not only self-control but also self-denial (Boskind-Lodhal 1976; Lawrence 1984; Orbach 1985, 1986; Steiner-Adair 1986; Wooley 1980). Some of these ideas have made their way into inpatient (as well as outpatient and residential) treatment programs through the work of individual therapists, and sometimes in a more structured fashion. A number of programs today (but not the one at Walsh) acknowledge a sociocultural context for eating disorders and incorporate discussions of women's and girls' socialization and their struggles with body image (Levendusky and Dooley 1985; Roth 1986).

The work of feminist therapists has influenced many of the ideas in this book. At the same time, my study unpacks certain culturally dominant assumptions that are left intact in much of this work: views about the creation of gender differences, about processes of "socialization," and about operations of power on the body. In contrast to poststructuralist feminist scholarship in the therapy world (Brown 1994; Hare-Mustin and Marecek 1990), many feminist therapists work with models of female development that codify distinctively feminine selves, and they sometimes slip into essentializing or totalizing understandings of male and female identity formation. Or, as feminist sociologist Morag MacSween (1993) puts it, they assume that "an individualized self exists a priori and in ungendered form, and that the social structure prevents women from fully developing this self. . . . What results is the *addition* of a feminist view to underlying bourgeois patriarchal models of self and the body, rather than a feminist *critique* of those concepts" (52–53). In this book, I attempt such a critique by examining the production of normalized and gendered subjectivities, bodies, and families in the clinic. I can therefore pose questions about the construction of health and illness that are not readily available as interesting or important questions in the absence of a "close-up" critical analysis of standard psychiatric practices.

This kind of critical analysis is particularly important, I believe, for larger institutional and economic reasons as well, given recent and rapid changes in the provision of health care. The past decade has seen

what many consider to be ill-informed decisions regarding program closures and shifts in the content, availability, and duration of treatments for eating disorders. With the rise of managed care and an effort on the part of some insurance companies to severely limit, or exclude altogether, coverage for eating disorders, many inpatient units have shut down, and those that remain open are focusing on medical stabilization and weight gain. There are serious concerns here about who has access to affordable and effective treatment, especially the kind of comprehensive (multidimensional) treatment that many would argue eating disorders require. On the other hand, there may be opportunities now to develop new therapies that are more effective than the current mainstream models. Indeed, a range of programs, including outpatient and day treatment centers, have recently emerged to provide alternatives to (or continuations of) more traditional inpatient care. While many of these programs offer some of the same treatments I analyze here, some incorporate practices such as yoga, biofeedback, 12-Step programs, music therapy, and meditation (Lemberg and Cohn 1999; see also http://www.edreferral.com). But without a thoroughgoing examination of dominant medical and psychological models—one that contextualizes and questions the very terms of health and illness at work within these models—both the effectiveness and the institutional power of alternatives may well be compromised.

This book attempts such an examination of mainstream psychiatric therapies. By situating a luxurious form of care by today's standards— Walsh is a costly unit with considerable resources—in its particular postindustrial cultural context, it is my aim to interrogate the disciplinary boundaries of psychiatry in one of its more prestigious, and therefore powerful, forms. In addition, by studying the everyday activities and meanings that constitute "normal medicine" in the treatment of anorexia, and investigating their potential to re-create the problem, I hope to generate an effective call for change.