# Brokering Authenticity

## Borderline Personality Disorder and the Ethics of Care in an American Eating Disorder Clinic

## by Rebecca J. Lester

This paper examines the moral work of a controversial psychiatric diagnosis—Borderline Personality Disorder—in an American eating disorder treatment center in the era of managed mental health care. Based on fieldwork at this clinic spanning more than 6 years, I consider how clinicians invoke aspects of Borderline Personality Disorder in everyday conversation, in a practice I call "borderline talk." I argue that borderline talk emerges in response to being caught between contradictory models of the subject entailed in managed care and psychodynamic discourses. Specifically, borderline talk enables clinicians to endorse a formulation of the subject that, although considered pathological, provides them with a clear path of ethical action in otherwise ethically ambiguous situations. These kinds of everyday ethical negotiations percolate throughout the American health care system and are key mechanisms through which notions of economic expediency become entangled with concepts of the healthy subject. As clinicians struggle out a course of action between competing ethical imperatives, they also struggle out the workability—and failures—of various articulations of the subject within contemporary American cultural ideologies of health and pathology.

## Models of and Models for: The Cultural Work of Diagnosis

Anthropologists and other students of cross-cultural psychiatry have long emphasized the "cultural load" of western psychiatric diagnoses and how such diagnoses can obscure the complexities of human suffering. Lopez and Guarnaccia (2000), for example, argue that ataques de nervios among Puerto Ricans are not the same as panic attacks, because they enfold culture-specific beliefs about human relationships. Kleinman and Good (1986) argue that, when viewed against the backdrop of the Cultural Revolution, Chinese neurasthenics should not simply be diagnosed as "depressed" but as expressing deep cultural as well as individual loss. Scheper-Hughes (1988) highlights the political meanings of "nervous hunger" among poor Brazilians, and Biehl (2005) defends Katarina's symptoms as complex resistance to an abusive marriage. These and other scholars have taught us that rendering the range of human experiences through the lexicon of western psychiatry both truncates and transforms patients' suffering by abstracting it from local cultural circumstances (e.g., Brown 1995).

Here, I want to pivot this standard analytical gaze just a bit, to consider less the effect of receiving a diagnosis on the patient and more the conceptual and moral work of the *act of diagnosing* itself *for professionals* as brokers of mental health care. I am particularly interested in how this works in the American managed care context, where diagnoses are the currency of value (Hopper 2001). My focus, then, is on clinicians at the eating disorder clinic—social workers, counselors, psychiatrists, medical doctors. I am interested in how the practice of diagnosing clients unfolds as an ongoing process of negotiation in the clinic rather than as a discrete, definitive event and how this process both articulates and transforms clinicians' own understandings of health, illness, and the process of recovery. I suggest that their clinical decision making renders visible some of the core cultural contradictions that shape much of contemporary American political, economic, and social life.

## The Managed Care Revolution

The rise of managed health care in the latter part of the twentieth century dramatically altered the moral and ethical landscape of mental health treatment in the United States, producing new understandings of mental illness and new re-

**Rebecca J. Lester** is an Assistant Professor in the Department of Anthropology at Washington University (Campus Box 1114, 1 Brookings Drive, Saint Louis, Missouri 63130, U.S.A. [rjlester@wustl.edu]). This paper was submitted 22 IV 08 and accepted 19 IX 08.

gimes of clinical care.[1] Managed care is first and foremost an economic model; a system of organizing and rationing health care services within a capitalist system where market forces determine both the cost and value of those services. Built on a rational-choice model of human action with profitability as the ultimate good, managed care is predicated on the standardization of a product (health care) across domains, a regulation of the provision of that product, and a rationing of the supply of the product in order to maximize economic profit and minimize loss (Baily 2003; Goldman 1995; Peterson 1998). To do this, managed care organizations (MCOs), such as Blue Cross, Aetna, United Healthcare, and so forth, contract with hospitals and providers to offer services to subscribers at reduced costs—what Donald (2001) calls "the Wal-Marting of American psychiatry."

The managed care approach[2] to mental health care straitjackets providers into offering manualized treatments standardized by diagnosis, while simultaneously disincentivizing forms of psychodynamic practice (old-fashioned talk therapy) that rely on the largely immeasurable and unreplicable nuances of human interaction. Social scientists, clinicians, and mental health care consumers alike have decried these changes, lambasting them as unethical, morally vacuous, and socially irresponsible (Danzinger and Welfel 2001; Davidson, Davidson, and Keigher 1999; Kleinke 2001; Rosenberg and DeMaso 2008; Schneider, Hyer, and Luptak 2000; Sullivan 1999; Zelman and Berenson 1998). The result has been what Cohen, Marecek, and Gillham (2006, 255) call a "fundamental clash between psychodynamic culture and the culture of managed care" and what Luhrmann (2000) has characterized as a moral dilemma at the heart of the American psychiatric system. The managed care revolution has been wrenching for many clinicians, who often find themselves torn between an ethical commitment to provide the best possible care for their clients and the practical reality that not following the managed care protocols may mean their clients get no care at all (Gostin

2000). How, then, do clinicians navigate this minefield of managed care and still feel ethical about what they do?

In her ethnography of American psychiatrists-in-training, Luhrmann (2000) asks a similar question. She proposes that young doctors must learn how to "see" mental illness in two distinct ways and must become adept at knowing how, when, and why to apply which set of "lenses" to a given situation. She characterizes the bifurcation of psychiatry into "biomedical" and "psychodynamic" approaches as a legacy of the Cartesian division between body and mind and demonstrates that this has far-reaching effects for our evaluations of human suffering and our moral responsibilities of care.[3]

Luhrmann's argument is elegant and persuasive. Here, I want to push this argument further by looking not at how trainees learn to *see* mental illness but at practicing clinicians at an American eating disorders treatment facility and how they struggle to *treat* mental illness in a managed care environment. I argue that many of the daily ethical challenges these clinicians face, and the moral reasoning processes through which they come to feel justified in making the clinical decisions they do, constitute the micropractices that underpin the broader strokes Luhrmann paints. In other words, I want to look at what happens on the ground when the philosophical conflicts Luhrmann identifies come up hard against everyday decisions that may, literally, mean life or death for a client. And I want to understand how clinicians themselves make sense of this.

## Eating Disorders

Eating disorders clinicians, perhaps more so than any other mental health specialists, inhabit the ethical worlds of *both* biomedical psychiatry and psychotherapy and must become habituated (in Bourdieu's 1977 sense) to both in equal measure. As a result, these clinicians face somewhat different challenges than those working in community psychiatry (Brodwin 2008; Kirschner and Lachicotte 2001) in that they must become skilled at negotiating multiple systems of care simultaneously.

Eating disorders such as anorexia and bulimia are devastating psychiatric illnesses that involve extreme self-punishing behaviors (see table 1). Anorexia is characterized by self-starvation to the point of emaciation, coupled with an intense, overwhelming fear of gaining weight or becoming fat. Ano-

---

1. Lammers and Geist (1997) identify six ways that managed care has transformed caring: "(a) It transforms patients from those who suffer into quasi-consumers with limited choice; (b) it transforms the medical care facility into a factory; (c) it transforms the patient into a population member; (d) it shifts cost risks from a third party to the patient and the provider; (e) it limits the reach of caring; and (f) it transforms providers into bureaucrats" (p. 45). See also Birenbaum (1997); Dranove (2000); Mechanic (2007); Morreim (1995a), (1995b); Scott et al. (2000).

2. I use the shorthand terms "managed care model" and "managed care approach" in this paper to characterize the overarching ideological and practical contours of managed mental health care in the United States, specifically, the primacy placed on cost effectiveness, efficiency, and predictability of outcomes. This is not to suggest that managed care is entirely monolithic or that all managed care organizations operate in exactly the same way. Rather, it is to highlight those characteristics that are largely shared among managed care organizations in the service of their institutional ends. In this regard, managed mental health care bolsters (and is bolstered by) particular formulations of psychiatric practice (e.g., biomedical psychiatry and cognitive-behavioral approaches) and sits in contradistinction to other more humanistic or psychodynamic approaches.

3. The rise of managed care, she argues, walks hand in hand with ascendance of biomedical psychiatry, which figures the causes (and cures) of psychiatric distress as dysfunctions of the brain rather than as laments of the mind. The biomedical approach views mental illness as more or less comparable to other bodily illnesses, like diabetes or liver disease. This sits in direct contradistinction to what Luhrmann calls the "psychodynamic" approach, which understands mental illness as something far more complicated, as entailing the kind of person you are, how you respond emotionally to the world around you, the idiosyncrasies of your personal history. In short, Luhrmann notes, "it is your 'You'" (2000, 6).

Table 1. Diagnostic criteria for anorexia and bulimia (APA 2000)

| Anorexia nervosa | Bulimia nervosa |
| --- | --- |
| 1. Body weight <85% ideal body weight (IBW) | 1. Recurrent episodes of binge eating |
| 2. Intense fear of gaining weight or becoming fat, even though underweight | 2. Recurrent compensatory behavior in order to prevent weight gain: vomiting, laxatives, diuretics, enemas, fasting, or excessive exercise |
| 3. Body weight/shape disturbance | 3. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 mo |
| 4. In postmenarcheal females, amenorrhea | 4. Self-evaluation is unduly influenced by body shape and weight |

rexic women (and they are almost always women[4]) engage in seemingly bizarre behaviors and rituals: weighing each piece of bread in a loaf to ensure that it equals the serving size listed on the package, and trimming off the crust until it does; cooking and eating one zucchini per hour—every hour—between 2 and 6 a.m., and nothing else the rest of the day. Bulimic women (and increasingly, men; see Parks and Read 1997) have episodes of consuming incredible amounts of food and then getting rid of it through vomiting, laxatives, exercise, or fasting. Often, binge foods are those deemed "bad"—salty foods, fats, sweets. One bulimic woman described a recent binge to me this way: "an entire pizza, three bags of chips, a dozen donuts, four gallons of ice cream, a loaf of bread. Then I chugged three glasses of water, threw up, and started all over again." Bulimics might binge and purge up to 10 or 12 hours each day. They may take 10, 15, or 20 laxatives or exercise for 4 hours each evening. The desperation involved in bulimia has led women I have met to steal, to lie, to betray family and friends—*anything* to get their fix. At the same time, the shame that accompanies this wanton indulgence of appetite, and the disgust most feel about the act of purging itself, fuels a cycle of self-loathing that keeps them caught. One woman I know actually propped a mirror up on the toilet seat so she could watch herself throw up, hoping it would shame her into never doing it again. Her strategy did not work.

Although anorexia and bulimia are notable for their often florid behaviors surrounding food, body, and weight, the psychological, emotional, and cognitive dimensions of these illnesses run far deeper. On the whole, women with eating disorders tend to view their bodies with abject disgust, to experience the weight and shape of their physical existence as intolerable and excruciating. This is generally coupled with a self-loathing that seeps into every crevice of self-knowledge and experience. As one recovering anorexic client described it to me, "I just miss seeing my bones. I miss that so much! Just seeing them through my skin. It made me feel safe to be so near death." Women with eating disorders often persist in their behaviors long after they have destroyed relationships, endangered careers, or interrupted schooling. "I saw what it was doing to my life," another client told me. "But the eating

disorder just felt so good that I didn't want to give it up. I couldn't. I didn't know who I would be without it."

Eating disorders, then, clearly entail psychological disturbance. But they ravage the body as much as the mind and carry both immediate and long-term consequences for health and functioning. In anorexia nervosa's cycle of self-starvation, the body is forced to slow down all of its processes to conserve energy, resulting in abnormally slow heart rate and low blood pressure. People develop osteoporosis, muscle loss and weakness, and severe dehydration, which can result in kidney failure. They often experience fainting, fatigue, hair loss, and the growth of a downy layer of hair called lanugo all over the body. The recurrent binge-and-purge cycles of bulimia can affect the entire digestive system as well as other major organs. Electrolyte and chemical imbalances from frequent vomiting can cause irregular heartbeats, leading to heart failure and death. Frequent vomiting can rupture the esophagus. Stomach acids can stain and decay the teeth. Ulcers and pancreatitis are common.

Perhaps not surprisingly, eating disorders have the highest mortality rates of any psychiatric condition (Harris and Barraclough 1998). What may be surprising, however, is that they are also among the least covered of all psychiatric illnesses in terms of health insurance. Despite increasing evidence about the long-term effectiveness of comprehensive treatments for eating disorders, individuals with these conditions are frequently denied adequate health insurance coverage. Some health policies even specifically exclude eating disorders treatment.

The American Psychiatric Association (APA; 2006) issued practice guidelines for the treatment of anorexia and bulimia: for anorexia, the recommended treatment is inpatient medical stabilization and gradual weight gain to within 90% of ideal body weight, accompanied by intensive individual and group psychotherapy. First-line recommended treatment for bulimia is intensive outpatient cognitive-behavioral therapy.

However, a recent study by Fox et al. (2003) found that only 3% of the 98 health plans they investigated would fully cover the APA-recommended treatment protocol for anorexia. A separate report by Striegel-Moore (2000) demonstrated that the average length of treatment is much lower than the APA's recommended standards of care for these disorders. It is estimated that, under current policy conditions, approximately

4. The American Psychiatric Association (2000) estimates that 90% of those who develop anorexia are female.

Table 2. Diagnostic criteria for Borderline Personality Disorder (APA 2000)

1. Frantic efforts to avoid real or imagined abandonment (e.g., clinging and controlling behavior)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation (may idealize caregivers or lovers early on and then switch quickly to devaluing them as cruel and uncaring)
3. Identity disturbance: markedly and persistently unstable self-image or sense of self (e.g., sudden and dramatic shifts in goals, values, vocational aspirations, types of friends)
4. Impulsivity in at least two areas that are potentially self-damaging (such as substance abuse, binge eating)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior (like cutting)
6. Affective instability due to a marked reactivity of mood (e.g., irritability, panic)
7. Chronic feelings of emptiness (easily bored, despondent)
8. Inappropriate, intense anger, or difficulty controlling anger (may display extreme sarcasm, bitterness, verbal outbursts, often followed by shame and guilt)
9. Stress-related paranoia or dissociative symptoms (e.g., depersonalization, feeling "unreal")

one-half of patients with an eating disorder recover, 30 percent improve somewhat, and 20 percent remain chronically ill. Those individuals who remain ill often return to treatment multiple times, utilizing additional medical and psychological services. They also show increased risk for a range of medical conditions related to adrenal, cardiac, and reproductive functioning.

Against this backdrop, eating disorder clinicians struggle to make ethical decisions about client care (Kaye, Kaplan, and Zucker 1996; Vandereycken 2003). A survey of eating disorder specialists around the country, representing nearly every inpatient eating disorders program in the United States found the following (National Association of Anorexia Nervosa and Associated Disorders 1999): (1) Nearly all (96.7%) believe their patients with anorexia are put in life-threatening situations because of mandated early discharge; (2) 100% believe some of their patients suffer relapses as the direct or indirect consequence of limitations of managed care; (3) 72% say that managed care routinely orders patients discharged without considering body weight percentages, contrary to medical guidelines; (4) The average weight for patients with anorexia when forced into discharge is 84% of ideal weight, well below the 95% benchmark recommended by most health professionals; (5) 18% believe that insurance company policies are indirectly responsible for the death of at least one of their patients; and (6) Nearly all (98.1%) believe legislation will be necessary to alleviate this situation.

It is clear, then, that the vast majority of clinicians view managed care as the enemy and perhaps almost as harmful to the client's health as the eating disorder itself (see also Robins 2001; Ware et al. 2000). How then do eating disorder clinicians function within such a system? What kinds of conceptual machinations might be necessary in order for these professionals to reconcile what they feel bound to do by professional ethics and what they are forced to do by economics?

In understanding clinical decision making among eating disorder practitioners, I have found it necessary to push Luhrmann's distinction between biomedical and psychodynamic approaches even further, considering these two models as unfolding contradictory philosophies of *authenticity* (i.e., they

the stipulate conditions of relationship between inner states and outward signs) with direct implications for client care. In this regard, my argument extends Luhrmann's by examining how notions of authenticity operationalize (and amplify) the different moral commitments of these models in clinical eating disorder practice. While this is usually a source of conflict, I will show how, in some extreme cases, debates about authenticity (perhaps ironically) actually enable clinicians to reconcile what seem to be irreconcilable ethical demands.

The remainder of this paper is divided into four parts. First, I will introduce the conceptual frame of Borderline Personality Disorder and its formulation of authenticity and pathology. We will then turn to the eating disorder clinic (which I call Cedar Grove[5]) for an overview of the local cultures of recovery generated within. Then, we return to the issue of *authenticity* and how it grounds the philosophical contradictions of care raised by Luhrmann in the context of the clinic. Finally, through a close examination of a recent case at the clinic, I will demonstrate how "borderline talk" becomes a way for clinicians at Cedar Grove to reconcile contradictory imperatives for care and to develop a plan of action that they may find distasteful but can endorse as ethically sound.

## Borderlines, Dementors, and Other Fearful Things

In the therapy world, borderline patients are considered by far the most taxing and difficult to work with. Individuals diagnosed with Borderline Personality Disorder (BPD) are thought to lack stable, coherent selves, which leads to intense interpersonal difficulties.[6] The current Diagnostic and Statis-

5. All names for people and places used in this article are pseudonyms
6. This understanding of Borderline Personality Disorder is predicated on a notion of "self" that is highly culturally contingent, namely, that the healthy self is coherent, bounded, and centralized as the experiential locus of thought, emotion, and action. Although this concept is arguably peculiar among human groups (e.g., Ewing 1990; Gaines 1992; Hollan 1992; Shweder and Bourne 1984), it is nevertheless central to contemporary western psychiatric practice, and I will use the term "self" in accordance with this cultural view.

tical Manual of Mental Disorders (DSM IV-TR; APA 2000) identifies nine symptoms of BPD, five of which must be present over time and in a variety of contexts to warrant a diagnosis (see table 2). In looking at the symptoms associated with BPD, one might wonder how such florid behaviors come to be read as evidence of *lack* of self. It seems that, like a black hole, the self-void at the center of BPD is thought to exert a pull on its surroundings and to be detectable precisely by the chaos that swirls around it. Working with borderlines in a clinical setting entails crossing this "event horizon" and plunging into the void. This is thought to be a risky undertaking for a clinician. Jen, a therapist at Cedar Grove, described the experience as "like encountering those Dementors in Harry Potter. Borderlines suck the life right out of you." In fact, a therapist's own emotional reactions to a client are thought to be an important diagnostic tool for identifying "borderlines." One of Luhrmann's (2000, 113) psychiatrists described it as the "meat grinder" sensation—if you [are] talking to a patient "and it fe[els] like your internal organs [are] turning into hamburger meat," she is probably borderline.

As one of the personality disorders, BPD is recorded on Axis II of the DSM's five axes. Axis II diagnoses are coded separately from those listed on Axis I because they are thought to represent more chronic, characterological difficulties that persist over the life course, as opposed to the usually more florid Axis I conditions (e.g., mood disorders like major depression or bipolar disorder, psychotic disorders like schizophrenia, eating disorders, and anxiety disorders). According to the DSM, BPD occurs about 75% of the time in females and often emerges in adolescence. It is considered difficult to treat and involves high risk of suicide. Although therapeutic interventions can mitigate the intensity of symptoms, "the tendency toward intense emotions, impulsivity, and intensity in relationships is often lifelong" (APA 2000, 709).[7]

### BPD and Eating Disorders

Although associated with women in general, BPD is seems to be overrepresented in women with eating disorders (Díaz-Marsá, Carrasco, and Sáiz 2000; Gartner et al. 1989; Wonderlich et al. 1990). The predominant hypothesis for this overlap is that eating disorders and BPD both, in theory, emerge from underdeveloped or incomplete selves. From this perspective, disordered eating behaviors function to construct a sort of self-in-relief. Through self-starvation or bingeing and purging, the literature suggests, women with eating disorders regulate and define the boundaries of a self that does not exist, at least not coherently. In this way, disordered eating can become one way in which borderline features manifest.

7. Borderline Personality Disorder differs from other Axis II disorders (such as Histrionic Personality Disorder or Dependent Personality Disorder) in that it is characterized by *instability* in mood, social relationships, emotional tone, and behavior. As we will see, this becomes pivotal in clinical discussions of authenticity and recovery at Cedar Grove.

### Controversies about BPD

Since its inclusion in the DSM in 1980, BPD has been a lightning rod of controversy, characterized by detractors as a junk diagnosis, an instrument of misogynistic psychiatric practice, a caricature of western cultural expectations of female behavior, and a way of justifying countertransference toward difficult clients (Akiskal, Chen, and Davis 1985; Shaw and Proctor 2005; Tyrer 1999). Even those who endorse the diagnosis as reflecting something "real" in the world have recognized that its mobilization in practice is often unsystematic and idiosyncratic (Paris 2005). For our purposes here, I am less interested in whether BPD exists a priori as I am in how *talk* about BPD enables a conceptual shift for clinicians when confronted with certain kinds of ethical dilemmas in client care. In other words, I leave aside the debate about whether BPD is "real" and instead examine the very real effects of the use of this diagnosis in the eating disorder clinic.

## Borderline Talk

Specifically, I want explore how BPD—as the *presence* of a *lack* of self—claims explanatory purchase at Cedar Grove in accounting for clients' difficulties in treatment. What is notable is that the practice I call "borderline talk" involves a specific figuring of the client's authenticity (or lack thereof) in relation to her actions. It is this feature of borderline talk, I suggest, that enables clinicians to develop a sort of compromise formation about what is "really" going on with a client and therefore to take action they can feel confident is ethical, even when it contradicts their clinical judgment.

Borderline talk at Cedar Grove is a mode of everyday discourse among clinicians that invokes BPD to shorthand clusters of behavioral and interpersonal concerns. It takes a number of forms. It can be *explanatory*, accounting for a client's behavior ("She's really borderline. She can't handle that kind of feedback from her peers without going into crisis"). It can be *cautionary*, as a way of preparing another clinician for an encounter ("Watch out! She's in full borderline mode today!"). It can also become a way for therapists to communicate to each other their *personal struggles* or even burn out (like the Dementors comment). Other examples of borderline talk include comments like, "That drama really shows the borderline side of her," "I think her borderline part is getting in the way of her recovery," or "Trying to do group therapy with all these borderlines is like herding cats."

From what I have observed at the clinic, borderline talk is not always clearly tied to symptomotology, or at least not consistently so. While it is certainly not random, borderline talk does seem to cohere around some clients more than others and to assume different intensity and serve different purposes in different circumstances. This would seem to suggest that borderline talk among Cedar Grove clinicians involves a metadiscursive process that goes beyond a simple diagnostic evaluation of a client. In fact, I propose that bor-

derline talk articulates at least as much about the therapeutic process in the clinic itself—and its inherent tensions and contradictions—as it does about any particular client or group of clients. I have become interested in how the rendering of a nonself in BPD articulates core, paradoxical formulations of "authenticity" in the clinic's own program of recovery—through which clients (often unsuccessfully) struggle to manifest convincing emergent selves—and how these paradoxes crystallize broader cultural contradictions about mental illness and valued "selves" enfolded in contemporary American psychiatric discourse.

## The Clinic: Cedar Grove

Cedar Grove is a private eating disorder treatment center nestled in a quaint suburb of a midsized midwestern town. Opened in 2001, Cedar Grove offers residential, day treatment, and outpatient programs for individuals with anorexia or bulimia. Although some men and boys have received treatment at Cedar Grove, the vast majority (98%) of clients are women and girls, most between the ages of 15 and 40.[8] Most clients are white and range from working class to extremely wealthy. In the seven years since it opened, Cedar Grove has become one of the premier treatment facilities in the nation, and clients come from around the country—and even the world—for care at the facility.

I began conducting fieldwork at Cedar Grove in 2002. Over the past 6 years, I have attended perhaps 200 treatment team meetings, dozens of therapist trainings, and several staff retreats. I have participated in countless group therapy sessions, gone on client meal outings, and witnessed multiple interventions. I have interviewed clients, staff, family members, therapists, psychiatrists, dietitians, and physicians. In 2006 and 2007, while completing my MSW, I assumed the role of practicum student at Cedar Grove and performed intakes and discharges, assisted in developing treatment plans, and communicated with insurance companies. Since May of 2007 I have held the role of therapist at the clinic, maintaining my own client load for individual psychotherapy and experiencing in a raw, direct way the pressures and contradictions I had observed as an ethnographer for years and which I describe here.

Most clients come to Cedar Grove at the insistence of relatives or doctors who fear for their health. When a client is referred to Cedar Grove, she undergoes a thorough intake assessment to collect detailed information about her background, family dynamics, family history of mental illness and addictions, previous treatments, current stressors, possible comorbid conditions, the history of her eating disorder, and her current reason for seeking treatment. Once the assessment is done, the intake coordinator recommends a level of care for the client: residential, day treatment, or intensive outpatient.

Whether a client enters treatment, and at what level, often depends on whether her insurance will cover the hefty cost, which ranges from \$475 per day for intensive outpatient treatment to \$1,100 per day for residential care.[9]

Given the cost of treatment, the vast majority of clients—even those who are financially well-off—depend on insurance benefits to pay for their care, and the trajectories and lengths of their treatment stays are often directly determined by decisions made by insurance care managers (many of whom have no specialized education in mental health issues, let alone eating disorders). Cathy, the utilization review manager at Cedar Grove, is responsible for obtaining the initial certification of insurance benefits for each client and then reviewing each case as required by the client's managed care company (sometimes as often as every 3 days) in order to argue for the medical necessity of continued care. Decisions about recertification rest entirely with the care manager at the managed care organization (MCO).

## Cedar Grove's Philosophy of Eating Disorders

The therapeutic orientation of Cedar Grove is perhaps best described as "eclectic psychodynamic." The program staff has crafted the program from best-practice research in a range of therapeutic modalities, including psychodynamic, cognitive-behavioral, dialectical-behavioral, mindfulness, family therapy, dance movement therapy, art therapy, and internal family systems therapy. Throughout the week, clients attend groups using each of these different modalities, and all Cedar Grove therapists are trained in one or more of these approaches.

Cedar Grove's philosophy of eating disorders, while eclectic, sits squarely within the psychodynamic paradigm. Cedar Grove views eating disorders as complex responses to toxic family environments or other traumatic circumstances. Eating disorder symptoms are thought to originate as protective coping mechanisms that "speak" the pain, hurt, rage, confusion, and other aspects of subjective experience that girls have often been forced to muffle and keep silent in order to survive. Over time, the eating disorder comes to eclipse a girl's sense of self, so that she fears she cannot exist in the world without her eating disorder.

A key part of treatment at Cedar Grove is to help a client understand how and why her eating disorder developed and what it was (and still is) trying to do for her. Once she is able to understand how her eating disorder speaks her needs (e.g., for empathy, to be taken seriously), she is better able to recognize how it actually *undermines* that very process (e.g., her parents are frustrated with her rather than empathic, she is viewed as "crazy" rather than as having legitimate complaints). At the same time, it risks her very life. Treatment

---

8. The youngest client to receive treatment at Cedar Grove was 12. The oldest was 58.

9. It is notable that Cedar Grove is less expensive than many other eating disorders facilities, some of which charge up to \$2,500 per day for residential care.

then focuses on helping her develop new ways for articulating these needs and getting them met productively. As a client increasingly is able to use her own voice (vs. speaking through the eating disorder), the eating disorder symptoms abate. This is a lengthy and difficult process, however, and it is expected that during periods of stress or vulnerability, a client may reach back to her eating disorder as a familiar coping mechanism. She must then work to regain her footing and to remobilize her new coping skills. Relapse, then, is considered part and parcel of the healing process and is generally viewed as an opportunity for continued growth rather than as a failure of the treatment itself.

The standard managed care view is very different from Cedar Grove's. In synergy with biomedical psychiatry and cognitive-behavioral approaches (which enable controlled outcomes research and, therefore, lend themselves to cost-benefit analyses in ways psychodynamic approaches do not), managed care tends to figure these illnesses as episodic cognitive-behavioral dysfunctions that are essentially resolved once the symptoms abate (Wiseman et al 2001). From this perspective, unlearning an eating disorder rests primarily on interventions targeting the specific behaviors involved (food rituals, caloric restriction, purging). The underlying causes and ongoing functions of an eating disorder are not a focus of concern, and issues such as "voice" or "sense of self" are deemed irrelevant. Managed care rests on a rational choice model that presumes people act out of a desire for self-preservation. In light of this, the etiology of eating disorders, and the difficulties clients have in relinquishing their behaviors, do not easily compute and are frequently viewed with skepticism and even dismissal by managed care providers. When I asked one care provider about why her company excluded eating disorders, she answered that eating disorders are "self-inflicted illnesses," so they should not be covered by insurance. Another told me that eating disorder clients are "a nightmare" for his company and his supervisors have told him to "get them off [his] caseload as quickly as possible."

## Surviving in a Managed Care Environment: Clinicians as Brokers

A constant, pervasive, and palpable tension permeates Cedar Grove with regards to the issue of managed care and the ethical treatment of clients. Clinicians, almost daily, are caught between providing what they feel is the *best* care for a client and getting certification for *any* care at all. Furthermore, they are operating in an environment where insurance coverage could literally be pulled at any time. I have witnessed at least seven cases where a client who seemed to be making good progress in treatment was informed that insurance denied recertification and the client had to leave immediately. Therapists and clients at Cedar Grove work in constant apprehension of these sorts of events.

Given this, clinicians at Cedar Grove must continually strike a balance between contradictory and conflicting imperatives about best ethical practice in treating their clients. From what I have seen, this usually entails a rather simple (if sometimes creative) process of "code switching" between the psychodynamic concepts and discourses used in everyday practice at the clinic and the more formulaic, objectivist discourses recorded in documents reviewed by the MCO, such as treatment plans and progress notes. Take, for example, the case of Bethany, a 16-year-old diabetic girl who had been bingeing on carbohydrates and then refusing to take her insulin in order to lose weight. After her second episode of diabetic coma she had been admitted to the Cedar Grove's residential program. The insurance company was adamant that a central treatment goal in this case was for Bethany's parents to take control of their daughter and force her to take the insulin injections at home (a strategy that had failed miserably in the months leading up to the admission). In the course of family therapy, it was discovered that Bethany's father was a serious alcoholic and, although frequently at home, was a far cry from the kind of responsible adult presence the insurance company assumed to be in Bethany's home. In the Cedar Grove view, one function of Bethany's eating disorder seemed to be, at least in part, to give voice to the destructive aspects of her father's addiction, which was a forbidden topic of conversation in the family.

In everyday conversation, Bethany's therapist would report things like, "Bethany did a great job yesterday. She finally named her father's alcoholism! That's the first time anyone in that family has named it. She was able to actually say that something is wrong in the family and didn't need her eating disorder to say it for her." When she went to write the progress note for the session, however, the therapist was careful to frame what had happened in language that the insurance company could easily identify and link up with stated treatment goals. She wrote, "Client was educated on self-assertion techniques and was able to employ these tools during family session." Certainly, both reflect what happened in the session, but they communicate very different things about how and why Bethany was getting better. Therapists must become self-consciously adept at switching between these modes of discourse and representing psychodynamic thinking about the client's progress in rational choice language about how that progress is made visible in observable behavior. To this end, therapists participate in mandatory quarterly trainings on how to write useful progress notes and document effectively, and this code-switching is openly discussed in weekly staff meetings (e.g., when therapists ask the utilization review manager to dictate what to write on a discharge form to "make it sound more insurance-y"). I want to be clear that this is not the same as lying. It is more a question of framing information in way to make it, as Cathy the insurance manager describes it, "more digestible" to the managed care companies (see also Anderson 2000). In this way, therapists learn to broker client behavior in order to receive continued treatment coverage.

Nevertheless, there is one arena where this code-switching

seems exceptionally problematic and where the incommensurability between the psychodynamic model and the managed care model of how to understand client behavior is, perhaps, too profound: *client noncompliance while in treatment.* Noncompliance can describe a range of things, from outright refusal of treatment interventions to other kinds of "acting out" behavior. It is in evaluating noncompliance that I suggest questions of a client's *authenticity* emerge as central to ethical decision making at the clinic. To what extent is she genuinely invested in her own care? How can we know? These questions turn on how we understand the relationship between a client's outward behavior and her internal commitments. Before turning to a specific case of client noncompliance and how borderline talk helps clinicians take action, I want to tease out some of the philosophical issues at stake in these questions.

## Autonomy, Authenticity, and the Healthy Subject

Both the managed care model and the psychodynamic model endorse the autonomous subject as the model of health. Both understand autonomy in the modern liberal political philosophical sense as a form of self-governance, as "acting within a framework of rules one sets for oneself" and having "a kind of authority over oneself as well as the power to act on that authority" (Oshana 2007, 1).[10] They differ, however, in how they formulate *authenticity* and whether authenticity is considered an integral component of this autonomy. This may seem like a minor point, but as we will see, it has very profound consequences for how these models become operationalized in clinical practice.

In the liberal humanist tradition (and in colloquial usage), "authenticity" often connotes a sense of being true to one's self, of expressing and inhabiting a core existential orientation to the world. But this is only one interpretation of authenticity, and a very specific one at that. In fact, the philosophical literature is replete with debates about the term "authenticity" and its use. Here, I want to build on Oshana's (2007) distillation of these debates and her distinction between what she calls *procedural* and *epistemic* authenticity as a way of teasing out the contradictions between the managed care and psychodynamic models that seem most troublesome to eating disorder clinicians. In brief, procedural authenticity has to do with the consonance (or not) of one's actions with one's stated moral values. One acts authentically when one behaves in a certain way. Epistemic authenticity is of a different order; it has to do with the degree to which one's internal "radio" is "tuned" to those values. In this model, correct action (that is, action consistent with the endorsed values) is incidental to epistemic authenticity in the sense that it follows from this

---

10. For historical discussions of the development of the concept of autonomy, see Dworkin (1988); Lindley (1986); Schneewind (1998); and Taylor (1991).

attunement (or, in some cases, can facilitate it), but exists at the level of the performative rather than at the more fundamental level of the existential. Let us look more closely about how these different formulations of authenticity unfold in psychodynamic and managed care discourses.

### *The Psychodynamic Model and Epistemic Authenticity: A Healthy Self Is a "True" Self*

"Psychodynamic" is a somewhat generic term that can include a number of different schools of thought, but we can reasonably characterize as "psychodynamic" those approaches that entail the following core set of assumptions about human behavior, human motivation, and psychiatric distress: (1) Human behavior is meaningful. This is thought to be true even when the meaning of the behavior is not readily apparent to the individual, the clinician, or others; (2) The meanings of human behavior derive from an interaction between an individual's life experiences and current social context; (3) The meanings of behavior are closely entangled with an individual's cognitive and emotional processes, which tend to organize themselves in functional response to an individual's social and interpersonal environments over time; (4) Individuals themselves may not be aware of the meanings of their behaviors or the substrates of emotion and cognition that motivate them and can even be perplexed or distressed by them; and (5) Therapists and other mental health professionals are specially trained to help individuals uncover the meanings of their behaviors (why they do what they do) or the origins of distress (why they think what they think, or why they feel what they feel).

What makes approaches with these assumptions "psychodynamic" (vs., e.g., "behaviorist") is a commitment to an understanding of human behavior as overdetermined, meaning that there may be several (sometimes contradictory) reasons that a given behavior (e.g., self-harm) assumes motivational meaning within the context of an individual's life circumstance. It follows, then, that psychodynamic interventions for a target behavior will work only if and when the complex motivations for the behavior have been adequately understood and addressed.

The psychodynamic tradition is firmly situated within commitments to an ideal of the modern liberal subject. One of the hallmarks of psychodynamic thinking is that it is predicated on an understanding of the healthy subject as developing along a trajectory from a state of total dependency to increasing individuation and autonomy, grounded in a sense of self-mastery and self-efficacy. How and when and to what extent such individuation occurs is a matter of great debate in psychodynamic circles, but the idea that mental health is characterized by the development and solidification of the "self" as a seat of largely independent thought, motivation, and action is central to all such models. Specifically, the notion that a healthy self is a "true" self forms the core of the psychodynamic approach. Authenticity, in its *epistemic* sense,

then, is viewed as necessary for the achievement of healthy autonomy.

## Managed Care and Procedural Authenticity: Healthy Is as Healthy Does

The managed care approach to health care rests on propositions that sit uneasily with those central to the psychodynamic approach. Specifically, the managed care model is built on a notion of autonomy as entailing *procedural*, versus epistemic, authenticity. In this view, authenticity involves the development of *capacities to act* in accordance with the values and ideals one endorses. Here, authenticity refers more to a *consistency of action within a moral system* rather than an expression of intrinsic, essential self. Authenticity in this sense involves bringing a subject's actions in line with the ideological commitments she espouses. To act authentically means to behave in a way that is consistent with these values.

As an economic model, managed care does not explicitly articulate a model of human psychological functioning, or, at least, it is not self-consciously so. One can argue, however, that in fact the managed care approach rests entirely on propositions about why people do what they do, how well we can predict such behavior, and how economics can be brought to bear on shaping that behavior. Grounded in a rational choice model of human behavior, the managed care approach assumes that patients will make good faith use of treatments as prescribed in order to maximize health and minimize harm. Accordingly, this model emphasizes a standardization of the provision of care, and services are "managed" according to such assumptions about client participation. This model assumes that individuals can and will freely choose from among an array of options and will maximize their health benefits in the service of self-preservation and development.

The managed care approach, like the psychodynamic approach, then, is predicated on a particular idea of the modern liberal subject and the centrality of autonomy in healthy (correct) action. The autonomy advanced in the managed care approach is one grounded in the capacity to reason and act in the world, unfettered by maladaptive impulses. In this regard, it elaborates the procedural notion of authenticity by emphasizing the quality and development of competencies as indicative of increasing autonomy. Whether such action reflects the kinds of authentic commitments (in an epistemic sense) of the subject is of little relevance to the exercising of autonomy in this fashion. Rather, authenticity in the managed care model is gauged as the degree of correspondence between a client's behavior and the indicators of health outlined by the MCO, whether or not such behavior reflects the personal values or commitments of the client herself.

Procedural and epistemic authenticity are not in and of themselves incompatible, but they differ in important ways. Take, for example, the following scenario: I believe in the value of helping those less fortunate than I. Each year in early December, I donate bags of old clothes to a local charity. My actions are in line with the values with that I identify, making this action authentic in a procedural sense. But whether it is authentic in the epistemic sense depends on my actual motivations for donating the clothes, and the degree to which I am aware of them. I may genuinely wish to help others and feel a moral obligation to share my good fortune. This would lend my act a degree of epistemic authenticity in addition to procedural authenticity. But perhaps I am motivated instead by the tax deduction I can take by making large charitable donations before the end of the year. This changes the context of the action that, although still procedurally authentic, now becomes epistemically *inauthentic*. I may or may not be aware of this underlying motivation for my charitable act—in fact, I may have convinced myself that my motivations are entirely unselfish and that the tax benefits are of no consequence. Whether this is actually true for me, and whether I know it, depends on my ability to reflect upon my own actions. The determination of epistemic authenticity is predicated, then, on a capacity and desire for critical self-reflection and self-awareness that risks discovering that one's motives are not necessarily what they seem. As we will see below, such tensions are far more than just obscure philosophical differences—they lead clinicians and managed care officers to differently evaluate indicators of pathology and recovery in eating disorder clients, and they shape the clinical decisions that follow from such evaluations.

## Authenticity and the Ethics of Care

The two formulations of authenticity in the managed care and psychodynamic approaches lead to different ethical trajectories of care (table 3). Contrary to managed care's rational choice assumption that an individual's prime directive is self-preservation, the psychodynamic perspective recognizes that mental illness often entails *self-destructive* intention (e.g., suicidal gestures, poor self-care, social isolation), the causes of which are frequently outside an individual's conscious awareness. Given the understanding of psychiatric distress as embedded within an individual's life history, psychodynamic approaches reject the managed care notion of "standardized" care delivered by clinicians acting as technicians and instead privilege individualized treatments and emphasize the primacy of the therapist-client relationship in the healing process. Similarly, treatment course and length are determined within the context of that relationship in the psychodynamic model, not a priori based on the diagnosis alone as in the managed care model. Psychodynamic treatment involves an ethos of care predicated on a holistic understanding of the person as made up of complex moods, experiences, thoughts, and behaviors that have developed over time in the context of social relationships with others. From this perspective, a client's present difficulties both are contiguous with her past and hold implications for her future. Her psychiatric distress is part and parcel of who she is as a person. The managed care model, in contrast, maintains an ethos of care focused

Table 3: Managed care versus psychodynamic trajectories of care

| Managed care model | Psychodynamic model |
|---|---|
| Autonomy predicated on procedural authenticity | Autonomy predicated on epistemic authenticity |
| Successful treatment: development of capacities as action as consistent with positive health outcomes | Successful treatment: development of critical self-reflection and "owning" one's actions |
| Rational choice—people act toward self-preservation | Stochastic choice: behavior is overdetermined and complex and may include self-destructive intention |
| Focus of treatment should be on acute symptoms | Acute symptoms manifest chronic difficulties; treatment must attend to both to prevent relapse |
| Psychiatric distress is episodic | Psychiatric distress if often chronic, with periods of flare-ups |
| Psychiatric symptoms are discrete, separate from person | Psychiatric symptoms are embedded in person |
| Symptoms abate in response to standardized *interventions* | Symptoms abate through the discovery of the functions of those symptoms for the individual and the development of alternative behaviors; this occurs in the context of a long-term *therapeutic relationship* |
| Care should be standardized and time limited | Care should be individualized and tailored to each client's particular needs |
| Symptom relief indicates the end of the acute episode of distress | Symptom relief indicates treatment is *in the process of working*, though several cycles of abatement and intensification of symptoms are expected in the process of healing |
| Mental health providers function as technicians, delivering interventions in standardized form | Mental health providers are specialists; the type and quality of therapeutic relationships they develop are individualized per client |
| The primary ethical imperative is cost effectiveness | The primary ethical imperative is client care |

on the isolation and treatment of disease as discrete and separate from the person as a whole. Unlike the psychodynamic view, the managed care perspective understands psychiatric distress as episodic rather than endemic, as a "state" the person is in versus a "trait" that endures.

Using a somewhat different theoretical lexicon, we might say that the managed care model construes *authenticity as a technology of action*, whereas the psychodynamic model construes *authenticity as a technology of self* (Foucault et al 1988). While these two formulations are perhaps often related, they are not necessarily so. Depending on one's theoretical commitments, it is conceivable to maintain that a technology of action does not necessarily involve a technology of self (e.g., a straight behaviorist perspective), though the opposite proposition (that a technology of self does not require a technology of action) is somewhat more difficult to endorse. Nevertheless, it remains the case that these two formulations of authenticity, as well as the implications they have for understanding and evaluating why people do what they do and whether that indicates progression towards autonomy and health, come into direct conflict in the context of eating disorder treatment.

Take, for example, a client named Courtney. Courtney, a 14-year-old white girl from a small midwestern town, was brought to the clinic by her parents. She did not want treatment for her eating disorder and was extremely angry and resentful that her parents had forced her into care. For the first few days, Courtney would not eat and refused to attend any therapeutic groups. The medical team placed a feeding tube and Courtney's parents told her if she did not comply with the clinic program she would be sent to a medical facility for refeeding and then returned to the clinic. Courtney capitulated—sort of. She accepted the feeding tube without protest. She began to eat her meals and snacks. She attended all therapeutic groups as well as individual therapy. She followed

all the rules. And she talked constantly about how as soon as she met her weight goal and was discharged, she would go right back to her eating disorder.

In evaluating Courtney's situation from the two different perspectives described above, we come to very different assessments of her recovery and what kinds of clinical decisions would be in her best interest. From a procedural standpoint, Courtney was much improved. She was eating. She was gaining weight. She was compliant with the program. Indeed, her managed care company was very pleased, and set a discharge date for her within 3 weeks of admission. From an epistemic standpoint, however, Courtney had made little if any progress at all; in fact, the therapeutic staff at the clinic felt that her pseudo-compliance spoke volumes about the severe and entrenched nature of her illness and her dire need for more treatment.

Despite these kinds of fundamental contradictions, however, managed health care and psychodynamic practice are intimately entwined in our current health care environment, as each requires the other for its continued production and legitimation. Managed care companies rely on providers to subscribe to their networks and to treat patients according to their guidelines. Providers rely on managed care companies for referrals and to pay for client care. Balanced at the nexus of this uneasy alliance are the treatment professionals who must translate between these competing models of treatment while at the same time retaining as their primary ethical commitment the wellbeing of their clients.

So what happens when the strategies for navigating the contradictory ethical imperatives of the managed care and psychodynamic frameworks fail? I have suggested that one place these strategies fail most miserably is client noncompliance while in treatment. I have also suggested that the practice I call borderline talk emerges in these circumstances

as clinicians, caught between two models of ethical action, are confronted with urgent ethical dilemmas about client care. To see how this happens, and why borderline talk "works," let us examine how it plays out in one client's story, which is representative of dozens I have followed at Cedar Grove.

## Caroline's Story

Caroline is a 20-year-old white woman who was transferred to Cedar Grove directly from the hospital where she had been treated for kidney failure as a result of her bulimia. Before her hospitalization, Caroline had been bingeing and purging for up to 10 hours a day. She spent hundreds of dollars a week on binge food and, for the past year, had even been prostituting herself to get money for her binges. She is also a cutter and has scars on both forearms from years of self-inflicted razor blade cuts. She has a long history of depression and has frequently felt suicidal, though she has never actually attempted suicide.

By the time she made it to Cedar Grove, Caroline was distraught. She had been in the hospital for 2 weeks straight and her urges to binge and purge were extremely high. She felt and acted like an addict desperate for a fix. She paced, she shook, she could not concentrate because of intrusive thoughts about food. She was a wreck. Eventually, she figured out a way to purge in secret at the clinic, and began to do so regularly. She was caught when Ziploc bags full of vomit were discovered hidden under her bed. Over the next several weeks, she continued to find new ways to purge but began to come to staff directly afterwards to tell them what she had done and to process what had prompted the behavior. She participated in groups, saw her therapist, and took her medications. Gradually, although she still struggled with strong urges, Caroline's episodes of purging began to decrease. She continued to be invested in treatment and gradually developed new strategies for modulating her urges. At one point, 3 months into her treatment, she went 17 days without bingeing or purging, the longest she had gone in over 6 years. She began, for the first time, to feel optimistic about the possibility of recovery, even though it still seemed distant.

It was at this point that Caroline's insurance company determined that she was no longer "acute" and should be discharged from treatment. When Caroline heard the news, she panicked. "I can't leave treatment!" she told me, sobbing. "I'm not ready! If I go out there, I know things will go back to the way they were. I can't go back to that life!" The evening of this decision, Caroline purged for the first time in over 2 weeks. The following day while on a pass she spent the entire 3 hours bingeing and purging. She cut. She became suicidal. The Cedar Grove staff initiated three insurance appeals on Caroline's behalf, all of which were denied. When pressed by the clinic's director for an explanation, the insurance case officer eventually revealed that the company had determined that Caroline was "borderline," and because, in his words,

"you can't treat borderlines," they were no longer authorizing coverage.

### Conceptual Dysfunction

Let us pause here to consider in more detail what, precisely, is being communicated between the care manager and Cedar Grove in this interaction. The care manager maintains that, because Caroline's acute symptoms of bingeing and purging have abated, she is no longer eligible for care. The cessation of symptoms marks the end of the present episode of disease. Whatever difficulties remain, he suggests, are due to an underlying, chronic personality disorder which, in his view, is outside the scope of the MCO's treatment purview, primarily because "you can't treat borderlines" (i.e., there is little evidence-based research on which to design standardized treatment interventions for this condition). Ignoring for the moment that this is factually untrue (Feigenbaum 2007), what the care manager seems to be communicating is that he recognizes that Caroline is not "well," but neither is she sick *enough*—or rather, not sick enough in the *right way*—to warrant further care. Because BPD is seen as a chronic, life-long condition, Caroline can presumably do nothing about it: once a borderline, always a borderline. Given managed care's privileging of the role of rational choice in achieving health, treating someone with BPD *for* BPD, where the capacity for rational choice is viewed as explicitly absent, indeed makes little sense.

The Cedar Grove clinicians, coming from a psychodynamic perspective, strenuously disagreed. The cessation in treatment of Caroline's eating disorder symptoms did yet not represent, in their view, an authentic shift in Caroline's subjectivity. If they could keep Caroline authentically engaged in recovery, they argued, she could continue to get better. But withdrawing treatment support prematurely and not treating Caroline for these more chronic, underlying issues, as the managed care company insisted, doomed her to relapse.

The conflict here between the MCO and Cedar Grove has to do with different assessments of Caroline's agentic efficacy (past and potential) in her recovery and the models of authenticity upon which such assessments were based. Both the MCO and Cedar Grove agreed that Caroline had worked hard to gain control of her self-destructive behaviors and to cease bingeing and purging. Both agreed that she exercised constructive, self-preserving agency in this regard. They differed, however, on whether this process was seen as contiguous with working through the psychological and emotional issues underlying those behaviors.

By characterizing Caroline as borderline (and therefore untreatable), the MCO care manager was asserting that the two are not contiguous and that they entail different sorts of processes with different likelihoods of success. Caroline's eating disorder symptoms had improved, bringing her actions more in line with the value of health as self-preservation. From a procedural standpoint, such as that endorsed by the MCO,

Caroline had developed new capacities for autonomous action vis-à-vis her eating disorder, and treatment was therefore a success.

From an epistemic viewpoint, however, such as that held by Cedar Grove, the persistence of Caroline's significant psychological difficulties despite the decrease in eating disorder symptoms indicated precisely the opposite—that treatment was not even *complete*, let alone a success. In fact, an increase in other symptoms might be expected when the coping mechanism of the eating disorder subsides. Cedar Grove argued that Caroline's eating disorder *was* contiguous with these other difficulties and objected to the procedural view that behavior consistent with an ideal of health necessarily indicates an endorsement of that ideal. They instead argued that, while healthy behaviors are important, they should not be taken to indicate a fundamental shift in a client's ability to embrace self-preservation but must instead be viewed with caution and within a more long-term understanding of the recovery process as difficult and often full of setbacks.

## Borderline Talk and the Ethical Ambiguities of Care

The MCO's denial of coverage for Caroline posed a real dilemma for the Cedar Grove treatment team in terms of what to do next. They were confronted with a client who was rapidly deteriorating, yet whom they could not continue to effectively treat. Although many of Caroline's behaviors were consistent with BPD (e.g., bingeing and purging, cutting, mood swings), the question of whether she was borderline had never been a focus of clinical concern. She came to Cedar Grove with a ranging, tenacious eating disorder, severe depression, and difficulty living day to day, and these had been the primary focus of treatment. Yet at the same time, they could not entirely dispute the insurance company's assessment. Caroline *was* a cutter. She *did* have problems with impulse control and *did* act erratically. In fact, the very symptoms the treatment team asserted as evidence that Caroline needed continued treatment only served to further support the insurance company's diagnosis of BPD and their denial of coverage. "We're stuck," said Kelly, Caroline's therapist, in a treatment team meeting. "This is a no-win situation." How, they wondered, should they proceed ethically in this situation?

What happened next seems puzzling at first glance. While still vehemently opposing the insurance company's position, over the next several days (as the insurance appeals were playing out), I noticed that in everyday conversation the staff at Cedar Grove began talking about Caroline in ways they had not done before. In fact, it seemed that clinical discussions about her symptoms involved a sort of doubling. When Caroline's bingeing and purging increased after the insurance denial, these behaviors were viewed (as before) as evidence of an ongoing, raging eating disorder. But at the same time, they were increasingly discussed with an edge of suspicion, as part of a manipulative strategy on Caroline's part to circumvent the insurance decision by appearing "sick enough" to warrant continued care. One might wonder (as I did) why Caroline would have to *try* to look "sick enough" if, as the treatment team agreed, she was nowhere near ready for discharge. When I asked about this, Kelly, Caroline's therapist, explained that the problem was that Caroline "needed to feel attached and dependent on us" and, as a result, was unable to accept the insurance decision without becoming unhinged. This, in Kelly's estimation, was what made Caroline's symptoms more about her personality issues (e.g., BPD) than about her bulimia per se. As Caroline's symptoms increased, so did the borderline talk among the clinicians. When Caroline returned late from a pass because she had been out purging, or when she told staff she was feeling suicidal, I began to hear comments in the clinical area like, "Now you're really seeing that borderline part of her" and "That's her borderline side coming out."

Why would these clinicians appropriate in such an apparently uncritical way the very language deployed by the view the opposed? I want to be clear that I am *not* arguing that the insurance company exerted some sort of hegemonic influence over clinicians' opinions of Caroline's illness. I actually do not think the clinicians' assessments of Caroline's symptoms changed. What *did* change, I think, is the degree of clarity the team had about what constituted, for *them,* ethical treatment for this client, and this is where borderline talk emerged as important. Clearly, Caroline was on a self-destructive rampage. Clearly, she needed further treatment. And clearly, her insurance company would not pay for it. Caroline and her family did not have the resources to pay out of pocket, so she had no other options. From what I saw, the borderline talk in Caroline's case—and in several others I have followed over the past 6 years—became a way for clinicians to work through the ethical imperatives of care in a no-win situation.

Specifically, borderline talk engages the conflicts between procedural and epistemic authenticity in a singular, if disturbing, way—by rendering epistemic authenticity itself impossible. I am reminded here of Lorna Rhodes's (2004) description of manipulation as an organizing principle in an American maximum security prison. In the prison, she says, "running a game" and "knowing the game" characterize all social interactions to the extent that, "unless [a prisoner] is floridly psychotic he has the near impossible task of proving that he is not manipulating" (2004, 169). This problematic was confirmed by a prison guard who observed to Rhodes:

> A person is not a liar because he lies, but he lies because he's a liar. The point is, how do we remove the liar out of a person? We can *postpone* lying—we can do it pretty easily—but that does not change the individual (2004, 171).

Rhodes argues that, taken to its logical limits, this perspective precludes the very possibility of a "real" or truthful self as a stable locus of experience and center of initiative and instead figures the "self" as performance, mask, and strategy. In this

way, the notion of "manipulation" in the prison articulates both a metaphysics of the person and a practical theory of human agency that juxtaposes external behavior and a perceived internal authenticity (or the lack thereof), as well as moral evaluations about the relative health or pathology of these uses of self.

Rhodes' description of the institutional dynamics of the prison resonates strongly with what I see at Cedar Grove in the practice of borderline talk. If, to paraphrase Rhodes's prison guard, Caroline's behavior is construed as manipulative in large part precisely *because* she is a manipulator, then it becomes difficult for the clinical team to *ever* perceive her as acting authentically, regardless of her motivations. In a context where authenticity (procedural, epistemic, or both) is understood as foundational to autonomy and psychological health, this rendering of Caroline as *incapable* of epistemic authenticity—because she has no authentic self from which to act—configures her as largely outside the purview of reasonable clinical intervention. It therefore upholds an evaluation of her treatment based on her outward actions alone. Under such circumstances, it becomes not only acceptable but *ethical* to discharge her from treatment until and unless she is prepared to invest in her own care, with the burden for demonstrating this readiness resting squarely with her.

## Conclusions

We can see how, in cases like Caroline's, invoking borderline talk enables a provisional resolution of the authenticity problem by rendering any reliable subjectivity at all unattainable for a given client. This, of course, requires clinicians to negate the very thing they claim necessitates their existence as trained professionals—the "self" as an entity deserving of care. At the same time, this practice affirms and supports the ends of the managed care organizations. In this regard, we might be tempted to conclude that clinical processes are co-opted in the classic work of ideology, which conceals its effects and persuades participants to advocate for their own subjection. In fact, one interpretation could be that, through borderline talk, the philosophical and ethical incoherence of the health care system becomes displaced onto the individual client, who then carries the symptom of the system—it is she, not the practitioners or the health care industry, who is rendered fragmented, conflicted, and incapable of decisive action.

But I propose that what goes on at the clinic is more than just a simple machination of ideology. The clinicians I work with are in many ways self-conscious of these dynamics and work actively to resist them in all sorts of ways all the time. Yet the positioning of the clinic within the American health care landscape complicates the pathways of ethical action open to them. In this regard, their choices generate what William James (1908, 61) and the pragmatists call "new truths," that function as go-betweens and smoothers of transitions in the context of competing value systems by "marr[ying] old opinion to new fact so as ever to show a minimum of jolt, a maximum of continuity." In other words, these clinicians are not simply interpellated by managed care ideology. Nor are they always successfully resisting it. Rather, by brokering plural ideologies of the subject, they become active participants in redefining the boundaries and meanings of mental illness, at least in this clinic and with these clients. In the process, they affirm an understanding of themselves as ethical professionals who remain instrumental in the project of healing.

These kinds of everyday ethical negotiations percolate throughout the American health care system and are key mechanisms through which notions of economic expediency become entangled with concepts of the healthy subject. As clinicians struggle out a course of action between competing ethical imperatives, then, they also struggle out the workability—and failures—of various articulations of the subject within contemporary American cultural ideologies of health. How these eating disorder clinicians negotiate competing ethical imperatives speaks not only to the issue of ethical decision making per se but the everyday sorts of micropractices that collectively constitute local cultural parameters of health and pathology.

## Coda

Caroline was discharged from Cedar Grove shortly after the events described here. She returned to the clinic several months later for a brief stay (for which she paid out of pocket) but had to leave again once her funds ran out. She participated in the free weekly aftercare group offered at Cedar Grove for a few weeks following this second discharge but then stopped attending. As I write this article, I do not know for certain where Caroline is or how she is doing, though I can speculate that she is struggling. I do know that the clinicians at Cedar Grove often wonder about her and wish her well.

## Comments

**Katherine Pratt Ewing**
Center for South Asian Studies, Box 90091, Duke University, Durham, North Carolina 27708-0091, U.S.A. (katherine .ewing@duke.edu). 2 I 09

Rebecca Lester frames the process of psychiatric diagnosis and subject constitution in terms of tensions generated by the economic constraints of managed care. Her focus on how managed care shapes diagnosis and treatment leads me to raise the question of the relationship between diagnosis and social class, a question that Lester skirts in this article, in part because the patients in the eating disorder clinic she worked in could be broadly construed as middle class and thus of the same class as the health care providers who work with

them. But this broad construal of the middle class is itself an instance of the persistent invisibility of class in a society where enacting class difference is a basic aspect of everyday life, as Sherry Ortner (2006) has pointed out.

Based on insightful scrutiny of the emergence of "borderline talk" at moments when treatment is terminated or denied, Lester argues that the attribution of a personality disorder marks an individual as lacking an authentic self and thus not being a normal middle-class subject. I suggest that this labeling is a process of social exclusion that enacts and redraws a class divide. Lester identifies a resonance between her own work and Lorna Rhodes's (2004) analysis of how inmates are constituted as subjects in a maximum security prison. In this latter case, guards presume that prisoners are manipulative; prisoners are thus inauthentic and incapable of being responsible middle-class subjects. There is a clear parallel between this assumption of inauthenticity and the way that borderline talk constitutes the eating-disordered patient as manipulative and inauthentic and thus no longer entitled to treatment. This parallel points indirectly to the issue of class. It could be argued that the attribution of specific symptoms that function as markers for a personality disorder diagnosis tends to be class based. For example, those at the top of the social hierarchy may be admired for their ability to work the system, while those who are powerless may be labeled "manipulative" and diagnosed with an antisocial or borderline personality disorder.

There are also parallels between Lester's research and that of Elizabeth Davis (forthcoming), who has focused on the social process of diagnosis for antisocial personality disorder. I note these parallels because the stark differences in their research sites may help foreground issues of class that remain in the background in Lester's analysis. Davis, who did ethnographic research among Greek psychiatrists involved in regulating the provision of state care to Gypsy patients, found that psychiatrists' use of the diagnostic label "antisocial personality disorder" conflates the therapeutic and the bureaucratic, just as Lester found that the diagnostic category "borderline personality disorder" is used for a similar conflation among United States eating disorder patients. According to both Lester and Davis, psychiatrists may use a personality disorder label as a way of signaling a withdrawal of care, justified by the assessment that a patient is manipulating care providers and cannot be helped because of the chronic nature of a personality disorder. Davis's research was done in a context where class and cultural dimensions are highly visible. In this context, the label "antisocial personality disorder" is identified as a cultural disorder by Greek psychiatrists, who cannot attend directly to the oppressive effects of underclass status on Gypsy communities. The resonances of Lester's concerns with the practices of Greek psychiatrists and United States maximum-security prison guards suggest that Lester's case may tell us something about the dynamics of class formation that are often obscured in the United States.

What might direct attention to class add to our under-

standing of personality disorder diagnoses? The very tension between a psychodynamic approach and a biomedical model encodes a class distinction that can be seen in a popular view that psychoanalysis and related approaches are elitist. This judgment has helped delegitimize psychodynamic approaches to treatment, thereby strengthening a managed care approach. Within this context, a DSM Axis II diagnosis, in turn, legitimates the denial of treatment. If those with less adequate health care coverage are more likely to be subjected to borderline talk (or any other axis II personality disorder diagnosis) because of the very limits of their coverage and thus are labeled as less responsible subjects and citizens, we see a circular process through which lower class status is produced and reproduced. This process can be seen as a new iteration of the use of medical science as a tool for managing populations. It is one of the more recent of a series of labels that legitimates the abjection of a class of people, analogous to the emergence of the label "alcoholism" in the mid-nineteenth century, when the underclass status of immigrant groups such as the Irish was justified because of their particular susceptibility to this medically identified syndrome.

Given the deepening disparities in health care coverage in the United States today, medical issues should be recognized as an important and growing factor in class positioning. Lester's approach, with its focus on the kinds of subjects that are constituted through the process of diagnosis, has the potential to make an important contribution to this inquiry.

**Helen Gremillion**
Department of Social Practice, Unitec New Zealand, Private Bag 92025, Auckland, New Zealand (hgremillion@unitec.ac.nz). 5 I 09

Lester's account of "brokering authenticity" in an eating disorders clinic is a welcome analysis of contradictions in everyday medical practice. At the same time, this article presents a rather narrow take on some knotty problems surrounding the provision of care.

Lester's focus on the micropractices of professional decision making in a managed care environment helps us to understand the complexities of human agency in the face of limited possibilities for action. This kind of analysis avoids the all-too-familiar tendency in studies of eating disorders in particular to bifurcate sufferers' worlds into those who wield power and those who are passive victims. In addition, Lester's linking of managed care ideologies with "procedurally authentic" identities ("healthy is as healthy does") and her reading of psychodynamic health as a form of "epistemic authenticity" ("a healthy self is a 'true' self") provides a useful framework for grasping implicit discourses of personhood at work when clinicians navigate competing imperatives in the treatment process.

There is surprisingly little critical commentary here about the ethics and politics of excluding certain patients—those

deemed "borderline"—from the clinic. While Lester clearly decries the effects of managed care on the treatment of eating disorders generally, and on so-called borderline patients in particular, she seems to reduce clinicians' exclusion of the latter to their efforts to preserve the integrity of psychodynamic paradigms (for nonborderline patients): borderline patients are incapable of epistemic authenticity; it is therefore sound, even ethical, to discharge them earlier than psychodynamically informed clinical judgment would allow.

Lester's account does capture some important aspects of clinicians' logic and intentions. She argues that health care professionals are not simply "dupes" of managed care policies, nor do they always resist these policies effectively. Rather, they are "brokering plural ideologies of the subject" while attempting to position themselves as ethical practitioners in a socioeconomic climate that will not allow the kind of therapeutic care these clinicians would prefer. But these plural ideologies of the subject are steeped in a range of cultural discourses that, when unpacked, deeply complicate an "ethics" of exclusion and warrant discussion.

Lester points out that procedural and epistemic authenticities are interdependent in practice, and importantly, they share a liberal political commitment to the idea of healthy subjectivity as a form of individualistic self-governance. But Lester focuses on the differences between the two versions of authenticity (on which her analysis depends). What is missing here is a wider analysis of the politics of personhood that threads through constructs of "health" more generally in the treatment of eating disorders. In my book *Feeding Anorexia: Gender and Power at a Treatment Center* (2003), I argue that clinical assessments of who is "fit" for treatment of an eating disorder in the contemporary United States are inextricably bound up with the gender, class, and racial politics of psychiatric health. I examine how the rhetoric of exclusion—particularly within managed care regimes—that is employed for patients deemed borderline serves not only to valorize but also to constitute (through contrast) the subjectivities of "true anorexics" in treatment, which arguably encode certain highly privileged understandings of identity. Lester's ethnographic data may well lead to different conclusions (although many of the themes we explore are quite similar: the idea that coherent selfhood for borderline patients is absent and the exclusion of many of these patients from full participation in treatment on that basis, the thorny problem of patient "noncompliance" and its effects on clinical negotiations, and an intriguing overlap in representations of borderline and eating disordered identities as incomplete). Nevertheless, it seems problematic within the terms of Lester's own arguments not to deconstruct psychodynamic approaches more fully. Lester is also quick to put aside the formidable critiques of "borderline personality disorder" that resonate in some important ways with feminist critiques of eating disorder diagnoses and treatments.

I do believe this article represents an important contribution to the study of eating disorders. There are very few ethnographic accounts of these disorders and their treatments; Lester's approach allows us to see some of the subtleties of the clinical decision making and power operations entailed in the ongoing production of healthy and ill subjectivities. Furthermore, both eating and borderline personality disorders are highly contested and have the potential to reveal what Lester calls "core cultural contradictions that shape much of contemporary American political, economic, and social life." In my view, Lester's ethnographic data and her analytic scope are too sparse to realize this potential richly. I'm not convinced that she shows how clinicians participate significantly in "redefining the boundaries and meanings of mental illness" or wrestle deeply with clinical ethics. However, the potential is there, and it is compelling.

---

**Janis H. Jenkins**
Department of Anthropology, University of California, San Diego, 9500 Gilman Drive, La Jolla, California 92093-0532, U.S.A. (jhjenkins@ucsd.edu). 9 I 09

It is worth pointing out from an analytic standpoint that the argument juxtaposes the *administrative* discourse of managed care with the *clinical* discourse of a psychodynamic approach. Without passing judgment on whether this is a logical flaw or an ethnographic observation, we can observe that in effect this formulation collapses the clinical discourse of biomedicine into managed care both with respect to the DSM diagnostic system and the relevance of biological psychiatry. This being said, the comparison between managed care and psychodynamic trajectories of care presented in table 3 is elegant and of considerable value in summarizing cultural and clinical dilemmas that characterize contemporary psychiatric care well beyond the domains of eating disorders and borderline personality disorder (BPD).

Two specific observations about the cultural logic of managed care are worth repeating. First is the recognition that coverage requires that one be "sick enough in the right way," where "right" implicitly carries a double sense of accurate and ethical. Second is identification of the assumption that behavior consistent with an ideal amounts to endorsement of that ideal, where "ideal" pertains both the behavior and self.

The moral/ethical aspect appears to be relevant on several levels at once in a way that is not always explicit in the text. That is it pertains to judgments about patients' character as worthy sufferers or motivated manipulators (did Caroline vindicate herself by paying for a second admission out of pocket?), about the managed care system as impartial adjudicator of scarce resources or uncaring administrator bureaucratic conformity (was the determination that Caroline was untreatable not only premature but callous?), and about clinicians as heroic advocates or helpless pawns (did Caroline's clinicians capitulate to managed care discourse in their borderline talk about her?).

The argument makes excellent use of the distinction be-

tween procedural and epistemic authenticity, but more could be said about authenticity as a cultural theme in its distinctive American context, along the lines laid out in Lionel Trilling's (1972) seminal discussion. Without this dimension being made more explicit, it is a challenge to tease apart the modulations of authenticity on various levels as a criterion of health for the patient as agentic self, an ethical challenge for clinicians engaged in diagnosis and treatment, a touchstone for anthropological analysis, or a systemic value within the health care system.

The role of borderline personality in the discussion also merits comment insofar as its multidimensionality has potential consequences beyond what is said here. It is evident from the examples of "borderline talk" that in some instances it is more salient as an interactive style than as a psychiatric disorder amplified by the cultural ambivalence that surround manipulation and an incorrigibly protean self. There is in addition an implicit ambiguity between whether borderline personality disorder is best considered as inclusive of or alternative to the eating disorders anorexia and bulimia. Finally is the seemingly intractable issue of whether BPD is essentially treatable or untreatable.

Beyond these considerations, it is not clear whether the issue of whether BPD is "real" can or should be sidelined for purposes of this analysis while "eating disorders" are not similarly held in skeptical view—is it because the latter can be observed and measured physically? Given the centrality of BPD "talk" to the argument, the cultural and clinical analysis of such problems might have been elaborated to good effect. Yet discussion of BPD "talk" appears only at the conclusion of the paper and presents (as Lester observes) more of a puzzle than a compelling interpretation. The puzzle is great insofar as reimbursement for treatment by managed care appears constantly in jeopardy. How can a person become involved in treatment in a manner that offers protection in the context of a clinical ethos of anxiety and instability?

Lester worked at the clinic site for a year to complete clinical training before taking on the clinician mantle more formally in the year following. This position affords an insider view of daily clinical machinations that is invaluable; however, little is revealed here about the anthropological challenges that we would expect the assumption of that role to entail. Being a clinician among clinicians is several steps beyond the engagement level of a participant observer, and it remains unclear through the paper how Lester herself managed the potentially conflicting commitments to managed care and psychodynamic discourses.

While the overall contribution of this work is without question, it is not entirely without weakness. Although Lester undertakes to extend the work of her dissertation advisor on the relation of biomedical and psychodynamic approaches, the argument only peripherally addresses and in general is weakly integrated with the relevant literature in psychiatric anthropology. For example, a theme that is introduced but not well developed is that of local cultures of recovery, particularly insofar as "recovery" is an increasingly central concept both within psychiatry and in the literature of psychiatric anthropology.

While the article justifiably focuses on clinicians, there is perhaps insufficient recognition of the anthropological importance of how clients accepted or rejected "eating disorders talk" beyond the clinical discourse of "compliance" to treatment.

**Suzanne R. Kirschner**
Department of Psychology, College of the Holy Cross, 1 College Street, Worcester, Massachusetts 01610, U.S.A. (skirschner@holycross.edu). 7 I 09

Lester's paper is a fertile contribution to the ethnographic study of how those involved in the delivery of psychiatric care do things with words. In order to contextualize the strategic and moral work performed by "borderline talk" at an eating disorders clinic, she explicates two different ways that patients are deemed to be, or not to be, "authentic." Psychodynamic ("epistemic") authenticity entails attunement to a true, inner self; behavior change alone is thus not enough to signify healing. By contrast, managed care organization (MCO) administrators read symptom abatement as a sign of recovery. Moreover, since MCOs consider going into treatment to be a straightforward index of wanting to get better, a patient who exhibits "noncompliant" behavior is understood to not be acting in good faith, hence to be inauthentic in what Lester calls a "procedural" sense.

Lester provides a careful and illuminating analysis of how the members of the clinical team shift towards deploying a "procedural" lens in order to pronounce the patient, Caroline, incapable of the kind of "true self" authenticity that these psychodynamic therapists endeavor to promote. She suggests that they do this in order to rationalize their powerlessness to keep Caroline at the clinic and their consequent inability to deliver what they would normally deem to be good care. In addition to appreciating the ways in which authenticity discourse is used, however, I am struck by the divergent perspectives on *agency* that are also visible here. The therapists at this clinic ordinarily evince a psychodynamic view of agency, in which the disordered self both wants and does not want to let go of her symptoms and recover. This depiction of a complex and divided agentic subject further implies an image of the self as inescapably lacking in transparency. Just as the patient is not aware of what her symptoms stand for, so also (initially, at least) does she not "own" those parts of herself that want to undermine her progress. The healing process, according to this view, does not only engender awareness that having her disordered eating "speak her needs" undermines the interpersonal wishes her symptoms express and the goals she seeks to achieve. It also entails a recognition that she could, in fact, act otherwise. Thus, this is a view of the ill self as being, in principle, capable of making choices

and taking responsibility but needing to undergo a difficult and not fully linear process of self-exploration and development in order to claim her repudiated agency. It is therefore different from the MCO model of agency, in which the rational, treatable subject is framed as having the capacity to make the "right" choice and stick with it. When Caroline deteriorates after she is denied further insurance coverage, the members of the clinical team attempt to rationalize the situation, and to reconcile the conflicting models of agency in which they are ensnared, by using the MCO pronouncement of her as borderline to convince themselves that they could not help her psychodynamically in any case. In enacting this conceptual strategy, they are not only denying Caroline's epistemic authenticity. They are also framing her, paradoxically (and, I suggest, incoherently), as being at once agentic—in the sense that she is responsible ("a manipulator"), even culpable, for what she does/who she is—and lacking in agency or even the capacity to develop it: incapable of doing the therapeutic work that would enable her to take ownership of her motives and behaviors, and to make more constructive choices.

When psychodynamic and MCO understandings of suffering and self-destructiveness are contrasted, as they are in Lester's study, it can be tempting to idealize the psychodynamic approach and to assume that the kind of borderline talk that these clinicians fall into in an atmosphere of ethical pathos is anathema to normative analytic culture (I hasten to add that I am not accusing Lester of such idealization). But, lest we forget, during the heyday of unbounded borderline talk (the 1970s and 1980s), psychodynamic theorists and therapists contributed to the popularity of the borderline concept and to its use to point to what was then a fairly heterogeneous collection of patients who were challenging to treat and who evoked difficult reactions in their therapists. Psychoanalysts thus have a pre-MCO (and pre-DSM III) history of making free and rather indiscriminate use of the kinds of attributions about authenticity and agency that Lester identifies as now emerging defensively, in the context of a morally challenging, anxiety-provoking situation. Nonetheless, this is not the only discursive strand that has been available to psychodynamic clinicians; the culture of post-Freudian psychoanalysis has been a rich, polysemous, and, at least in some respects, pluralistic one. Thus, it has participated not only in the reification, "othering," and disparagement of challenging patients, it has also offered more constructive ways to cope with the anxieties and ambivalence inevitably induced in the therapist as she bears witness to suffering and as she seeks to understand, and to help attenuate, seemingly intractable maladaptive patterns. Lester's study suggests that although MCOs may not be completely remaking psychodynamic clinicians' professional *habitus*, they nonetheless may be contributing to the shrinking of therapists' professional and ethical resources in more than just a material sense.

**T. M. Luhrmann**
Department of Anthropology, Stanford University, Building 50, Stanford, California 94305, U.S.A. (luhrmann@stanford.edu). 6 I 09

This paper is important and it will be controversial, because it suggests—rightly, I believe—that clinicians sometimes make clinical judgments that do not serve their clients' interests but instead serve their own. Stated baldly, this does not sound particularly controversial within the world of critical medical anthropology, although it still sounds alarming. What makes the paper unsettling is that the anthropologist author is not blaming anyone. She does not think that the clinicians are bad people, and she does not particularly think that the medical system in which they work is a bad system, though I suspect she has unkind thoughts about managed care. But the point of the article is not to denounce managed care, or to show how the institution has coopted its clinicians, or to demonstrate that in such a system patients cannot get adequate care. She is not trying to stir us, her readers, into moral outrage. Instead, she is illustrating that when people must work within a world of intolerable moral choices, their understanding of those choices may shift, so that they see the world in a way that allows them to be decent human beings. The point of the article is that good, reasonable, self-aware human beings—which we all aim to be—find themselves reinterpreting their clients and in effect, blaming their patients, when they cannot help their patients in the way they think is best. The author does not think they do this because they are bad, but because they are human.

This is important work for two reasons. First, it helps us to understand the dynamics of the modern clinical workplace and the way that workplace feels the impact of economic tightening. There is, of course, much to be outraged by in the modern medical world. Drug companies are focused on profit and do sometimes market their wares unethically. Clinicians are sometimes seduced into unethical behavior in order to make huge profits. And of course Nurse Ratcheds, real and metaphorical, are everywhere.

But the lesson of this paper is more subtle. As we lose the resources with which to pay for long-term psychotherapy, we lose the capacity to believe in a model of a subject who acts but does not intend to act and who must be allowed to develop into an intentional, choosing, willing agent. It becomes simply too expensive to believe that someone who is acting well is still ill. We cannot afford to believe in complex unconscious behavior or in epistemic authenticity, at least in the clinic. And I expect this shift to intensify in the current economic climate. I expect to see it as well in other settings—schools, for example, where perhaps students who struggle will no longer be given as much leeway or so easily interpreted as disabled rather than as misbehaved. The clinicians in this paper began to call their patient "borderline" with the intent of communicating that if she was not willing to be treated

with the therapy they had to offer, they would not try to treat her. A society can only afford to understand the model of a subject it has the resources to support. This paper suggests that the richly complex psychodynamic subject that must be emphatically understood and supported is, literally, a luxury.

The second reason this is important work is that it suggests that there are insights in medical or psychiatric anthropology that speak to larger questions around morality. Here I am thinking not about being stirred to moral action but rather about what this ethnography suggests about moral reasoning in humans. This work illustrates that judgment is vulnerable to cognitive dissonance. The clinicians wanted to treat the patient for longer, but they could not, and faced with the conflict between the insurer, who refused to pay, and their own belief that they would be morally culpable if they released a patient who still needed their help, their understanding of the patient shifted so that they could release the patient without feeling morally negligent. These kinds of shifts in judgment have been known within social psychology for decades. For example, social psychologists have demonstrated that people—good, decent people—tend to interpret bad things that happen to themselves as happening by accident but to interpret bad things that happen to other people as the result of the limitations of those poor souls. I slipped on the sidewalk because I was not looking, but you slipped because you were clumsy. Lester's paper is among the first that I have seen that pursues these uncomfortable insights in the clinic, but even more, within anthropology. Moral judgment is greatly complex and profoundly altered by the social structure in which it occurs, but within anthropology we are at the beginning of an understanding of its process. This paper should lead our field in a broad scholarly inquiry.

**Charles Nuckolls**
Department of Anthropology, Brigham Young University, Provo, Utah 84606, U.S.A. (charles_nuckolls@byu.edu). 4 II 09

Lester describes the conceptual machinations clinicians employ to reconcile the ethics of responsible care with the dictates of managed care and its treatment guidelines. She bases her analysis on the ethnography of an eating disorder clinic that serves an overwhelmingly white and middle-class patient population. There, opposing views of patient "authenticity" compete with each other, and therapists, she argues, must become adept at switching between psychodynamic and managed-care (i.e., cognitive-behavioral) explanatory systems. Lester argues that compromises are difficult and that the diagnosis "borderline" functions simultaneously to represent and resolve competing definitions of "authenticity."

The bulk of the article is devoted to explicating the different conceptions of authenticity in psychodynamic and managed care models. The psychodynamic model constructs an "epi-

stemic" authenticity based on a set of assumptions that describe human behavior as meaningful—the result of an interaction between life experiences and social context. The managed care model, on the other hand, defines authenticity in "procedural," not epistemic, terms and focuses on the development of capacities to act. Lester argues that borderline talk functions to deprive the patient of her authenticity as an epistemic self. Clinicians can be induced to engage in such talk against their preferences when the insurance system refuses to pay anything more for a condition it deems an intractable personality disorder.

A patient named "Caroline" is first treated for an eating disorder, and she improves. Her clinicians believe she can be helped, and they request more time for in-patient treatment. But the insurance company refuses; since her bulimia has improved, any remaining difficulty is due to untreatable personality problems because she is a "borderline." Forced to relent, the clinicians adopt "borderline talk" to describe Caroline as way of resolving their own ethical dilemma.

Most of the Axis II (personality) disorders can (and probably do) function in the same way. What makes "borderline" uniquely serviceable? There is something procrustean in Lester's description of all the clinicians as psychodynamically oriented until forced to come to terms with managed care. These days, most clinicians have been trained in precisely the model Lester says they oppose—cognitive-behavioral therapy—and would react with surprise to the suggestion they are psychodynamic. To see clinical decision-making as a battle between heroic Freudians and managed-care bean-counters overgeneralizes from a specific case and risks missing the essential features of the borderline diagnosis.

Borderline personality disorder is surely one of the few medical conditions diagnosed chiefly in relation to how a patient makes the clinician feel. To label someone "borderline" is to create a level of disapproval not unlike the opprobrium brought to bear on the recipients of "shunning" (*meidung*) among the Old Order Amish. Why? For one thing, it is possible that the historical association between borderline personality and the intermediary condition that the term was first used to describe—halfway between neurosis and psychosis—still resonates in modern psychiatry. Neurosis and psychosis constitute the categories mediated by the liminality of the borderline, and this presents difficulties. Like the classical neurotic, the borderline is consumed by contradictory impulses toward dependency and independence, but unlike the neurotic, the borderline suffers more acutely impaired reality testing and the inability to maintain a core sense of self. On the other hand, borderlines cannot be considered full-fledged psychotics since their ability to test reality comes and goes. Clinician discomfort with borderlines, therefore, might reflect not only irritation with their behavioral antics but also the cognitive dissonance of category confusion—the result of the borderline's structural liminality.

Lester does not mention, except in passing, the preponderance of women among those diagnosed with the disorder.

Is this fact incidental to the construction of authenticity? Consider the prototypic borderline: she is seductively dressed and flamboyantly flirtatious in interaction with her (prototypically) male clinician. She is demanding, but when, inevitably, her demands cannot be satisfied, she becomes moody or volatile. The borderline is overly interdependent, and uses various behavioral strategies to maximize this value. Lester argues that "borderline talk" renders the patient incapable of epistemic authenticity because "she has no authentic self from which to act." I disagree. The borderline is possessed of an authenticity allocated to her on the basis of gender, which she exaggerates to the point of caricature.

It is the supercharged authenticity Devereux (1978) said was typical of the "social cynosure," a category that commands attention because it represents, in high relief, a cultural value of central importance. The borderline exaggerates interdependency, a value historically assigned to women. One could say that she "functions" to calibrate the scale according to which we measure conformity to the gender stereotype. This same can be said of the diagnosis "antisocial," an overwhelmingly masculine personality disorder. In this case, the assigned value is "independence" and the antisocial provides the prototype of this value taken to an extreme. The other personality disorders, I would argue, are variations on the same gender-based logic and function (to varying extents) as personality cynosures. But the borderline and the antisocial are special because they represent, in extremis, values assigned to women and men, respectively. This may be one of the reasons we talk about them so much.

---

# Reply

As I read them, concerns expressed by the commentators fall into four broad categories: (1) issues of social class; (2) my views on the ontological status of BPD; (3) whether I unjustly juxtapose psychodynamic *clinical* discourses and managed care *administrative* discourses, and the degree to which Cedar Grove clinicians actually find themselves in conflict; and (4) my own ethical stance on the withdrawal of care from certain clients, and how this may be complicated by the fact that I am a clinician as well as an anthropologist.

As Ewing, Gremillion, and Jenkins rightly point out, BPD clearly functions as an ethics of exclusion in this clinic. They each ask, in slightly different ways: to what extent are these exclusionary processes informed by and/or constitutive of notions of normative middle-class subjects as the only sort deserving of treatment?

First, a point of clarification is in order. Those who are ejected from treatment early, or become the subjects of borderline talk, are in no way distinguishable in social or economic class from other clients in the clinic. Access to treatment at Cedar Grove is certainly class-based in the sense that

having insurance *at all* means someone in the client's life has a job with benefits (Cedar Grove does not accept Medicare or Medicaid). This skews clientele towards middle- to upper-class populations. As a result, clients at Cedar Grove are more or less on equal footing in terms of social class. But this does not mean they have equal access to treatment. In fact, social class turns out to be a relatively poor proxy for quality of care.

How is this possible? Insurance policies are marketed to employers (not individuals), who purchase plans for their employees. Any number of permutations exists: plans with no mental health coverage, with yearly maximums, with coverage for some, but not all, conditions. When a crisis occurs, clients with solid middle-class or even executive jobs may find to their dismay that they have little or no mental health coverage, through no choice of their own.

Others may have good mental health coverage, but an insurance case manager may refuse to release benefits for use. Just because a policy provides, for example, 30 days of residential mental health treatment does not mean an individual can actually *use* those benefits any way they choose—the allocation of benefits rests with the insurance case managers, who can deny further treatment, even when benefits exist.

This was, in fact, the situation with Caroline. Caroline had relatively good insurance. She had coverage remaining. The clinicians and Caroline herself wanted her to remain in treatment. But MCOs are profit-making enterprises. Insurance case managers are under enormous pressure to *deny* coverage. Perhaps ironically, then, battles between clinicians and insurance often become an issue at Cedar Grove if a client has *good* (rather than poor) coverage. With a limited number of treatment days, the MCO knows the upper limit of costs they will incur for a given treatment episode, and clinicians and clients can plan ahead for the best use of treatment days, even if they find them inadequate. When someone has more flexible benefits or a higher dollar limit (like Caroline), the pressure on case managers to find reasons to terminate treatment-in-process is greater. Once inside the clinic, then, access to adequate treatment is not predictably tied to characteristics of the client's social class, or even necessarily to the specifics of her clinical case. It is this seemingly random distribution of care that produces such an atmosphere of anxiety and uncertainty in the clinic, for clients and clinicians alike.

If, then, borderline talk at Cedar Grove cannot be tied in a material way to issues of social class, what about the deployment of BPD to reinscribe boundaries of middle-class subjectivity? This is certainly a possibility. But, surely, we would expect all clients to be subject to these class expectations, not just a few. Most clients at Cedar Grove exhibit at least some borderline characteristics, as these often overlap with features of other conditions such as depression, anxiety, and eating disorders. Yet borderline talk emerged around only around some clients, and only in some circumstances. Why?

One might reasonably wonder whether some clients are simply "more borderline" than others. This leads us to the

question the ontological status of BPD and my stance on this issue. I think the characteristics associated with BPD (e.g., fears of abandonment, chronic feelings of emptiness, impulsivity and reactivity) are very real, and they tend to hang together in patterns much as described in the DSM. As a descriptive heuristic, then, I believe BPD does correspond with something "out there." However, in my experience, and as supported in the literature, what is diagnosed as BPD is often part of a complex adaptation to persistent chaotic or traumatic circumstances. This is not captured in the diagnostic criteria, which are silent on the kinds of systemic dysfunctions that can lead to dysregulated emotional and behavioral patterns. Instead, responsibility is located solely in the client's disordered personality; a personality that can never really be repaired. Because of this, the diagnosis of BPD can ideologically obscure relationships of power (including those of gender, race, and social class) that produce systematic structural violence and trauma. In this I am in full agreement with many of the comments offered here.

But this does not go very far in helping us understand what is happening in the clinic. Clients at Cedar Grove are all women in the throes of a medical and psychiatric crisis. Most of them exhibit many of the symptoms associated with BPD. The question then becomes why and how these features assume explanatory and directive power for clinicians in some situations and not others, and how this is bound up with processes far removed from the client herself.

With regard to these broader processes, Jenkins wonders about the comparison of clinical and administrative discourses, and this raises an important point. MCOs are businesses. They use medical diagnoses to justify the payment (or not) of health benefits. While MCOs employ physicians as advisors, and case managers may have a modicum of training in how to apply DSM criteria, Jenkins is absolutely correct that diagnostic discourses within MCOs are administrative, not clinical.

The troubling issue is that MCO administrative discourses have real clinical effects. If a case manager determines that a client no longer meets the MCO's "medical necessity" requirement for treatment—even if this contradicts American Psychiatric Association guidelines or the opinions of the client's own doctors—the client will not be able to use her benefits. In this regard, the MCO administrative classification becomes a de facto clinical decision, and the distinction between clinical discourses and administrative discourses is largely erased.

This erasure can cause the illusion that MCOs and therapists are engaged in the same endeavor, as revealed in Nuckolls' question about therapist orientation. He notes that most clinicians today are trained in cognitive-behavioral therapy (CBT; the approach most favored by managed care) and wonders, then, to what extent Cedar Grove clinicians actually find themselves to be in conflict with MCO guidelines. It is important to note that while all of the clinicians do use CBT to some extent, they do not do so exclusively. Cedar Grove (like most treatment centers) employs a range of techniques (CBT, dialectical-behavioral therapy, expressive therapies, psychodynamic perspectives) with the understanding that clients respond differently to different kinds of interventions. But even those clinicians most wedded to CBT frequently find MCO decisions about treatment baffling and infuriating. To return to Jenkins' observations, MCOs are operating with an administrative model, not a clinical one. While they may show preference for CBT in that it is easily mapped onto an economic model, MCOs are not *themselves* engaged in CBT. They are engaged in making a profit. To the extent that this is consistent with what clinicians feel will help the client clinically, things run smoothly. But at the end of the day, the MCO's bottom line is an economic one, not a therapeutic one. Being trained in CBT does not protect clinicians from being blindsided by case manager decisions or feeling ethically torn when forced to provide what they feel is less than optimal care. A clinician does not need to be a "heroic Freudian" to feel hijacked by managed care.

This raises the issue of my positioning in the clinic. I began my work there as an ethnographer in the traditional sense and entered clinical training 2 years later. Like many anthropologists, I felt that a fuller participation in the world of my subjects (in this case, clinicians) was critical to the fieldwork. But becoming a clinician brought some unique challenges. Specifically, it pushed me to think more clearly about my own ethical commitments and, at times, to make difficult choices. As a rule, when I felt my roles of clinician and ethnographer to be in conflict, I erred on the side of being a clinician first, researcher second. I placed the needs of the clients first, without question. In this, I feel I was no different than the clinicians I worked alongside every day, although such issues pale in comparison to the kinds of ethical dilemmas faced regularly regarding managed care. I struggled, as did the other clinicians, to reconcile the economic realities of care with the profound human suffering of our clients. I did not always— or even often—do so successfully. My own clinical experiences dealing with managed care have certainly affected my interpretations of the ethnographic data; they could hardly do otherwise.

Regarding access to treatment more broadly, I agree completely with Gremillion that excluding clients from needed care at Cedar Grove (or elsewhere) is profoundly unethical. I disagree with her, however, in terms of where I settle this ethical responsibility. To put a finer point on Luhrmann's characterization of my views, I find our current health care environment reprehensible. The provision of mental health care in particular is deplorable, even shameful. I am outraged when people have to leave treatment before they are ready or when debilitating conditions are minimized or dismissed as unworthy of care. But unlike Gremillion (in her book and in her comments here), I do not hold clinicians to be the central perpetuators of these abuses. Certainly, clinicians are the most visible embodiments of "the system." They are, understandably, tempting targets. And some clinicians undoubtedly act

in unethical ways. But to place ethical responsibility for a broken health care system on their shoulders not only robs individual clinicians of self-reflectivity and personal agency but also obscures the forces that constrain what kinds of ethical action are possible. I am interested not just in *what* the clinicians do, but *why* they do it, and the answer to the "why" is complex. I am not arguing that these clinicians— or any of us—always act ethically; rather, I suggest that what constitutes ethical action is sometimes ambiguous at best, but this does not stop people from trying to do the right thing. I do not know the clinicians Gremillion interviewed. I do know, however, that the clinicians at Cedar Grove were deeply troubled by this situation. Rather than operating with an ethic of "first, do no harm," they were forced to adopt a stance of, "do the least amount of harm possible," a far cry from the profound desire to heal that motivates them. How they made sense of this—and continued to act anyway—reveals dimensions of moral reasoning obscured by more simplistic understandings of human agency.

—Rebecca J. Lester

# References Cited

Akiskal, H., S. Chen, and G. Davis. 1985. Borderline: an adjective in search of a noun. Journal of Clinical Psychiatry 46:41–48.

Anderson, C. 2000. Dealing constructively with managed care: suggestions from an insider. Journal of Mental Health Counseling 22:343–353.

APA (American Psychiatric Association). 2000. Diagnostic and statistical manual of mental disorders. 4th edition, text revision. Washington, DC: American Psychiatric Association.

———. 2006. Practice guideline for the treatment of patients with eating disorders. 3rd edition. Washington, DC: American Psychiatric Association.

Baily, M. 2003. Managed care organizations and the rationing problem. Hastings Center Report 33:34–42.

Biehl, J. 2005. Vita: life in a zone of social abandonment. Berkeley: University of California Press.

Birenbaum, A. 1997. Managed care: made in America. Westport, CT: Praeger.

Bourdieu, P. 1977. Outline of a theory of practice. New York: Cambridge University Press.

Brodwin, Paul. 2008. The coproduction of moral discourse in community psychiatry. Medical Anthropology Quarterly 22(2):127–147.

Brown, P. 1995. Naming and framing: the social construction of diagnosis and illness. Journal of Health and Social Behavior 35:34–52.

Cohen, J., J. Marecek, and J. Gillham. 2006. Is three a crowd? clients, clinicians, and managed care. American Journal of Orthopsychiatry 76:251–259.

Danzinger, P., and E. Welfel. 2001. The impact of managed care on mental health counselors: a survey of perceptions, practices, and compliance with ethical standards. Journal of Mental Health Counseling 23:137–150.

Davidson, T., J. Davidson, and S. Keigher. 1999. Managed care: satisfaction guaranteed. Not! Health and Social Work 24:163–169.

Davis, Elizabeth. Forthcoming. Bad souls: an ethnography of madness and responsibility in Greek Thrace. Durham, NC: Duke University Press. [KPE]

Devereux, George. 1978. Ethnopsychoanalysis. Berkeley: University of California Press. [CN]

Díaz-Marsá, M., J. Carrasco, and J. Sáiz. 2000. A study of temperament and personality in anorexia and bulimia nervosa. Journal of Personality Disorders 14:352–359.

Donald, A. 2001. The Wal-Marting of American psychiatry: an ethnographic study of psychiatric practice in the late twentieth century. Culture, Medicine, and Psychiatry 25:427–439.

Dranove, D. 2000. The economic evolution of American health care: from Marcus Welby to managed care. Princeton, NJ: Princeton University Press.

Dworkin, G. 1988. The theory and practice of autonomy. Cambridge: Cambridge University Press.

Ewing, K. 1990. The illusion of wholeness: culture, self, and the experience of inconsistency. Ethos 18:251–278.

Feigenbaum, J. 2007. Dialectical behaviour therapy: an increasing evidence base. Journal of Mental Health 16:51–68.

Foucault, M., L. Martin, H. Guttman, and P. Hutton. 1988. Technologies of the self: a seminar with Michel Foucault. Amherst: University of Massachusetts Press.

Fox, H., M. McManus, and M. Reichman. 2003. Private health insurance for adolescents: is it adequate? Adolescent Health 32:12–24.

Gaines, A. 1992. From DSM-I to DSM-III-R; voices of self, mastery, and the other: a cultural constructivist reading of U.S. psychiatric classification. Social Science and Medicine 35:3–24.

Gartner, A., R. Marcus, K. Halmi, and A. Loranger. 1989. DSM-III-R personality disorders in patients with eating disorders. American Journal of Psychiatry 146:1585–1591.

Goldman, D. 1995. Managed care as a public cost-containment mechanism. Rand Journal of Economics 26:277–295.

Gostin, L. 2000. Managed care, conflicts of interest and quality. Hastings Center Report 30:27–28.

Gremillion, Helen. 2003. Feeding anorexia: gender and power at a treatment center. Durham, NC: Duke University Press. [HG]

Harris, E., and B. Barraclough. 1998. Excess mortality of mental disorder. British Journal of Psychiatry 173:11–53.

Hollan, D. 1992. Cross-cultural differences in the self. Journal of Anthropological Research 48:283–300.

Hopper, Kim. 2001. Commentary: on the transformation of the moral economies of care. Culture, Medicine, and Psychiatry 25:473–484.

James, W. 1908. Pragmatism: a new name for some old ways of thinking. New York: Longmans, Green.

Kaye, W., A. Kaplan, and M. Zucker. 1996. Treating eating-disorder patients in a managed care environment: contemporary American issues and a Canadian response. Psychiatric Clinics of North America 19:793–810.

Kirschner, S., and W. Lachicotte. 2001. Managing managed care: habitus, hysteresis, and the end(s) of psychotherapy. Culture, Medicine, and Psychiatry 25:441–456.

Kleinke, J. 2001. Oxymorons: the myth of a U.S. health care system. San Francisco: Jossey-Bass.

Kleinman, A., and B. Good. 1986. Culture and depression: studies in the anthropology and cross-cultural psychiatry of affect and disorder. Berkeley: University of California Press.

Lammers, C., and P. Geist. 1997. The transformation of caring in the light and shadow of "managed care." Health Communication 9:45–60.

Lindley, R. 1986. Autonomy. Atlantic Highlands, NJ: Humanities Press International.

Lopez, S., and P. Guarnaccia. 2000. Cultural psychopathology: uncovering the social world of mental illness. Annual Review of Psychology 51:571–598.

Luhrmann, T. 2000. Of two minds: the growing disorder in American psychiatry. New York: Knopf.

Mechanic, D. 2007. Mental health services then and now. Health Affairs 26:1548–1550.

Morreim, E. 1995a. Lifestyles of the risky and infamous: from managed care to managed lives. Hastings Center Report 25:5–12.

———. 1995b. The new medical ethics of medicine's new economics. Washington, DC: Georgetown University Press.

National Association of Anorexia Nervosa and Associated Disorders. 1999. Anorexics sentenced to death. Glamour Magazine 97:212–215, 253–255.

Ortner, Sherry B. 2006. Identities: the hidden life of class. *In* Anthropology and social theory: culture, power, and the acting subject. Pp. 63–79. Durham: Duke University Press. [KPE]

Oshana, M. 2007. Autonomy and the question of authenticity. Social Theory and Practice 33:411–429.

Paris, J. 2005. The diagnosis of borderline personality disorder: problematic but better than the alternatives. Annals of Clinical Psychiatry 17:41–46.

Parks, P., and M. Read. 1997. Adolescent male athletes: body image, diet, and exercise. Adolescence 32:593–602.

Peterson, M., ed. 1998. Healthy markets? the new competition in medical care. Durham, NC: Duke University Press.

Rhodes, L. 2004. Total confinement: madness and reason in the maximum security prison. Berkeley: University of California Press.

Robins, C. 2001. Generating revenues: fiscal changes in public mental health care and the emergence of moral conflicts among care-givers. Culture, Medicine, and Psychiatry 25:457–466.

Rosenberg, E., and D. DeMaso. 2008. A doubtful guest: managed care and mental health. Child and Adolescent Psychiatry Clinics of North America 17:53–66.

Scheper-Hughes, N. 1988. The madness of hunger: sickness, delirium, and human needs. Culture, Medicine, and Psychiatry 12:429–458.

Schneewind, J. 1998. The invention of autonomy: a history of modern moral philosophy. New York: Cambridge University Press.

Schneider, A., K. Hyer, and M. Luptak. 2000. Suggestions to social workers for surviving in managed care. Health and Social Work 25:276–279.

Scott, W., M. Ruef, P. Mendel, and C. Caronna. 2000. Institutional change and healthcare organizations: from professional dominance to managed care. Chicago: University of Chicago Press.

Shaw, C., and G. Proctor. 2005. Women at the margins: a critique of the diagnosis of borderline personality disorder. Feminism and Psychology 15:483–490.

Shweder, R., and E. Bourne. 1984. Does the concept of the person vary cross-culturally? *In* Culture theory: essays on mind, self, and emotion. Richard Shweder and Robert A. LeVine, eds. Pp. 158–199. Cambridge: Cambridge University Press.

Striegel-Moore, R. 2000. One-year use and cost of inpatient and outpatient services among female and male patients with an eating disorder: evidence from a national database of health insurance claims. International Journal of Eating Disorders 27:381–389.

Sullivan, W. 1999. What is left of professionalism after managed care? Hastings Center Report 29:7–13.

Taylor, C. 1991. The ethics of authenticity. Cambridge, MA: Harvard University Press.

Trilling, Lionel. 1972. Sincerity and authenticity. Cambridge, MA: Harvard University Press. [JHJ]

Tyrer, P. 1999. Borderline personality disorder: a motley diagnosis in need of reform. Lancet 354:2095–2096.

Vandereycken, W. 2003. The place of inpatient care in the treatment of anorexia nervosa: questions to be answered. International Journal of Eating Disorders 34:409–422.

Ware, N., W. Lachicotte, S. Kirschner, D. Cortes, and B. Good. 2000. Clinician experiences of managed care: a rereading of the threat. Medical Anthropology Quarterly 14:3–27.

Wiseman, C., S. Sunday, F. Klapper, W. Harris, and K. Halmi. 2001. Changing patterns of hospitalization in eating disorder patients. International Journal of Eating Disorders 30:69–74.

Wonderlich, S., W. Swift, H. Slotnick, and S. Goodman. 1990. DSM-III-R personality disorders in the eating disorder subtypes. International Journal of Eating Disorders 9:607–616.

Zelman, W., and R. Berenson. 1998. The managed care blues and how to cure them. Washington, DC: Georgetown University Press.