

SECTION ONE



Provocations

Introduction

“You *cannot* be serious!” Danya, a dietician, blurts out in the middle of the regular Wednesday morning treatment team meeting at Cedar Grove. Mirroring Danya’s incredulity, the rest of us look around at one another, trying to process what we had just heard.

“I’m afraid I am serious,” affirms Dr. Casey, the clinic’s medical director, speaking up over the mutterings and exclamations of the staff. “I know it sounds crazy—I know! But we have looked at this from every angle. This really is the best option for Hope and for the family.”

“Never have I been asked to put an anorexic on a *diet* to make her *lose weight*,” Danya grumbles under her breath. Then, more loudly: “Hope is nowhere near her goal weight. It’s going to undo all the progress she’s made over the past two weeks. We’ve just finally gotten her up to where she needs to be calorie-wise with her add-ons! She has worked *so hard*. Now we’re going to tell her, ‘Guess what? Never mind! Time to start restricting again!’”

“It’s an anorexic’s dream,” quips Joan, the assistant medical director.

“I think she’ll view it as punitive,” observes Brenda, Hope’s therapist. “Like, ‘You’re bad for gaining weight, and so now we’re going to take food away.’”

“That’s a real danger,” agreed Dr. Casey. “This could totally fuel the anorexia and make everything worse. But really, it’s the only chance she’s got.”

Under what conditions would putting an anorexic client on a diet inside an eating disorders clinic become the “only chance she’s got”?

HOPE

Hope was thirteen years old when she entered treatment at Cedar Grove, one of the youngest clients at the clinic. At the time of the treatment team meeting excerpted above, she had been at the clinic for just under two weeks.

Hope came to Cedar Grove directly from a local children's hospital, where she had spent a week on bed rest under close observation as her vitals stabilized. She had arrived at the hospital not only painfully underweight (at 72 percent of her ideal body weight) but also completely dehydrated—nurses struggled to find a good vein for placing an IV and eventually had to settle for one in her left hand. Utterly panicked by the amount of fluids that were being pumped into her body, Hope found ways to exercise when the nurses weren't looking and to dump fluid from the IV bag so it looked like it had gone into her body when in fact it had gone down the toilet. She refused to eat anything but vegetables in the hospital and would drink only juice (unsweetened), iced tea (unsweetened), and occasionally milk (skim). To stave off hunger pangs, she chewed gum (sugar-free) and sucked on the occasional Jolly Rancher. On threat of an NG tube being placed to force-feed her, Hope began to eat slightly more during meal times. Yet she also increased her exercise to compensate. Her weight continued to go down, and an NG tube was placed.

Hope still had the NG tube in when she arrived at Cedar Grove. Like most who have “the tube,” Hope was highly ambivalent toward it. On the one hand, she hated it with a flaming passion. “Oh my god, this thing is awful!” she told me, explaining:

It hurts, and it moves around, and when I lie down I can feel it down the back of my throat. And the tube gets all crusty in your nose. It's totally disgusting. And then, when they put the liquid in, it's just gross having this stuff running down through your nose and into your stomach. I get stomachaches from the Boost [a liquid nutrition supplement] like a lot of people do. And my body is so slow to digest stuff that I'm still full and it's time for the next “feeding.” And I hate how they call it a “feeding,” like I'm a horse. Or a baby. I just want it out.

But even as much as she hated the tube, Hope (and others) did find some degree of relief in being able to bypass the actual act of eating. She continued, “I will say, it's nice to not have to deal with meal planning or sitting down to a plate full of food and thinking, ‘How will I ever eat that?’ It just gets shoved

up my nose,” she laughed, “and I don’t really have to think about it. I think the whole time about all the calories, and that’s horrible. But at least I don’t have to physically put the food in my mouth and eat it.”

Over time at the clinic, Hope began to eat more food by mouth, and by the time of the abovementioned treatment team meeting, she had been off the tube for four days and was doing well.

How, then, did Hope, a dangerously underweight adolescent who was just starting to allow herself to eat, come to be put on a diet *inside* an eating disorders clinic? How was this determined to be the best care the treatment team could provide? Eating disorder clinicians face untenable ethical positions like this on a daily basis. Making sense of apparently nonsensical scenarios like Hope’s requires us to radically rethink what eating disorders are and to critically retool our approaches to treatment and recovery. And to do that, we need to understand the fundamentals.

WHAT EATING DISORDERS ARE (AND AREN’T)

Most people today know (or think they know) what eating disorders are. After all, references to eating disorders frequently pepper the covers of magazines (“Angelina Jolie—Anorexic!”), take center stage in movies, or appear in news reports or feature articles. But popular understandings of these illnesses—that they are about wanting to be beautiful, seeking attention, trying to fit in, and/or excelling at control—barely skirt the edges of what eating disorders truly are and what it’s actually like to live with one.

Let me start with being clear about what eating disorders are *not*. Eating disorders are not diets that have gone “too far.” Nor are they like cocaine or heroin addictions, where an addict can conceivably go cold turkey, detox for thirty days, and essentially be back to baseline as long as they avoid the drug. They are not juvenile temper tantrums, though they can be an expression of anger and rage. They are not “phases” someone goes through. They are not about superficial vanity or self-aggrandizement, though this is how they may look from the outside.

So, what *is* an eating disorder? This seems like a simple enough question, but it is deceptively so. In fact, what an eating disorder is depends on who is asking, and why.

The current *Diagnostic and Statistical Manual of Mental Disorders (DSM)*¹ identifies four main categories of eating disorders: anorexia nervosa,

bulimia nervosa, binge eating disorder, and other specified feeding and eating disorder.²

Anorexia nervosa is characterized by acute self-starvation and the inability or unwillingness to maintain a body weight necessary for normal physiological functioning. Generally, this is accompanied by a deeply held conviction that one is overweight or fat, although instances of non-fat-phobic anorexia nervosa have been documented around the world and even in the United States.³ The *DSM* identifies a number of subtypes of anorexia nervosa, including restricting subtype (where the person sustains underweight through not eating), purging subtype (where the person restricts intake and also purges through the use of laxatives, vomiting, diuretics, or exercise), and binge-purge subtype (where periods of starvation are punctuated by instances of bingeing on large amounts of food and purging it).

What is not captured in these diagnostic criteria is the lived experience of having anorexia and the way it cripples everyday functioning. People with anorexia are terrified of food and other substances entering their body in the same way a person with claustrophobia is afraid of small spaces. Food and eating send them into utter panic. They starve themselves, even when they are severely underweight, and may also restrict the intake of liquids (including water) and even medications.⁴ Their fear and panic is so great that it outweighs any cautions about medical risks—the future possibility of damage or death pales in comparison to the perceived certainty of the immediate danger of eating. Anorexia is extremely harmful, affecting every organ system in the body. The brain starves and can lose mass. The heart can be permanently weakened. The liver and kidneys can shut down. Bones and muscles are depleted as the starving body cannibalizes itself for fuel—I have known nineteen-year-olds with osteoporosis, and one who fell and broke a hip. Some of this damage is reversible if caught early enough. Some of it is not. Anorexia is relatively rare (0.3 percent prevalence),⁵ but it is deadly. It kills one out of five sufferers, making it the most lethal of all mental illnesses.⁶

People with bulimia manage their relationships with food differently. Rather than avoiding food completely, they alternate between bingeing and purging, consuming large amounts of food and then ridding themselves of it through vomiting, exercising, fasting, or using laxatives or diuretics. Indeed, the hallmark of bulimia is this alternation between consumption and undoing. Bulimia damages the entire digestive system and places significant burden on the other organs. One woman I knew had so much scar tissue in her throat and esophagus from purging that she could no longer swallow solid

food. Bulimia is particularly dangerous for the heart, as it destabilizes the electrolytes in the body, which can cause cardiac arrest. People with bulimia may be of normal weight or even slightly above it, which makes it especially difficult for them to get insurance approval for treatment—to show medical necessity, the person must be at *immediate* risk for cardiac arrest or organ failure before they will be authorized for treatment. The really dangerous thing about bulimia is that someone can have perfectly normal labs and still be one purge away from a heart attack. And labs tell you nothing about a person's actual functionality. I knew a woman who was so consumed by her illness that she quit her job, dropped out of school, and did nothing but binge and purge ten to twelve times *a day*, yet she had normal lab results, so we could not get her authorized for inpatient treatment. Bulimia affects approximately 1 percent of the population, a similar rate as schizophrenia.⁷

People with binge eating disorder binge on food but do not “undo” the binges through purging or other compensatory behaviors, as in bulimia. The distinctive feature of this condition is that the person wants to stop eating but can't. They feel a compulsion to eat, the same as a person with obsessive-compulsive disorder feels a compulsion to wash their hands or check the stove. As much as they may try to not overeat and as much as they may be committed to not bingeing, the compulsion to do so is so overwhelming that they are unable to prevent themselves from doing it. All the while, they feel self-loathing, shame, and disgust, yet they cannot stop. One woman I know described it as “living with a monster. Every day I would swear I wasn't going to do it again, but then it would happen and I couldn't stop it. I wanted to die.” Binge eating disorder is the fastest growing eating disorder diagnosis, affecting approximately 3.5 percent of American women and 2 percent of American men.⁸

Other specified feeding or eating disorder (OSFED, previously referred to as eating disorder not otherwise specified, or EDNOS) is a category used to describe conditions that share symptoms across two or more of the other eating disorders or do not meet the duration or frequency requirements of a single disorder. For example, someone may restrict, as in anorexia, but then binge and purge once or twice a week. Or they may oscillate between periods of anorexic restriction, bulimic behavior, and bingeing for weeks or months at a time. People with orthorexia (obsessed with “healthy eating”) currently also fit within the OSFED diagnosis, though recognition of orthorexia as a separate disorder is likely on the horizon. Although OSFED is something of an “other” category, this does not diminish its seriousness: more people are

diagnosed with OSFED than either anorexia nervosa or bulimia nervosa, and it is just as damaging and deadly. People die from it. Nevertheless, many insurance companies—even those that do actually authorize treatment for eating disorders—often exclude OSFED on the false assumption that people with this condition do not have a “real” eating disorder.

Eating disorder specialists differ on whether they believe the various eating disorders are truly discrete phenomena with their own separate etiologies, trajectories, and patient profiles or whether, instead, eating disorders should be considered as expressions along a spectrum. I endorse the latter view. People often move across different eating disorders during their lifetime, suggesting a continuum rather than fully discrete disease entities. In addition, all of the eating disorders share important core features in terms of sufferers’ lived experiences and the issues at stake in their illnesses and recoveries.

Although eating disorders are notable for behaviors surrounding food, body, and weight, the psychological, emotional, and cognitive dimensions of these illnesses run far deeper. On the whole, people with eating disorders tend to view their bodies with abject disgust and 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 client diagnosed with anorexia 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.” People 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.” As we will see through the following chapters, eating disorders are what we might call *existential* disorders in that they structure and give meaning to a person’s entire life and mode of being.

THE MAP IS NOT THE TERRITORY

The *DSM* definitions of eating disorders describe behaviors and cognitive features that clearly map onto experiences of real people. This is good and important. But do they really capture the phenomenon of what an eating disorder is? Do they capture the sleepless nights spent calculating calories, the depths of self-loathing that lead you to claw at your thighs, the panic that

makes you break out in hives when you realize you mismeasured your cottage cheese at lunch? Do they capture the shame that interferes with intimacy for years after recovery, the inability to look at yourself in the mirror without cringing, the almost monumental effort required to allow yourself to take a break, to breathe?

Eating disorders are not simply a collection of behaviors, body weights, lab values, or cognitive distortions. Eating disorders are physically and emotionally devastating conditions where food and eating become the vectors and means by which deep existential concerns are made manifest and struggled out.

With this in mind, I will make a potentially provocative claim: Eating disorders do not exist *within* people; they emerge *between* people. They are not individual psychological (or even physical) illnesses; rather, they are continually conjured as “things” in the contexts of shifting interpersonal, structural, and material relationships within which they do very particular kinds of work. As deeply embodied conditions that entangle existential, phenomenological, and relational concerns, eating disorders manifest as sites where profound issues of intimacy, trust, obligation, and care are struggled out as the illnesses are lived, identified, and treated.

Specifically, one key argument of this book is that eating disorders in the contemporary United States *emerge in and through the circulation of knowledge and practices among treatment providers, research agendas, and insurance companies*. What counts as an eating disorder and what does not is produced through negotiations among powerful interests that, all too often, are motivated primarily by profit or prestige rather than by healing. The result is a clinical “reality” in which patients’ “failure” to overcome the double binds within which that reality was created serves to further justify the structures that gave rise to it.

This is *not* to suggest that people are not suffering before, after, or outside of these structures—they most definitely are. But the synergistic aims of these three domains shape what eating disorders are thought to be, how they are diagnosed and treated, how they are experienced, and what happens to people who have them.

How an eating disorder is manifested in a given interaction—what is included as materially important and what is excluded as unrelated (and by whom); how the pieces are thought to interact and hang together; what is thought to cause them; what effects they are believed to have; and how they should be treated—varies not only from person to person but from context

to context. One person's eating disorder is never identical to another's, and each is construed differently in different contexts, from the doctor's office to the therapy room, the insurance case manager's docket to everyday life. What delineates the boundaries of an eating disorder and what constitutes its phenomenology are negotiated anew in each and every interaction and in different situational and material circumstances. *Eating disorders, then, emerge and exist between people and in the spaces between people and shifting structures of care.*

In taking this position, I wish to be exceedingly clear. Eating disorders are real. Treatment providers, researchers, and insurance companies do not *create* these illnesses out of nothing. Clearly identifiable patterns of behaviors, beliefs, cognitions, affects, and phenomenological experiences characterize these conditions. Self-destructive behaviors such as self-starvation, bingeing and purging, and compulsive exercise absolutely exist, as do obsessive concerns about weight and shape, distorted perceptions of body image, and fears of getting fat. Symptoms such as osteopenia, low heart rate, and electrolyte imbalance result from these behaviors and have direct physical consequences. Terms such as "social withdrawal," "phobia," "shame," "self-loathing," and "discomfort with intimacy" describe genuine struggles, and these characteristics hang together in recognizable patterns.

But I want to push against this reality in certain ways. When we say a person has an eating disorder, what exactly is it that they have? A pattern of restricting food intake? A distorted body image? A fear of getting fat? Difficulty with affect regulation? Recurrent bingeing and purging behaviors? Problems with intimacy and interpersonal communication? Compulsions to overexercise? Self-loathing? Some combination of these and other features, certainly. But one hundred different people can meet the same diagnostic criteria for anorexia nervosa and yet have profoundly different illness profiles and experiences beyond the narrow set of items outlined in the *DSM*. What, then, is this "thing" we call an eating disorder? What are its boundaries? What aspects of the person are part of it, and what are not? These are not simple or straightforward questions, and how we answer them tells us as much about the larger cultural contexts in which these conditions emerge as about the individuals suffering from them. What constitutes the "thingness" of an eating disorder, then, is a *relational* question, not a psychological or physiological one, although body and mind are deeply involved. Ontologically speaking, the thing termed "eating disorder" unfolds as an interpersonal process.

CONTESTED SUFFERING

Contemporary western biomedicine thrives on deriving certainty from uncertainty. By distilling collections of symptoms—pain here, numbness there, dizziness, abnormal lab values, loss of function—into constructs we call “diseases,” and designing interventions aimed at restoring “health,” biomedicine banks on the correspondence between such disease constructs and actual biological reality. In this way, biomedicine is invested in making claims to truth, where the body becomes the primary bearer of evidence (or lack thereof).

Individuals with what anthropologist Joe Dumit calls “contested illnesses,” like chronic fatigue syndrome or fibromyalgia, often experience medical encounters as if they must *prove* their illness and their suffering to others through the mobilization of facts.⁹ That is, until and unless these patients can demonstrate through biomedically recognized markers that their diseases are “real,” they are treated with skepticism, suspicion, and even scorn. In such situations, biomedical facts come to play a crucial role in how clinicians render judgments about patients, their symptoms, and their claims to care.¹⁰ As Dumit notes, in the biomedical context, “one must have laboratory signs in order to be suffering; one must suffer in code in order to be suffering . . . or one does not suffer at all.”¹¹ Measurement and quantification of the material body’s processes come to stand in as proof that something is “really wrong.”

Importantly, however, biomedical facts themselves are, as Dumit notes, “susceptible to being framed and reframed by participants” as they attempt to “emplot and counter-emplot each other.”¹² In other words, biomedical facts can be used to tell different kinds of stories, depending on the teller, the audience, the evidence, or all three. These facts become critical narrative “flexers” that can leverage different kinds of interpretations of what is otherwise seen as vague or overdetermined information. Often in such cases, there is, Dumit observes, “not enough research and at the same time too many facts,” meaning that fights over definitions, diagnosis, response, and prevention come to wield a great deal of power in such situations, despite the fact that they often depend disproportionately on a small amount of underfunded research.¹³

Eating disorders are, in many ways, contested illnesses in Dumit’s sense, although with a bit of a twist. They are not contested in terms of their existence—the *DSM* clearly outlines diagnostic criteria, prevalence and

incidence data, etiology, and course information, and the American Psychiatric Association (APA) publishes clear treatment guidelines. What is contested about eating disorders is not whether they constitute “real” illnesses but whether and to what extent a given patient is thought to be *suffering appropriately* from an eating disorder and is therefore deemed worthy of care.

This is a key claim of this book, so let me unpack it further. Notably, much of the suffering and debility involved in eating disorders happens *around the edges* of the official diagnostic criteria, in what I call “halo features,” such as relentless perfectionism, difficulties with interpersonal boundaries, and challenges in maintaining intimacy.¹⁴ These features effloresce in clinical and anecdotal descriptions of clients and in lived daily experience but are not captured in the official diagnostic coding criteria. Importantly, what does show up in the diagnostic criteria are the elements that appear more choice based (not eating enough, purging, bingeing), skewing the way these conditions are viewed. What is not captured is the constant battering of shame, the paralyzing fear, and the relentless obsessive thoughts. Why do official diagnostic categories leave out such features? Historically, this hasn’t always been the case. But as we will see in chapter 4, the shift in the *DSM* in the 1980s to a more descriptive mode of diagnosis (versus an etiological or interpretive one) emerged hand in hand with economic transitions in healthcare funding that focused on increased efficiency and cost savings and were based on outcomes that could be quantified and tracked. Contested illnesses, and indeed all types of psychiatric distress, were reconceptualized beginning with the *DSM-III* as collections of cognitive, behavioral, or biological symptoms that could be objectively measured.

As Dumit notes, in the face of systematic delegitimization, sufferers of contested illness often respond “by emphasizing not the bottom of things, but the surfaces, the micro-tactics of decision making.”¹⁵ That is, people learn to express their distress in ways that are locally recognized as legitimate, whether or not these expressions capture the full range of their experiences. With eating disorders, this leads clients, clinicians, researchers, and insurance companies alike to focus on such things as calorie levels, goal weights, and frequency of compliance with clinic programs. Not that these are unimportant things—they are very important. But they are not where the core of the issue lies. In the context of for-profit managed care, however, such biomedical facts come to constitute the reality of what an eating disorder is, shaping the ways care unfolds as a result.

THE TREATMENT LANDSCAPE: CEDAR GROVE AND ECOLOGIES OF CARE

Treatment for eating disorders at Cedar Grove is conditioned by this broader healthcare landscape. Cedar Grove is a private, residential eating disorder facility in the American Midwest that treats anorexia nervosa, bulimia nervosa, binge eating disorder, and other specified feeding and eating disorder. Since its initiation in 2001, Cedar Grove has become one of the premier treatment centers for eating disorders in the United States, particularly known for its top-notch medical care and its use of evidence-based best practices in treatment. Patients come from all over the country for treatment, sometimes waiting weeks or even months on a waiting list to get in (see chapter 5 for more on the clinic's setting and program). The clinic provides three different levels of care: twenty-four-hour residential care, a partial hospital (day treatment) program, and an intensive outpatient program. Patients (as they are called at the clinic¹⁶) receive comprehensive psychiatric, medical, and psychological assessments prior to admission, and the specifics of a patient's treatment plan depend on these factors as well as on the precipitating events surrounding the development of the eating disorder and a patient's progress while in the program. We will explore this more in section 2.

Cedar Grove and its programs are situated within a broader ecology of mental health services. The American mental health system is composed of a range of levels of psychiatric care for people experiencing different degrees of crisis or difficulty. Inpatient hospitalization serves the most acute cases, when someone is in danger of harming themselves or others or is significantly medically compromised. Generally, this is considered a short-term, targeted intervention to get someone out of the danger zone—then they are discharged. Outpatient care can consist of anything from occasional meetings with a therapist and/or psychiatrist to participation in a day treatment program for several hours a day. Insurance companies often pay for acute hospital care only in cases of marked suicidality or medical instability, and whether and to what degree they cover outpatient care varies. Some cover day treatment (partial hospital treatment) as well as weekly therapy visits, whereas others exclude day treatment and will pay only for once-a-week appointments. It depends entirely on the specific insurance plan a patient has.

Eating disorders treatment requires containment and oversight above and beyond that needed for standard medical or psychiatric care, as well as specialists who know what to look for and how to intervene if needed. This

complicates their place within existing services, creating special challenges. As Dr. Casey, Cedar Grove's medical director, told me, "When our patients go to the hospital for medical or even psychiatric issues, they often come back much sicker with their eating disorders. The staff at hospitals are not trained to make sure someone is eating enough, or isn't purging, or isn't exercising when no one is looking. They don't have the staffing power for it. It's just not what they're set up for." The result is that when eating disorder patients are relegated to nonspecialized care, they often get sicker rather than better.

To address these sorts of issues, a third level of intervention occupies a sort of interstitial space between inpatient acute hospital care and outpatient treatment: residential care at clinics like Cedar Grove. Residential care is designed primarily for ongoing, potentially life-threatening conditions that may not currently be medically destabilizing but could become so if not treated, such as drug addiction, alcoholism, trauma, self-harm, and eating disorders. These clinics provide containment along with therapy and oversight in home-like settings that may have medical personnel on staff but are not hospitals.

Some insurance policies cover residential care and others do not. Some insurance plans will cover residential treatment for certain conditions, such as drug addiction, but not for others, like eating disorders. Many insurance companies will pay only for either acute hospital care, which may not be needed, or outpatient treatment, which often does not provide the kind of structure or oversight someone with an acute eating disorder needs. "I'm just not convinced that outpatient therapy works for adolescents," one Cedar Grove therapist told me. "I think they get sicker. It makes them worse. They go to therapy, get all activated, and then go away for a week. To do what? What are they supposed to do with the feelings? The parents don't know what to do and they think their kid is getting treatment, so they don't pay attention. Everyone is in denial: the therapist, the patient, the family, everyone. And the poor person who is sick is left twisting in the wind." In other words, the *very level of care many eating disorder clients need is, more often than not, rendered structurally invisible.*

Places like Cedar Grove exist to provide the critical level of residential care for these clients. But they must do so within a healthcare system that makes the delivery of such care highly problematic. In order to get clients approved for coverage for residential treatment at a non-hospital-based center like Cedar Grove, clinicians often have to justify not only the necessity of care for the individual but the legitimacy of the very existence of these centers as a treatment option.

SCARCITIES OF CARE: MANAGED CARE AND THE WRONG KIND OF SICK

Why is it so hard to get adequate, comprehensive care for eating disorders? To understand this, we need to take a brief detour into the history of managed healthcare in the United States.

Today's managed healthcare structure originated in early twentieth-century collective health organizations that sought to reduce health costs and increase access to care for workers through the institutionalization of regional prepaid health plans. This approach was formalized by the Health Maintenance Organization Act of 1973, under which HMOs functioned as innovative nonprofit institutions that emphasized provision and integrated services. However, the ground was laid for the incursion of for-profit interests, and by the late 1990s the majority of regional HMOs had been taken over by just a handful of larger managed care organizations, which, following legislative changes, began to run them as for-profit enterprises. With the expansion of managed care in the 1990s, many managed care companies moved from being disinterested gatekeepers to also providing insurance benefits themselves, which gave them a powerful, vested economic interest in minimizing the benefits used, regardless of how necessary or cost effective they were.¹⁷ In other words, what began as a system to protect patients from unscrupulous providers wasting valuable healthcare benefits became a system where the industry regulating the release of benefits is also the industry that profits the most from withholding them.

Today, managed care organizations do what the name implies: they manage care by gatekeeping the release of insurance benefits to patients by (in theory) serving as a kind of middle-person between the physician and the insurance provider (often the managed care organization itself), ensuring that recommended interventions are indeed necessary and not excessive before allowing insurance benefits to be utilized to pay for care. Operating on a philosophy of explicit rationing, the motivating assumption of managed care organizations is that efficiently managed money equates to expertly managed care.

The effect of the transition to managed care on patient outcomes is a hotly debated point. On the one hand, managed care has enabled some types of access to some types of care for some types of patients. At Cedar Grove, for example, a treatment course can easily cost a year's salary or more. Clinicians and clients *need* the managed care system for the clinic to exist, and it is only