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Critical Therapeutics:
Cultural Politics and Clinical Reality in Two Eating Disorder Treatment Centers

Recent studies suggest that eating disorders are increasing in Mexico and that this seems to correspond with Mexico's push to modernization. In this respect, Mexico exemplifies the acculturation hypothesis of eating disorders, namely, that anorexia and bulimia are culture-bound syndromes tied to postindustrial capitalist development and neoliberalist values, and that their appearance elsewhere is indicative of acculturation to those values. Available evidence for this claim, however, is often problematic. On the basis of five years of comparative fieldwork in eating disorder clinics in Mexico City and a small Midwestern city in the United States, I reframe this as an ethnographic question by examining how specific clinical practices at each site entangle global diagnostic categories with local social realities in ways that problematize existing epistemologies about culture and illness. In this regard, debates about acculturation and the global rise of eating disorders foreground issues of central epistemological and practical importance to contemporary medical anthropology more generally.

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On my second day of fieldwork at a Mexican eating disorder clinic, I met a young, anorexic woman named Lucy. Lucy had been brought to the clinic against her will, through an intervention. When the clinical team went to her house to pick her up, even they—seasoned professionals with decades of experience treating eating disorders—were shocked by what they found. Lucy was bedridden, hooked up to oxygen tanks, barely able to move. Her heart had stopped twice. She refused all food and only took three small sips of water a day. Lucy would not let the clinical team weigh her on admission. A full week later, she weighed in at 52 pounds. She is five foot three inches tall.

The clinic where I met Lucy is located in a sprawling house in a posh Mexico City neighborhood. When it opened in 2002, it was the first and only residential facility in Mexico dedicated specifically to the treatment of eating disorders, although more services have since become available.[1] In the five years it has been operating, it has

treated over 200 women like Lucy. It is usually filled to capacity and often has a waiting list.

I began fieldwork at this clinic, which I call Marisol, in 2002 with over 10 years of research experience working with eating disorders in the United States. I had recently initiated parallel research in a facility in the U.S. Midwest. In the context of this comparative project, I was interested in how similar existential struggles about gender and embodiment might be differently expressed in the two contexts: that is, how eating disorders, as stylized forms of social suffering, might look different in Mexico.

In fact, it turns out that the behaviors and clinical symptomatology of anorexia and bulimia in Mexico look practically identical to those in the United States, and they seemed to be coupled with the same sorts of personality characteristics common in U.S. settings.[2] Yet despite these "objective" similarities, I found that the therapeutic programs in these two centers construct very different clinical realities of eating disorders and eating-disordered patients. Although both clinics treat "eating disorders" in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-4-TR)* sense (American Psychiatric Association 2000), it soon became apparent that, in practice, they are treating what are two fundamentally different diseases. My interest then turned to the question of how these local clinical cultures come to attribute different underlying dynamics to the same manifest symptomatology, and how these links come to be experienced as clinical reality by clinicians and clients alike.

Theoretical Frame

I aim to puzzle out what Lee calls "the cultural construction of authorized clinical reality" (1995:31) in these two clinics; that is, how knowledge about eating disorders is locally generated and legitimized in dialogue with particular moral and practical commitments and within complex social dynamics. I find the literature on ritual and rites of passage to be a helpful starting place for thinking through these issues.

I propose that being in treatment—for an eating disorder or any other condition—entails a process of *liminality* (Turner 1967) as a client moves from a locally construed "sick self" to an imagined future "healthy self," and that a close examination of this process can illuminate the mechanisms through which clinical reality emerges in dialogue with local ideological commitments. As with other sorts of rites of passage, a client in treatment for an eating disorder receives knowledge, learns skills, and practices behaviors that are specifically intended to reorient her understanding of herself and the world around her. Values deemed important to recovery (such as personal responsibility) are grounded in specific practices (such as requiring clients to make the bed each morning). Over time, assuming a client engages with treatment, the repetition of such practices within the ideological frame of the clinic helps the client develop new ways of understanding and experiencing herself and others. It is expected that she will undergo a profound emotional, psychological, and physiological transformation that will enable her to rejoin outside society and function there effectively in a way in which she was incapable before.

The approach to ritual I adopt here builds on Catherine Bell's (1992) understanding of the ritualization of practice, wherein the power of ritual is not to solve problems but to reframe them. Ritualization, she argues, entails three key

components: (1) setting apart a domain of practice as somehow "other than" every-day life, (2) reordering participants' experiences within that domain by foreground-ing new connections among existing cultural concepts, and (3) grounding these new associations in embodied practice.

This is what happens in the eating disorder clinics. Following Bell, and adapting a modified critical-interpretive approach (Lock and Scheper-Hughes 1990), I argue that different eating disorder treatments configure selective cultural proscriptions about agency, sexuality, desire, and femininity within the ideological and practical commitments of each setting. Engagement in therapeutic interventions persuades participants (and here I include staff as well as clients) to make new connections among these elements, to ground them in everyday practice, and to imbue them with moral significance. As a result, despite a shared diagnostic clinical language, what emerges in the Mexican and U.S. clinics are divergent understandings of what sits at the heart of an eating disorder, what treatment should look like, and how recovery should be evaluated.

Eating Disorders in Mexico

Recent studies suggest that eating disorders are on the rise in Mexico (Álvarez et al. 1998; Díaz et al. 1999; Gómez Peresmitré 1993; Román 1998; Unikel et al. 2005; Vázquez et al. 2000).

When I lived in Mexico in 1994 and 1995 to conduct my dissertation research with young women entering a Catholic convent (Lester 2005), eating disorders were nowhere on the national radar. Few people had even heard of such things, let alone known someone afflicted. By the time I began research at Marisol in the spring of 2002, things had radically changed. Government-sponsored public service announcements outlining the warning signs of anorexia and bulimia appeared on television and in popular fashion magazines. An after-school special portrayed the struggle of a family of a bulimic teenager. A participant on the Mexican version of the reality show *Big Brother* was sent to treatment by the producers for her anorexia. Because there were so few eating disorder training programs in Mexico, U.S. profes-sionals were brought to Mexico to conduct specialized training sessions at the major universities and for clinicians who found their waiting rooms filling up with clients.

Although anorexia and bulimia have long been considered the consummate "culture-bound syndromes" of modern Euro-American societies (Banks 1992; Crisp 1980; Gremillion 1992; Prince 1985; Rothblum 1990; Swartz 1985), new research suggests that these illnesses are on the rise across the globe, particularly in developing countries like Mexico. This rise seems to coincide with economic and social changes associated with modernization and acculturation to "Western values" (e.g., height-ened consumerism, individualism, media saturation, an ethos of independence, and an idealization of self-discipline, coupled with the constant seduction to "supersize" everything, from french fries to TVs to SUVs), which are thought to render disor-dered eating behaviors such as bingeing and purging or self-starvation culturally syntonic (cf. Becker 1995; Gunewardene, Huon, and Zheng 2001; Lake et al. 2000; Lai 2000; Lee, 1996; Littlewood 1995; Nasser 1997; Nasser et al. 2001; Yoshimura 1995). This approach, which I have come to think of as the "acculturation hypoth-esis" of eating disorders, is succinctly stated by Brumberg (2000), who argues that

"Americans export eating disorders along with McDonald's hamburgers, Disney movies, and Michael Jordan."[3]

At first glance, recent developments in Mexico would seem to support the acculturation hypothesis. Mexico is one of the largest consumers of U.S. material, media, and political culture, although its relationship to this cultural influence is often conflicted and highly contested (cf. González 1994; Raat 2004; Tatto 2003). In all standard indicators of modernization (e.g., economic development, health status, literacy rates, technological development, and political participation) Mexico has excelled, and the effects appear to have been far reaching (Arbatov 1992; Rubio and Fernández 1995). The recent rise of eating disorders in Mexico might reasonably be viewed, then, as resulting from these changes.

But other inquiries suggest a more complicated picture. Caballero et al. (2003), for example, found significant differences between matched eating disordered subjects in New York and Mexico in terms of the specific food and body preoccupations experienced, the behaviors associated with these preoccupations, and motivations for change. And contrary to the expectations of the acculturation hypothesis, Bojorquez and Unikel (2004) found eating disordered behavior to be elevated among rural and semiurban Mexican women as compared to their "more acculturated" Mexico City counterparts.

It remains unclear, then, how best to make sense of the Mexico data. In part, this may be owing to the relative scarcity of information about these illnesses in Mexico (Caballero et al. 2003; Unikel and Bojorquez 2007). But I suggest that, more fundamentally, this ambiguity derives from a conflation of concepts whereby "culture" assumes explanatory force when, in fact, it is itself something that needs explaining. There are a number of issues at play here, including the reliance on epidemiological data derived primarily from clinical and university populations and the confusion of correlation and causation.[4] However, the most problematic in my reading is the proposition that the appearance of eating disorders in a given society is evidence of acculturation to Western values precisely because eating disorders are Western culture-bound syndromes. Such arguments leverage a psychiatric diagnosis predicated on cultural assumptions to make an argument about culture. The effect (clearly unintentional) is an appropriation of the notion of culture that gives the illusion of cross-cultural substantiation for psychiatric diagnostic criteria while, in fact, obscuring genuine cultural analysis.[5]

The dangers here extend beyond the arena of eating disorders per se, and certainly beyond the realm of psychiatry. Medical anthropology has long contended with the ways in which Western biomedical categories inform cross-cultural research. Somewhat less attention, however, has been given to the ways in which the idea of "culture" itself has been configured as a conceptual category and the implications this has for cross-cultural inquiry. In this regard, the issues of acculturation and the globalization of eating disorders foreground issues of central epistemological and practical importance to contemporary medical anthropology more generally.

Local Clinical Realities: Approaches from the Underside

Given its limitations, the acculturation hypothesis is clearly problematic for making claims about the cultural causes of eating disorders. What the cross-cultural research
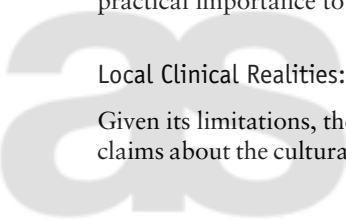
on eating disorders might suggest, however, is a possible association between certain social and cultural factors and the diagnosis of eating disorders as distinct clusters of troubling thoughts, behaviors, and emotions. Eating disorders have traditionally been thought to center on issues of thwarted independence and individuation,[6] which in turn presumes individuation and autonomy to be central components of healthy selfhood (Gaines 1992). It might seem reasonable to suspect, then, that the appearance or rise of diagnoses of eating disorders in developing societies in which no such thought–emotion–behavior clusters were previously recognized might indicate a shift toward privileging individuation and autonomy as hallmarks of psychological health. This is an empirical question. Does the local relevance of diagnostic categories for eating disorders necessarily imply an endorsement of psychological health consistent with "Western" cultural values? If so, this would offer support for the acculturation hypothesis, at least at the level of diagnosis. If not, however, this would help us tease out how culture, as a concept, is configured in these debates as well as the practical on-the-ground implications of such assumptions. It might also open up productive new lines of theoretical inquiry and methodological focus.

The Research

This research builds on fieldwork spread over 15 years (see Lester 1995, 1997, 2000). In 2002, I began concurrent, staggered fieldwork at an eating disorder clinic in a small city in the U.S. Midwest, which I call Brentwood Park, and at Marisol in Mexico City. This research is ongoing.

Research among vulnerable populations such as those in residential treatment facilities entails special ethical concerns. In addition to obtaining standard university institutional review board (IRB) approvals, my research protocol was reviewed and approved by the program staff at each facility. I then obtained oral consent from each client and each therapist to observe and participate in group activities in the clinics (group therapy sessions, meals, outings, treatment team meetings, etc.), and I obtained written consent for individual interviews. Clients under the age of 18 were not included. Confirmation of consent was recorded in my field notes. All subjects were advised that they could withdraw consent at any time without consequence.

Because I was primarily observing activities that were already part of the therapeutic program at each clinic, it seemed unlikely that my presence would place subjects at additional risk for distress; however, I relied on the clinical judgment of the staff at each facility and the comfort level of clients in determining the appropriateness of my participation in any activities. In those cases in which I did conduct individual interviews with clients I did so only with the knowledge and approval of the client's individual therapist. All names in my field notes and in this article are pseudonyms.

The research consisted of intensive participant-observation at each site across a range of activities, such as group therapy sessions, client meals and outings, group activities, staff interventions, clinical trainings, and treatment team meetings. Semistructured formal and unstructured informal interviews with clinical staff, clients, and families were also conducted. I also gathered what I call "event narratives," in which I separately interviewed participants about an event that occurred (e.g., when a client at the U.S. clinic was accused of removing her own feeding tube)

to elicit different interpretations about what precipitated the event, what actually occurred during the event, and what were the consequences (or anticipated consequences) of the event. In the feeding tube incident, for example, I interviewed the client herself (who maintained that the tube fell out in her sleep), medical staff (who said this was impossible), clinical staff (who speculated about the client's lack of motivation for recovery), and other clients (who generally believed the client's story and were angry at staff for mistrusting her). Ultimately, the treatment team is empowered to determine the "truth" of such events, and it is their interpretation that carries specific, tangible treatment consequences (in this case, the client lost all passes for a week and had to increase her calorie level). It is in such varied enactments that clinical reality is generated and emplaced in social interactions.

Here, I offer a detailed exegesis of two commonplace events in the production of clinical realities: a treatment team meeting at the Midwest clinic and a group therapy session at the Mexico City clinic. These examples are typical of their respective sites and exemplify how the therapeutic process generally unfolds in each setting. In fact, I selected them for analysis precisely because they are so "ordinary" and, as such, help to illustrate the everyday sorts of ritualizations that continually (re)create clinical reality in each site. They also foreground how ritual productions and enactments of clinical reality percolate throughout the therapeutic environment (rather than working hegemonically from the top down) and inform the experiences of staffs as much as clients.

Yet because these contexts are so different from each other in term of participants, structure, and aims, I do not endeavor to make a direct comparison between these two events. Rather, I want to explore how these sorts of practices crystallize, communicate, and reaffirm fundamental assumptions and beliefs about eating disorders and attendant issues in each context that lead to divergent on-the-ground interpretations of the same symptomatology and diagnostic criteria. Specifically, I suggest that these practices can productively be understood as ritualizations of local moral commitments regarding proper subjectivities and behaviors that engage the liminality of treatment in concrete ways.

Brentwood Park: Launching the Autonomous Individual

At a recent treatment team meeting at the Midwest site, clinicians debated what to do about Kelly, a 20-year-old, white, upper-middle-class woman with a five-year history of anorexia. She had been in three inpatient and two outpatient facilities before coming to Brentwood Park. The day prior to the meeting the staff caught Kelly using her personal laptop and the facility's wireless Internet connection to access a number of pro-anorexia websites. These sites, with names like "Emaciate Me," "Little Baby Nothing," "Cut Me Open," and "Beautifully Insane," promote anorexia as a "lifestyle choice." Participants encourage each other in their eating disorders by providing tips and tricks on how to beat hunger when on a fast, how to fool parents or doctors, and how best to mix laxatives and stimulants. The sites also offer "thinspirational" photographs and maintain message boards. Kelly had been using these boards to post a chronicle of her treatment at Brentwood Park, including photos of herself taken with her camera phone in various states of undress.

Kelly's conduct was the focus of the next day's treatment team meeting. These weekly meetings aim to integrate disparate information about patients collected over the previous week, such as weight gain or loss, calorie levels, participation in therapies, and interaction with staff and patients. Present for the entire two-hour meeting each week are Jane (the director and psychiatrist), Liz (a psychiatric nurse who is the program director), the nutritionist, an adolescent medicine physician, the clinic therapists, the insurance certification person, and the anthropologist. Each patient is discussed and assessed according to medical and psychiatric (incl. medication management), nutritional, and clinical (therapeutic) parameters. Requests for passes or changes in privileges are reviewed, and specific treatment recommendations for the following week are noted. Discussion of each patient ends with a summary for the insurance manager about how best to present a patient's progress to the managed care company. Discussion winds between what Mattingly (1998) calls "chart talk" and "storytelling," as clinicians try to piece together a coherent picture of a client's progress.

These discussions are sometimes far from smooth, and the final outcome often does not reflect consensus among the staff. Members of the treatment team often strongly disagree about how to interpret a client's behavior or how to proceed clinically. It is within these disagreements that clinicians' shared assumptions, as well as ambivalences, about eating disorders become most visible. As these disagreements are negotiated and resolved (albeit sometimes imperfectly), the team meetings emerge as ritualized processes.

In discussing the incident with Kelly, two camps emerged. I have come to think of these as the "hardliners" and the "soft peddlers." Clinicians who come from working in the justice system or with other addictions tend to favor clear treatment guidelines and rules with unambiguous consequences. These are the hardliners. They tend to be younger clinicians who have been trained in the wake of the managed care revolution. In the case of Kelly, these clinicians argued that Kelly's laptop should be taken away from her and she should be forbidden to access the Internet.

In contrast, clinicians operating with a more psychodynamic perspective tend to favor individualized consideration and a flexibility of treatment parameters. These are the soft peddlers. They tend to be the more seasoned clinicians who find it difficult to translate their years of experience into managed care frameworks. In this particular team meeting about Kelly, this group argued that, once discharged, Kelly would be able to access the pro-anorexia sites anyway, so it was better for her to make her own decision about whether or not to do so within a therapeutic context in which her choices could be engaged clinically. The latter argument, which was championed by Jane, the clinic's founder and director, won the day. Kelly was brought into the team meeting and asked to please not access the proanorexia sites while in treatment, and she was allowed to keep her laptop.

After the meeting, Susan, one of the hardliner clinicians, complained bitterly in the staff room that "Kelly *so* played Jane. She knew exactly what to say to get her way. That girl is a professional patient. We need to have more rules here. This is ridiculous. We can't just have our patients accessing pro-anorexia websites while in treatment! It's the stupidest thing I've ever heard." Barbara, however, had a different take on the situation. As she told me in a separate conversation, "Kelly is a very difficult case. She does well in treatment but then crashes when she leaves the structured

environment. It's important for her to learn to take chances and make choices, even if they're the wrong ones, while she's here and can get support. Otherwise there's no way she'll make it on the outside."

These ways of talking about Kelly construct her as a patient in very different ways. Is she a calculating manipulator or a vulnerable invalid? Should the clinicians be protective of her or do they need protection from her?

Susan and Barbara offer differing interpretations of the dominant U.S. approach to eating disorders to which Brentwood Park subscribes. This understanding of eating disorders takes the core conflict of these illnesses as the girl's struggle for autonomy, usually from an overinvolved mother (Winston 2005). As a result of this enmeshment, it is believed that the eating-disordered girl has not formed a sufficiently solid sense of self as separate from others (Zerbe 1993). As she moves into adolescence, this then leads to a host of other difficulties, including the need for validation to feel seen—by becoming the "perfect" daughter or student, the most popular in school, the best athlete (Levenkron 1978; Steiner-Adair 1986). In this context, food is understood to be the one area over which the eating disordered girl feels she has sole control. Specifically, acting out against her own developing female body is generally understood as a rejection of adult womanhood (i.e., the mother) and a desire either to remain childlike or to attain a more androgynous (or even masculine) state (Bruch 1973). Although such assumptions might translate into very different types of therapeutic action (e.g., a psychodynamic therapist might focus on "ego functions," whereas a cognitive-behavioral approach would target problem thoughts and behaviors), such approaches share the core commitment that the cause of eating disorders, and the enduring problem keeping a client in distress, is a lack of an individuated self.

The work of recovery, then, regardless of the specific theory or technique involved, is conceptualized as developmental, in the sense of helping the patient to achieve independence and autonomy. To this end, clinics like Brentwood Park often configure themselves as a sort of substitute family system whose job is to reparent a client, facilitating the development of a more solid sense of self (Gremillion 2003).

There seem to be two different perspectives at Brentwood Park about how best to do this. One is to insist on the importance of clear limits and boundaries as providing a much-needed structure to rein in a chaotic, unruly self. This is the perspective taken by the hardliners. Another is to assume that a healthy self is brought into being through supportive and empathic connection. This is the soft peddlers' approach. For both groups, however, the developmental aim is to prepare the client to leave the protective bosom of the clinic and strike out on her own.

Brentwood Park assesses how well clients are achieving this developmental task by progressively reducing structural constraints and then assessing the kinds of choices clients make with their new freedoms. For example, clients are given restaurant passes to test their ability to make healthy food choices and remain on their meal plans outside the clinic. Weekend passes let clients challenge themselves at home and in social contexts. Do they choose to binge and purge? Skip a snack? Call a friend? Isolate? The specific choices a client makes when given these windows of independence are thought to index her progress toward recovery.

Kelly's actions were also framed through this lens of choice—clearly a wrong one—although clinicians disagreed about how they should respond. The hardliners

maintained Kelly was unable to make healthy choices at the moment, as evidenced by her behavior, so the treatment center must make them for her. The soft peddlers suggested that, indeed, Kelly could make healthy choices if given the proper support, and they saw the incident as a way to leverage a more honest relationship between Kelly and the staff.

But despite these differences, framing this incident as an issue of "choice" allowed for a bridging of these two perspectives; it situated Kelly and her illness squarely within an understanding of eating disorders as pathologies of control, as evidence of a weak or misdirected self, or as a developmental stall. Focusing clinical attention on the manifest result of Kelly's choice as indicative of her internal state of recovery encouraged the treatment team to make connections between issues of freedom and choice, notions of proper individuation and mature development, and specific client behaviors: connections to which they could all subscribe despite their other differences. In this way, the foregrounding of choice as a core issue in the meeting allowed for a provisional coherence among the treatment team members despite deeper divisions about clinical imperatives. And by grounding these commitments in specific treatment decisions—Kelly was permitted to keep her laptop and modem—such productions of local clinical reality assume real, tangible implications for clients and staff alike.

Marisol: Negotiating Control and Responsibility

The kinds of discussions that unfold in the Mexican clinic are quite different. There, the central issue is not one of choice, but of self-awareness. The dominant concern is less about limits and transgressions and more about reorienting one's focus from the external to the internal. This both reflects and enacts an understanding of eating disorders—and their treatment as more about process than outcome.

As awareness about eating disorders in Mexico has grown over the past decade and more and more women present for treatment, the clinicians at Marisol have become increasingly frustrated with what they experience as a mismatch between the theories and treatment strategies in which they have been trained and what they encounter on the ground. As Monica, one therapist, told me:

> It's a constant process of translation between what we learned in school and what's actually relevant in working with our clients. Most of our training is based on American and European approaches, and those interventions are just not appropriate here. We need to develop a Mexican model for treating eating disorders.

Much of Marisol's programmatic refinement over the past five years has been informed by such concerns.

The perspective that Monica and the other Mexican clinicians at Marisol find so troubling is the dominant one in the United States. This approach, as we saw at Brentwood Park, conceptualizes eating disorders as being first and foremost about thwarted individuation, with treatment designed to move the client toward autonomy. In Mexico, however, the ideal of healthy adulthood—and particularly healthy womanhood—traditionally has not been predicated on becoming an independent,

autonomous individual. Rather, one should strive to become a socially embedded and responsive person who takes an active, responsible role within a broader system of relationships (Keller et al. 2006). Although such "traditional Mexican values" (e.g., familism) have been somewhat destabilized by recent economic, political, and social developments (Covarrubias Cuellar and Uribe Alvarado 1998; Lawson and McCann 2005; Maass and González 2005), they retain powerful cultural capital in Mexico (Diaz-Loving 2006) and inform clinical practice at Marisol. As Olivia, another Marisol therapist, told me:

> The United States has a very different understanding of the individual and the family than what we have in Mexico. Our families here are very involved, very close. If you tell a mom or a dad here that they need to back off their involvement with a child, even an adult child, it's like telling them to cut off their arm. They won't do it. This is especially true with daughters. Daughters here are very overprotected until they are much older, in their twenties or thirties even. Here in Mexico it's expected that your parents will have authority over you until you're married. Even in the most progressive, liberal families, this is the case. It's part of our culture.

In terms of autonomy and independence, she said, "the kind of autonomy valued in the United States is interpreted as rather aggressive here in Mexico. The U.S. ethos of 'I can take care of myself, I don't need anyone or anything' just seems so out of line with our experience here. It's just out of synch with our cultural reality."

The hallmarks of healthy adulthood in the United States—self-sufficiency, individual autonomy, and emotional separateness from one's natal family—against which eating-disordered behaviors are read in the U.S. clinic are, then, at best, ambivalently configured in Mexico. Given this, it is perhaps not surprising that the Mexican clinicians felt uneasy with their charge of pathologizing culturally valued forms of relating and of steering clients toward what they viewed as problematic configurations.

How, then, have they managed this disjuncture? One strategy has been Marisol's adoption of the discourse of "codependency" as an explanatory model for eating disorders that attends to the manifest symptomatology of these illnesses without necessarily endorsing the autonomous-individual model of health. Popularized in the U.S. addiction and recovery movement in 1980s, the notion of "codependence" has since largely been abandoned by U.S. practitioners, although it has gained precedence in Japan (Borovoy 2005). In rudimentary terms, codependency entails a symbiotic relationship where both participants "fill in" emotional or functional gaps in the other (Webscheider-Cruse and Cruse 1990). Codependency is when, in the words of Jerry McGuire, "*You* complete *me.*"[7]

"Codependency" as used at Marisol, then, is similar to the "enmeshment" discourse at Brentwood Park, but the two concepts differ in important ways. As clinicians at both sites explained to me, codependency involves being psychologically dependent on another to meet one's needs, whereas enmeshment is characterized by a lack of differentiation between self and other. Codependency, then, presupposes a separation between participants (although they continue to function in a symbiotic dance of dependency), whereas enmeshment is characterized by a lack of primary

separation. Most importantly for our purposes here, codependency, as the name suggests, requires a two-person psychology (and therefore a way of talking about processes of interaction), whereas enmeshment, by definition, does not. As we will see, this has wide-ranging ramifications for how treatment unfolds at Marisol and how recovery is conceptualized.

Rather than moving a client out of enmeshment and toward individuation, the task of recovery at Marisol is thought to be a more nuanced, yet at the same time more radical, process. Recovery at Marisol is not thought to require forging a self that has not yet fully developed, but rather making a shift in the management of emotionality in relationships with others. In this model, the task is not to achieve independence but, rather, to develop a capacity for a different sort of dependency. The focus is shifted from a concern with psychological structure (building a stable sense of self) to a concern with interpersonal processes.

A closer look at a group therapy session at Marisol can help illustrate the contours of this process. Last spring, Carla, a 19-year-old middle-class Mexican woman with a history of both anorexia and bulimia, was the focus of a group therapy session. Still small and frail looking despite being in treatment for three months, Carla moved reluctantly to the front of the room and began the task of the group—recounting her life story for her peers. For the next 45 minutes, Carla spoke, uninterrupted. She talked about how her eating disorder began when she was 13, when her father and brothers started teasing her about her developing figure. She started a strict diet and lost almost 20 pounds in just three months. She told of how her anorexic restriction eventually gave way to bingeing and then panicked purging to keep the weight off. She recounted stealing money from her parents to buy food, lying about her purging, getting caught. She talked about her deep shame and humiliation about her behaviors and how she resisted getting help until she began to throw up blood. As she spoke, the other clients took notes, making reference to photocopied lists of "character defects" and "tools of recovery" handed out by the therapist before the group began. When Carla finished, Julia, the group therapist, asked the other clients to come to the front of the room and, one by one, list on a dry-erase board behind Carla which elements they perceived in her story.

Compared to what I had seen at various clinics in the United States, including Brentwood Park, Carla's presentation struck me as frank, authentic, and quite insightful. But by Marisol standards, Carla's story said something else. One by one, as the other clients began to mark things down on the board behind Carla, a very different picture emerged than what had been my initial impression. "Manipulation" wrote several under the "character defects" heading. "Self-pity" wrote others. "Infantile," "prideful," "blames others," "perfectionist," "hostile," "not aware of illness," "exhibitionist." As the marker squeaked on the board behind her, Carla began to sob quietly. When Julia finally asked her to turn around and look at the list, her sobbing increased. Feedback from the group began. "From what I heard," said Anita, a 24-year-old client, "you blame your father and your brothers for a lot of your illness and paint yourself as a passive victim." "I agree," added Maria, a 17-year-old client:

And you didn't talk at all about your feelings, just your physical sensations with bingeing and purging. You show some exhibitionism with the way you
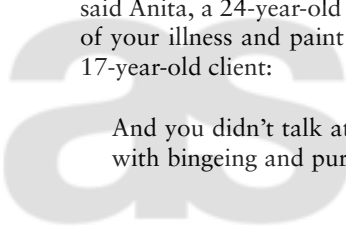
focused on how much you ate or didn't eat, how often you purged, what it felt like. You're still in your symptom, even here, using your behaviors to avoid talking about what's really going on.

Lourdes, a 19-year-old client, offered perhaps the most searing commentary.

You wear a mask of self-pity, Carla, but you do this to get attention from others, so they'll feel sorry for you. You do this here in Marisol in the way you interact with the group, and you can see it in the way you tell your story, too. But you're sick because you want to be sick. The only one responsible is you.

In summing up, Julia (the therapist) stressed to Carla that her illness is extremely serious and that she has been wasting her time in treatment by focusing on trying to get everyone to like her and not dealing with her underlying problems. "What has wearing social masks here gotten you?" she asked Carla. "Have you accomplished anything in these three months? Very, very little. What's going to happen when you leave? When are you going to become responsible for your own life? Who are you going to blame?" The only hope Carla has of beating her eating disorder, Julia told her, is for her to go deeper, to stop focusing her attention on the external, and to look hard at how she is approaching and engaging the world around her. The group closed with an affirmation. Carla appeared shell shocked. Several of the clients straggled after the group to hug Carla and tell her they care about her and want her to get well.

This group was a special kind of practice at Marisol called an *Espejo de Vida*, or Life Mirror, which foregrounds core elements of the clinic's philosophy. Drawing on the 12-step model, Marisol conceptualizes eating disorders as a form of addiction similar to alcoholism or drug addiction. The central assumption is that addictive behavior in relation to the drug of choice—in this case, self-starvation or bingeing on and purging food—both evidences and compensates for a deep alienation from self and spirit: an internal disconnect. As such, the goal of treatment involves a radical reformulation of a patient's understanding of herself—and more precisely, a reformulation of her self-in-relationship that proceeds through the language of codependency.[8]

We can see this in the group's feedback to Carla following her narrative. Underlying all of the comments is the proposition that Carla remains in tenacious denial about her own responsibility for her eating disorder, that she persists in focusing on blaming others and configuring herself as a victim. If this were true, then Carla's only hope for recovery would be if others change or if others somehow rescue her. This is the hallmark of codependency. By helping Carla to understand her own role in her eating disorder and empowering her to take ownership over how she positions herself in social relationships, Marisol aims to facilitate a developmental process, but in a different way from the individuation process stressed at Brentwood Park.

Carla's Espejo de Vida both enacted the dynamics seen as central to her eating disorder and walked her through an alternative. By making the specific elements of this process explicit and helping clients like Carla make new associations among self-awareness, disordered eating, and social relationships, group therapies like the Espejo de Vida operate as ritualized processes. They slowly and over time help clients

to dismantle existing uses of self and then to develop new strategies of interpersonal interaction without resorting to their eating disorder. As Candice, Marisol's clinical director, told me, "Girls go through a crisis of identity here—but without the symptom."

Ambiguities and Ambivalences

It is interesting to note that, by focusing on the development of internal authenticity and personal responsibility (rather than external definitions of self), the Marisol program might appear to be advocating an individualism akin to that perceived to be characteristic of the United States and contrary to what are represented at Marisol as mainstream Mexican cultural values. Codependency, by definition, requires "two to tango," and the codependent cycle cannot continue without one's willing participation. Indeed, clients learn that ultimate responsibility for their recovery rests with them and them alone.

Similarly, the paternalism of the U.S. clinic might seem to run counter to the ethos of independence and personal responsibility advocated as central to recovery. Clients are held accountable for their behaviors and choices, yet they are also generally understood to have impaired judgment because of their eating disorder.

Both clinics, then, engage with problematics of dependency at multiple levels, and these engagements are not always internally consistent. What I describe here, then, are not clear-cut, hard-and-fast distinctions between "individualist" and "interdependent" cultural ideals that find hegemonic articulation in the clinics but, rather, mutlilayered processes involving relative degrees of emphasis along a continuum. Indeed, I suggest that it is precisely in light of such ambiguities and ambivalences that clinical activities emerge and function as ritualized practices. They order disorganized feelings, thoughts, and experiences (for clinicians as well as clients); they systematically link different levels of experience (cognitive, behavioral, emotional, psychological, and interpersonal) and imbue these clusters with meaning (as in the debates about Kelly's choice to visit pro-anorexia sites); they facilitate a reordering of experience within new ideological frames (as in the case of Carla's Espejo de Vida group); and they provide a common language, available to clients and clinicians alike, for articulating both suffering and healing.

Both Brentwood Park and Marisol, then, understand their aim as moving clients through a developmental, liminal process toward a particular model of healthy adulthood, and both mobilize therapeutic interventions to ground these values in specific interactions with clients. But they understand both the aims and the mechanics of the process differently, producing very different configurations of eating disorders and eating disordered patients along the way.

Discussion

It seems clear (at least in the case of eating disorders in Mexico) that the acceptance of *DSM-4-TR* categories as legitimate descriptors of troublesome clusters of behaviors does not necessarily entail a wholesale endorsement of psychological health consistent with Western cultural values. Although I take seriously the cautions by Gaines (1992), Nuckolls (1998), and others about the "cultural load" carried

by many *DSM-4-TR* diagnoses, it nevertheless seems that local engagements with such categories can, in practice, diverge significantly from their elaborations in U.S. contexts.

Although I focus here on eating disorders, this research highlights issues of fundamental concern in the cross-cultural research on health and disease more broadly. Clearly, although clients at Brentwood Park and Marisol meet the same *DSM-4-TR* diagnostic criteria for eating disorders, the clinical realities of what that means are distinct. Although this does not indicate that there are no shared elements or that they are completely incomparable on all levels, it does mean that privileging behavioral symptomatology as definitive of meaning banks on what Hopper (1991) calls psychiatry's "epistemological warrant" and obscures a great deal of important information that could potentially shift our understandings of these behaviors.

This tension between what we might call "hard diagnosis" (diagnosis according to standardized criteria like the *DSM-4-TR*) and "soft diagnosis" (the working models clinicians use in assessing what is causing the difficulty) is critical; it is within this tension that the "work" of culture occurs. I find Luhrmann's (2000) distinction between the diagnostic strategies of "bird watching" and "playing chess" helpful for thinking through these dynamics. The bird-watching approach involves using prototypes to determine what is wrong with a given patient, highlighting certain criteria and minimizing factors deemed unrelated to existing categories. Playing chess, by contrast, involves a more subtle, interpersonal process of engagement, where what is wrong with a patient becomes manifest within the context of human social interaction. In other words, what one sees is largely a product of how one sees.

A similar problematic exists in cross-cultural studies of illness and is evident in the material presented here. Biomedicine offers a lexicon for articulating distress that, on a global scale, appears to be increasingly persuasive (or, at least, pragmatically useful) for laypeople and clinicians alike. Although one might speculate as to the causes of this development (e.g., Lakoff 2005), it remains the case that the language and categories of biomedicine can lead us to conflate—in bird-watching fashion—certain clusters of features with the thing-in-itself. If, however, we approach the "what" of diagnoses and the "how" of diagnosing as ethnographic questions, we are in a stronger position to explore how local engagements with biomedical categories ground broader cultural values through the shaping of epistemologies and phenomenologies of health and illness.

Notes

1. Although the Instituto Nacional de la Nutrición and the Instituto Nacional de Psiquiatría have both maintained inpatient treatment facilities since the mid-1980s, both programs are part of larger hospital care settings. Similarly, several residential centers across the country provide eating disorder services in addition to those for drug and alcohol addiction. However, Marisol was the first residential treatment program in Mexico designed specifically for the treatment of eating disorders.

2. Anorexia is characterized by restricted eating, very low body weight (less than 85 percent of ideal), and intense fear of gaining weight or becoming fat. Bulimia entails bingeing and purging, either by vomiting, use of laxatives or diuretics, or exercise. Personality traits common to individuals with eating disorders are thought to include perfectionism, a desire to please, and difficulty articulating feelings (American Psychiatric Association 2000).

3. Just precisely how these aspects of Western culture translate into the self-destructive behaviors associated with eating disorders is a matter of debate. See, for example, Bordo 2004; Brumberg 1998, 2000; Hesse-Biber 1997; Gremillion 2003; Maine 2006; and Wolf 1991 for a range of perspectives.

4. Although a number of community-based studies have appeared in recent years (cf. Latzer and Tzischinsky 2004; Tolgyes and Nemessury 2004), the vast majority of cross-cultural data on eating disorders derives from clinical or university populations.

See Soh et al. (2006) for an excellent critique of the acculturation literature.

5. Pike and Borovoy (2004), for example, question the importance of "Westernization" as the socioepistemological ground for self-starvation in some Japanese women, pointing instead to local concerns with modesty (rather than body image and weight concerns) as the central organizing feature of these behaviors. Even eating disorders within a given culture may carry significantly different meanings for individuals, as Banks 1997 suggests.

6. From the psychological, psychodynamic perspective that dominates clinical practice in the United States and Europe, the core conflict of these illnesses is construed as the girl's struggle for autonomy and her failure to develop clear ego boundaries and a solid sense of self as separate from others (e.g., Zerbe 1993). In sociocultural models of eating disorders, too, these illnesses are configured as struggles over individuation and autonomy, although these perspectives locate the pathology in the broader social and cultural arena rather than in the minds of individual women (e.g., Bordo 2004; Gremillion 1992; Orbach 1986; Wolf 1991).

7. See Irvine (2006) and Rice (1992, 1996) for an exploration of the rise of codependency as a folk psychology and its current iterations, Babcock and McKay (1995) and Haaken (1990, 1993) for the gendered implications of the concept, and Sandoz (2004) for a critique of its clinical and scientific shortcomings.

8. The concepts and language used in the group were consistent with how therapists and clients talked outside of therapy sessions and characterized the Marisol approach more generally. Although most clients were unfamiliar with the codependency language at the beginning of treatment, many soon became as nimble with it as the therapists.

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