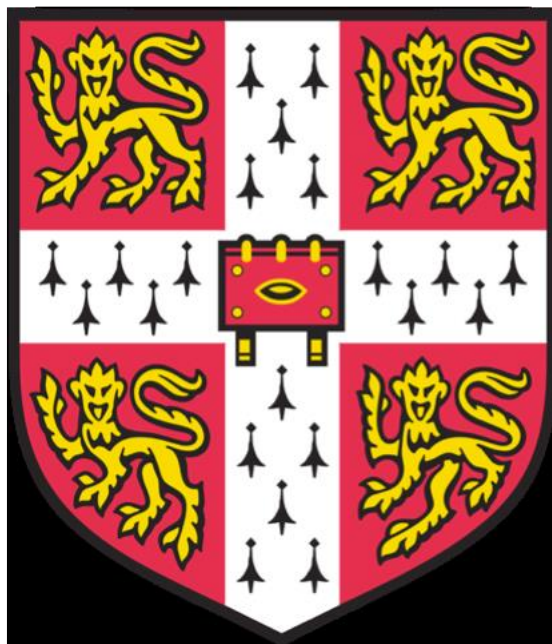


Tinkering with Food and Family: Striving for Good Care in an Eating Disorder Treatment Centre in Italy

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Declaration

This dissertation is the result of my own work and includes nothing which is the outcome of work done in collaboration except as declared in the Preface and specified in the text. It is not substantially the same as any that I have submitted, or, is being concurrently submitted for a degree or diploma or other qualification at the University of Cambridge or any other University or similar institution except as declared in the Preface and specified in the text. I further state that no substantial part of my dissertation has already been submitted, or, is being concurrently submitted for any such degree, diploma or other qualification at the University of Cambridge or any other University or similar institution except as declared in the Preface and specified in the text. It does not exceed the prescribed 80,000 word limit for the Archaeology, Anthropology and Sociology Degree Committee.

Title

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Author

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Abstract

This thesis examines practices of care in an Italian public treatment centre for people diagnosed with anorexia and bulimia nervosa. Drawing on patient-focused anthropological accounts of eating disorders as ‘technologies of the self’, and on existing ethnographic works that have highlighted the failures of eating disorder treatment in other countries, the thesis makes a case for a study of treatment that goes beyond a binary conception of success or failure. By focusing on the professionals of a treatment team, and examining the difficult care work that they do as they encounter patients and their families, the chapters highlight the grey areas between failure and success – and suggest how, when difficulties arise and things seem to be failing, novel forms of care emerge as team members try other ways to make their interventions work.

The thesis sits at the intersection between anthropologies of science and biomedicine, and anthropologies of ethics, care and kinship. It shows that what patients experience as a self-care project, professionals frame as a potentially deadly pathology that has ‘taken over’ the ‘self’ of the patient. By framing the eating disorder in this way, the treatment team makes sense of the seemingly coercive practices that come with treatment. Both the patients’ and the professionals’ constructions point to the fact that eating disorders are ‘not really about food’ – but about issues with relatedness that are seen to be expressed *through* food. The chapters show, first, how the structure, knowledges, and everyday practices of treatment aim to create ‘healthier bodies’ and ‘healthier minds’ in patients – by gradually substituting their self-care projects with a definition of health that is jointly constituted by psychotherapists, psychiatrists, nutritionists, endocrinologists and educators. Second, with professionals seeing eating disorders as markers of ‘things gone awry in family relations’, other chapters show that the work of transforming the patient is felt to succeed only if the patient’s family is transformed, too. In focusing on how professionals tinker with kinship care by trying to channel its ‘dysfunctional’ aspects into ‘functional’ aids towards recovery, the thesis goes beyond exploring the potentially ‘dark side’ of kinship to suggest that kinship here becomes a therapeutic tool – albeit a difficult one to use.

For Michi

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Introduction

I would wake up at 6. I would weigh myself and write down my weight. Then I would do one hour of sit-ups. At 8 I would have breakfast with an apple. Then study. At 1, lunch with two carrots and a fat-free yogurt. Then one more hour of sit-ups. I would study again until 5 and go swimming for an hour. Then shower. At 8 I would have dinner – some salad and a tomato. I would go to sleep at 10. And then everything would start again. I was making it, I was becoming the master of myself. And here they are ruining everything... I felt much better when I could see my bones.

Sofia, 19

This is how 19-year-old Sofia described to me her ‘usual day before admission’ to the eating disorder treatment centre where I conducted fieldwork in Italy. Weighing 38 kg at the time of admission – which was medically seen as a dangerously low weight for her height of 1.70m – this young woman had been diagnosed with ‘severe anorexia nervosa’ and had been brought to the facility by her parents. During treatment her daily behaviours, deemed pathological, were constantly challenged. She had to eat complete meals under close supervision to restore her weight, was prevented from doing physical exercise, and was subjected to psychological therapy to understand the reasons behind her condition. Professionals would often characterize her as ‘unaware’ of the severity of her condition, as ‘manipulative’ and ‘resistant to treatment’. In the Clinical Director’s own terms, the aim of treatment was to deconstruct Sofia’s ‘pathological self’ and craft, together with her, an altogether ‘new self’ for her.

This brief example contains, in a nutshell, the key conundrum of the thesis. Without questioning the concrete risks and consequences of Sofia’s food restriction and her physical exercise to the point of exhaustion, we can see that what the healthcare professionals cast as pathological is, for Sofia, a way of ‘mastering myself’. Despite their stark differences, both the treatment centre’s understanding of the condition and the patient’s experience suggest an individuated, internal and autonomous ‘self’ bounded by the skin and made up of ‘reason’ and ‘emotion’, with a ‘will’ and ‘choice’ manifested in behaviour (McDonald 2015:42-45; see also Lock 1993:138; Rose 1996). This self recurs in this thesis, and figures prominently in treatment but it takes shape within starkly different constructions of what is going on and what is required. The thesis seeks to explore some of the assumptions and the practices of care involved in a treatment centre in Italy, where these different constructions have to be

reconciled. The thesis also highlights how the willingness *to receive* care shapes the extent to which, and the way in which, carers can *give* care in clinical landscapes, and how complex moralities circulate around suffering, care and expectations for ‘recovery’ (cf. Dragojlovic and Broom 2018:8).

In this introduction, we turn first to a brief history of the emergence of ‘eating disorders’ as an object of interest in psychiatry and in the clinical sciences, and subsequently in history and in the social sciences. I then focus on a review of the anthropological literature on eating disorders and eating disorder treatment. We will see how in the last three decades, anthropological studies of eating disorders have called into question much of what has been seen as the ‘common sense’ regarding these disorders, developing accounts instead of how disordered eating is grounded in social structures and relationships that tend to be obscured in popular but also in clinical framings (Eli and Warin 2018). I will situate my research within such work and other relevant anthropological literature to suggest the key contributions of my project, and then give a brief overview of the chapters’ content.

‘Eating disorders’

Classified as ‘mental illnesses’ by the *Diagnostic and Statistical Manual of Mental Disorders*¹ (DSM-5) of the American Psychiatric Association (2013), what are now known as ‘eating disorders’ are a growing concern globally. They first appeared in the clinical literature as ‘eating disorders’ in 1981, with the creation of *the International Journal of Eating Disorders* (Yates 1989:814). Eating disorders have been defined as ‘a social epidemic’ linked to ‘Westernisation’ (Gordon 2004): every year in the world, millions of people are reported to fall ill, and international research suggests that the numbers keep growing (Dalla Ragione and Giombini 2014:21; Smink, van Hoeken, & Hoek 2012). Among eating disorders, ‘anorexia nervosa’ and ‘bulimia nervosa’ are defined in the DSM-5 as ‘a persistent disturbance of eating-related behaviour’ due to body weight and shape becoming an ‘obsessive preoccupation’. They are described as being characterized by ‘insufficient or excessive food intake’, often accompanied by ‘self-induced vomiting, purging and compulsive exercise’

¹ The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) is presented by the American Psychiatric Association as the product of years ‘of effort by hundreds of international experts in all aspects of mental health’ resulting in ‘an authoritative volume that defines and classifies mental disorders in order to improve diagnoses, treatment, and research’ (see <https://www.psychiatry.org/psychiatrists/practice/dsm>).

(American Psychiatric Association 2013). With a crude mortality rate of between 4% and 5%, anorexia and bulimia are reported to have the highest mortality of all mental health conditions, and figure as the second leading cause of death among young Europeans and North Americans after road accidents (Arcelus et al. 2011; Crow et al. 2009; Smink, van Hoeken and Hoek 2012). This is linked, the scientific literature reports, to the high rates of relapse after treatment (Khalsa et al. 2017). Although a fixed definition of ‘recovery’ is problematised both by those living with eating disorders and by scholars (Eli 2016; LaMarre and Rice 2021), according to clinical definitions, fewer than half of patients with anorexia or bulimia fully recover (Schmidt et al. 2016).

Two clarifications are needed here. The first one is that this thesis examines care in a treatment centre for anorexia and bulimia nervosa. These are considered the most severe forms of eating disorders (see Gibson, Workman and Mehler 2019), but they are not the only ones, and it is being increasingly recognized that other forms, such as ‘binge eating disorder’, are no less dangerous (American Psychiatry Association 2013). However, the reader will notice that most of the literature that I refer to here is based on research conducted on anorexia. This is because bulimia was theorized as a separate illness from anorexia only in 1979, having existed until then as a ‘sub-type’ of anorexia (Squire 2003:17). Although it is now clinically recognised that the two conditions share a desire for thinness, body dissatisfaction, and fear of weight gain – and that they can often turn into one another during one lifetime (Fairburn, Cooper and Shafran 2003) – they are categorized as separate pathologies because their behaviours seem radically opposed: anorexia mostly consists in self-starving, bulimia in binge eating and purging. As pointed out by the feminist psychologist Burns (2004:269,270), this strict categorization obscures the relatedness between the two conditions: bingeing is often a consequence of extreme dieting, and many anorexic women practise binge eating and purging. The feminist scholar Squire (2003) has suggested that bulimia is placed lower in the medical hierarchy than anorexia because bulimic practices embody a liminality that disrupts normative values of western femininity, whereas anorexic practices are read within a continuum of approved feminine behaviour and ‘western assumptions about successful selfhood’: anorexics are supposedly seen by both patients themselves and by professionals as having ‘something extra’ that distinguishes them from the ‘weakness’ of bulimics (Burns 2004:276). However, in this thesis I will not be paying much attention to distinguishing patients according to their specific diagnosis, as this was not something that seemed to matter in my field site. By this I do not mean that

observations such as those made by Squire did not hold there – in fact, I did occasionally hear comments along those lines, both among professionals and among patients themselves. Nevertheless, usually such comments had the aim of criticizing simplistic views, and did not come to shape differently the issues I examine in the thesis.

The second necessary clarification is that I will be referring to female patients in this thesis – unless otherwise specified – because virtually all patients in my field site were female. I will not be discussing why eating disorders seem to affect many more girls or women than boys or men, for example. A lot has been written on this already, especially by feminist-cultural scholars in the late 1980s and 1990s (e.g., Orbach 1986, Bordo 1993, MacSween 1993, Weiss 1999). However, it is worth mentioning here that whereas, until recently, it had been taken for granted in the literature that about 90% of eating disorder patients were female, researchers and clinicians have started commenting that these numbers might be incorrect (Raevuori et al. 2014): many adolescent boys and men seem now to be suffering from what might be called ‘an obsessive relationship’ with their body, physical exercise and food – a relationship that, instead of manifesting itself in the search for extreme slenderness, finds expression in the search for an extremely muscled physique, what some call ‘bigorexia’ (Mosley 2009). It has been suggested that the reason behind such great disparity in numbers is therefore not so much that boys and men ‘are not affected’, but that 1) they are less willing to seek help because of the very idea that eating disorders are ‘women’s stuff’, and 2) that eating disorders in males assume not only the forms of anorexia, bulimia or binge eating, but also forms that have not been explored and categorized as illness yet (Dalla Ragione and Giombini 2014:27,28). These are all important issues that call for further research, but issues that I will not be addressing in this thesis.

From early clinical accounts to feminist analyses

What is now called ‘anorexia nervosa’ has been a named clinical entity since the 1870s. Although the British physician Richard Morton is credited as the first to describe a seemingly similar condition as a psychiatric illness in 1694, under the name of ‘nervous consumption’, it was only in the 1870s that the medical doctors Lasègue (1873) and Gull (1874) used the modern terminology, in France and England respectively². Following the psychiatric

² For more on this historical account, see Pearce 2004.

nosology of the time, these clinicians associated ‘anorexia’ with other ‘hysterical affections’³ and identified its roots in ‘suppressed emotional troubles’ occurring during maturation (Lasègue 1997[1873]:492,493). As the linguistic etymology of ‘anorexia’ suggests (incorrectly, it would now be held), these scholars saw a ‘want of appetite’ – not due to any physical disorder, they thought, but to ‘a morbid mental state’ (ibid.) – to be the crux of the condition. The assumed ‘want of appetite’ was also observed to be accompanied – notwithstanding the emaciation that resulted – by a ‘peculiar restlessness’ and hyperactivity (Gull 1997 [1874]:499,500; Lasègue 1997[1873]:494). In the following century, during so-called paradigm shifts in psychiatry, the German-American doctor and psychoanalyst Bruch (1962) published an article in *Psychosomatic Medicine* based on her treatment of twelve young patients with anorexia, describing it as being characterised by ‘three areas of functionally disordered psychological experience’ (ibid.:188): (a) ‘a disturbance in body image of delusional proportions’ – hence the fear of becoming fat; (b) ‘disturbance in the accuracy of perception or cognitive interpretation of stimuli arising in the body’, such as hunger, fatigue and weakness; and (c) a ‘paralyzing sense of ineffectiveness’ (ibid.:188-91). However, it was Bruch’s monograph *The Golden Cage* (1978) that, drawing on conversations with her patients, and influenced by social changes later classified as feminist, brought anorexia into broader public consciousness. Here she argued that for young women pressured to satisfy social expectations, anorexia was a means of asserting control and power through an extreme practice. At about the same time, the British psychiatrist Crisp (1980) similarly framed anorexia as an ‘adaptive disorder’, whereby the prepubertal body size achieved through starvation allowed women to avoid an adult social and sexual life.

As a doctor, Bruch had also noted how starvation likely played a role in influencing ‘thinking, feeling and behavior’ (Bruch, 1978: 4), turning ‘formerly sweet, obedient and considerate’ girls into ‘demanding, obstinate, irritable and arrogant’ ones (ibid.:2) who, ‘like other starving people’, were now ‘eternally preoccupied with food and eating’ (ibid.: 8). In recognition of these effects of starvation, Bruch emphasized the importance of ‘weight correction’ in the first phase of treatment, since one could not expect to do ‘meaningful therapeutic work with a patient who is starving’ (1978:129). However, she also remarked that weight correction must occur ‘as part of an integrated approach’ (ibid.: 98) which might include ‘family disengagement’ (ibid.:112) and ‘changing the [patient’s] mind’ (ibid.: 128).

³ For more on how ‘anorexia’ was associated with ‘hysteria’, see Charcot 1883; Féré and Levillain 1883; Janet 1907; Freud and Breuer 2004 [1895].

She thus warned against treatment that relied simply on ‘behavioral modification’ to achieve weight gain, as that would generate a ‘battle of wills’ (ibid.: 99). Individual psychotherapy was her preferred treatment method, through which she aimed to help patients develop a ‘capacity for self-directed actions’ (ibid.:130).

In the same year that Bruch’s masterpiece was published, two other works later considered ‘ground-breaking’ in the field of eating disorders came out: Salvador Minuchin, an Argentinian physician who trained in child psychiatry and psychoanalysis in New York, published with his colleagues at the University of Pennsylvania a book titled *Psychosomatic Families: Anorexia Nervosa in Context* (Minuchin, Rosman, & Baker 1978). This book placed anorexia, as well as its cure, in the family system: it argued that since anorexia developed within a family context characterized by ‘rigidity’, ‘enmeshment’ and ‘conflict avoidance’, rather than separating the child from their parents – as Bruch seemed to suggest – treatment had to be directed at families to address these problematic aspects. At about the same time, in Italy the psychiatrist Mara Selvini Palazzoli also called for shifting from ‘individual therapy’ to ‘family therapy’ in the treatment of anorexia (see Selvini Palazzoli 1978). These theories informed research work undertaken at the Maudsley Hospital in London during the 1980s, laying the foundation of ‘family-based therapy’ for eating disorders (see Russell et al. 1987).

In the meantime, in the UK, the psychiatrist Russell (1979) first distinguished bulimia nervosa as ‘an ominous variant’ of anorexia characterized by overwhelming ‘urges to overeat’ that lead to binges and purging measures. Accordingly, the publication in 1980 of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), in which a section on ‘eating disorders’ appeared for the first time⁴, also included a separate diagnostic category ‘bulimia nervosa’. In the 1980s and 1990s, several eating disorder ‘diagnostic scales’ were developed. Among these were the Eating Disorder Inventory and the Eating Disorder Examination Questionnaire, the subs-scales of which aimed to quantify issues such as ‘drive for thinness’ and ‘body dissatisfaction’ (Marks 2019:1384). In the publications of the DSM-IV (American Psychiatric Association 1994) and DSM-IV-TR (text revision) (ibid.:2000), respectively, diagnostic categories were refined for anorexia nervosa, specifying ‘restricting type’ OR ‘binge-purging type’; and bulimia nervosa was categorized

⁴ Before then, the 1952 DSM-I had listed anorexia nervosa as a ‘psycho-physiologic reaction’, and the 1968 DSM-II as a ‘feeding disturbance’ (American Psychiatric Association 1952, 1968).

as ‘purging type’ OR ‘non-purging type’ (binging followed by compensatory exercise or restrictive eating).

From the 1980s, historians and social scientists in the US and Europe took an interest in the history of anorexia. They traced its origin back to late nineteenth century Victorian bourgeois families, but they also associated it with self-starvation among medieval Catholic women (see Brumberg 1988, Vandereycken and van Deth 1994). Specifically, the American historian Bell (1985) argued that thirteenth- to sixteenth-century Italian ascetics manifested in their ‘holy anorexia’ dynamics that also characterize contemporary anorexics, and that both conditions reflect a desire for female autonomy within patriarchal social structures (Bell 1985, as summarized in Lelwica 1999:27). Bell’s colleague Bynum (1987) argued against such equation, proposing instead a socio-political explanation. Food, she observed, was the only thing medieval ascetics could control, and renouncing food allowed them to exercise ‘self-determination’ – leaving the family, avoiding marriage duties, and reaching redemptive leadership roles within the Church.

At the same time, with the rise of feminist psychology, political analyses of this ‘feminine pathology’ (Orbach 1986) started proliferating. The feminist sociologist MacSween (1993) suggested that anorexic *practices*, rather than women’s vulnerabilities, should have been the focus of enquiry. Accordingly, the feminist philosophers Bordo (1993) and Weiss (1999) analysed anorexia as an extreme practice embodying social denigration of the body and the feminine. Through these literatures, ‘anorexia nervosa’ emerged as a condition with a multidimensional causation, a seemingly rich history, and a peculiar epidemiology. A ‘biocultural disorder’ for some (Eli and Ulijaszek 2013), it became interesting to anthropologists.

Anthropology gets in the picture: from a culture-bound syndrome to an embodied process

When anthropological work on anorexia was first published in the 1980s, models of ‘culture-bound syndromes’ were the focus of medical anthropology and transcultural psychiatry. Since these syndromes seemed to be unique to populations in the ‘developing world’, anorexia was an attractive example because it was felt, at the time, to be one syndrome exclusive to ‘the West’ (see Prince 1985; Swartz 1985; Di Nicola 1990). In the 1990s, the culture-boundedness of anorexia was problematized by calling attention to the religious ascetic dimension that informs self-starvation (Banks 1992) and to the cultural ‘ordering’ of

the disorder performed by Euro-American psychiatry (Gremillion 1992). ‘Non-fat-phobic anorexia’ was introduced to refer to forms of anorexia now being found in China and Hong Kong (see Lee, Ho and Tsu 1993; Lee 1996). Further anthropological work challenged the link of anorexia to ‘Western cultural concerns’ with body fat or weight (Littlewood 1995; Ritenbaugh, Shisslak and Prince 1996), laying the foundation for analyses of eating disorders in the Eastern hemisphere and the Global South. These were brought together in the *Culture, Medicine and Psychiatry* special issue (Becker 2004a) on ‘New Global Perspectives on Eating Disorders’, offering a compelling argument against the framing of eating disorders as ‘disorders of the West’ simply transportable to other contexts via ‘Westernization’ (e.g., Becker 2004b).

In recent decades, in fact, shifts of theory and interest in medical anthropology – from culture-bound syndromes and explanatory models of illness, to globalization and ethnographies of ‘the body’ and ‘self’, for instance – aligned anthropological studies of anorexia with critical analyses of experience and practice. Anthropological work on eating disorders largely shifted to analyses of local European and American contexts, with a focus on the micro-scale of lived experience, calling attention to the ‘cultural logics’ (Eli and Warin 2018) that drive eating disordered practices, and showing how these practices are embedded within normative social environments. It has been noted that the more recent ethnographic work has analysed anorexia as an embodied process, rather than as a disordered state (Eli and Ulijaszek 2013; Eli and Warin 2018; Eli and Lavis 2021).

In imposing a Cartesian mind-body split, medicalization had tended to make anorexia a mental disorder – the mind’s war on the body – requiring psychological conjectures. But by erasing the Cartesian division and by looking at people with anorexia in their context – a context in which bodies have increasingly become moral arenas wherein eating and exercise test one’s strength of character (O’ Connor and Van Esterik 2008:7:8; Niola 2015) – people with anorexia emerged as ‘misguided moralists, not cognitive cripples’, and their seemingly extraordinary asceticism appeared then to have very ordinary roots in local values and practices (O’ Connor and Van Esterik 2008:7). The question then became: how exactly do those who suffer from anorexia become ‘misguided moralists’? British anthropologist Sue Benson (1997) characterized eating disorders as ‘epidemics of the will’ – as extreme enactments of Euro-American fantasies of an individuated self controlling its body. In this framework, ‘the body’ is experienced as a project of the ‘self’: sufferers try to rewrite their self by changing their body through a paradoxical mixture of voluntarism and compulsion.

Extreme food restriction, Benson notes, offers the promise of becoming a master of one's body by winning over hunger, but it ends up undermining 'the very autonomy it seeks to establish' (ibid.:136).

American anthropologist Rebecca Lester (1997) also tried to address this question by analysing the construction of 'the self' among anorexics. She argued that feminist framings of anorexia as 'the crystallization of culture' (Bordo 2003 [1993]; see also Gremillion 2002) – as an extreme embodiment of 'Western' ideals about women's bodies and roles – depicted it as an unconscious, self-destructive social protest. Women were conceived as passive bodies and their 'self' was left unexamined, preventing the understanding of its embodied articulation (Lester 1997:479-481). Drawing on fieldwork in an eating disorder clinic in the US, Lester proposed to analyse anorexia through Foucault's notion of 'technologies of the self' – as a deliberate shaping of the self achieved through culturally meaningful bodily practices (Foucault 1986). She suggested that the body is seen as the material vehicle of the 'internal self'. Restriction of food, invested with meanings about dependency and nurturance, is therefore used to re-construct the boundaries of the 'body-self', communicating autonomy (Lester 1997:486). As a response to an extreme awareness that our bodies define us, shaping a chosen body becomes the goal. It is essential, Lester thus argued, to first consider the theoretical project of anorexia – 'the self which is being pursued' – and then examine 'its practice' – the behaviours that bring about the self-transformation (ibid.:485-486). The 'self' that is pursued by the anorexic is a self-restraining self, in which 'reason' rules over 'emotion' and the enjoyment of food. A slender body is thus the first visible aim because, in what Lester calls 'the West', it reflects a self that can 'rise above' the need to eat – a morally superior self (ibid.:486).

Carrying on from Lester's approach in her ethnographic study of an outpatient eating disorder unit in Israel, Sigal Gooldin (2008) suggested that anorexics construct their selves as moral selves through the experience of enduring and overcoming hunger, seen as 'an out of the ordinary accomplishment'. Hunger, which involves physical pain and suffering, is experienced by patients as an enjoyable 'hyper' feeling of power and self-efficiency, becoming a 'selfing device' that make themselves 'moral agents', since self-inflicted hunger is experienced 'as a heroic way of being in the world' (ibid.:290). Going deeper than Lester into the specific element of the 'technology of the self' that creates such selves, Gooldin suggests that being anorexic is about being hungry and giving meaning to it, no less than it is about 'shaping the body' (ibid.). Gooldin's account constructs anorexia in terms of

transforming one's self through an existence that may be numbed through active detachment from one's bodily sensations – but, by being active, this existence is also 'fiercely sensed' (Eli 2012:2).

Lester's and Gooldin's framing of anorexia as an experiment with 'the self' could itself be said to be culturally specific. Anne Becker (1995) has pointed out how the interest in reflexively cultivating one's body depends on the cultural validation of personal agency with respect to the body, which is in turn linked to the experience of self vis-a-vis the community; it presupposes that the body represents a personal resource for expression (ibid.:37). In her ethnography of bodily aesthetics in Fiji, Becker outlines a relationship between self, body, and society that highlights aspects of self and body boundaries, agency and identity that situate both Lester's and Gooldin's accounts.

In Fiji, Becker shows, the cultivation of bodily space is a collective rather than a personal enterprise (Becker 1995:5). Bodies and the crafting of their form are the responsibility of the community that cares for them. Therefore, what bodily form communicates is how one has been nurtured or neglected in his or her social universe, not the attitude of one's personal self. It also encodes one's capacity and propensity to serve one's social universe in return: in an interesting inversion, too-slim bodies are associated with laziness and inability to work, whereas bigger bodies are associated with productivity and willingness to contribute to the community (ibid.:56-58). The cultivation of the self through personal manipulation of the body therefore emerges as a concept related to 'Western' values that encourage autonomy, independence, and competitive work to raise oneself above other selves (ibid.:127-129). It is the generally European and North American identification of 'the self' with a cultivated, individuated 'body', seen as a reflexively and personally manageable resource, that makes an antagonistic relationship between any body and its governing self possible (ibid.:134).

Nevertheless, to the extent that Lester's and Gooldin's accounts speak to their own contexts, they are useful in enlightening what was missing from previous analyses of 'anorexia nervosa'. They also have important implications for clinical practice, helping to understand why patients can be so resistant to treatment. If the eating disorder is experienced by patients as in some sense an ethical project of self-cultivation, treatment will easily be perceived as an external, intrusive attempt to make their personal project fail. Lester's and Gooldin's studies strongly suggest that if eating disorders are addressed as stemming from 'pathological selves', rather than taken seriously as the very practices by which sufferers *form*

their ‘self’ (Tait 1993:205), biomedical care will continue to fail. The question thus remains of how to approach these issues in a way that takes people’s self-projects seriously, without this appearing to result in a neglect of the severe consequences that the same projects can bring.

Lester’s and Gooldin’s accounts, considered ethnographically and in light of Becker’s study, seem to call for finding ways to make anthropology less the ‘anthropology of’ any particular entity that pre-exists ethnography, and more the ethnographic exploration of how analytical objects – in this case the ‘self’ of the ‘patient’ – ‘precipitate out of processes that are at once social, material, and representational’ (Taylor 2005:742). Following what Mol (2002:83) argues about ‘disease’, if we stop assuming ‘the self’ to be a universal entity under the body’s skin and start studying selves ‘enacted in daily practices’, they multiply. Taken together, these accounts prompt us to ask how specific ways of imagining and narrating selves relate to specific ways of materially intervening in them; and how both relate to social relations and practices (Taylor 2005:746). Instead of assuming what a self and its boundaries are, exploring how selves ‘are given surface’ can make us open to more possibilities of how they might be ‘enacted’ (ibid.:749).

Ethnographic literature on eating disorder treatment

We have seen that there has been an extensive anthropological literature on the possible ‘causes’ and ‘nature’ of eating disorders. Less attention has been given to treatment – a perfect place for analysing the ‘selves’ of daily practice. As we have seen, recent ethnographies have framed eating disorders as ‘technologies of the self’ (Lester 1997, Gooldin 2008, Eli 2018). In line with such accounts, a consistent strand of the few ethnographic works on treatment has focused on ‘patients’ perspectives’: on their ambivalence towards treatment as a key element of their ‘anorexic being-in-the-world’ (Warin 2010) – including, most recently, on how the materialities of treatment shape patients’ ambivalence about illness and their ‘resistance’ to recovery (Eli and Lavis 2021).

Lester (2014), for instance, highlighted how patients undergoing treatment in the US restrict their intake of medication – psychotropic drugs that tackle related symptoms such as depression and anxiety, but also vitamins and mineral supplements – in the same way that they restrict food. Drawing on her earlier work (see Lester 1997), she suggested that

medication refusal is for these patients a means of ‘self-communication’ within a larger ethical project. Taking medications presumes someone who strives towards health, but for these patients the optimal state seems to be deprivation (Lester 2014:249). Lester’s study helps understand why the common practice of presenting food to patients as ‘medicine’, on the assumption that they will feel less ‘guilty’ about eating, often does not work: taking medicines is experienced by patients as a way of ‘taking care of one’s body’; this goes against their self-cultivation project based on overcoming bodily needs (ibid.:243-249).

Eli (2014), Musolino et al. (2015, 2016) and Lavis (2015,2016) subsequently reinforced Lester’s findings with similar ethnographic studies conducted in Israel, Southern Australia and England respectively. Restricting food is experienced by patients, even those who recognize its dangers and negative side, as a form of caring for themselves, as their only way out of suffering, providing them ‘safety’. This is why even if they feel the eating disorder is harmful, they want to maintain it (Lavis 2016:71,72). Looking at these contradictions ultimately means questioning the notion of an individuated, unified self who can give informed consent to treatment (Berliner et al. 2016:5).

In 2018, a special issue on ‘Anthropological Perspectives on Eating Disorders: Deciphering Cultural Logics’ was published in *Transcultural Psychiatry* (Eli and Warin 2018). This special issue aimed to explore how anthropological approaches to eating disorders have developed in the decade since the 2004 special issue of *Culture, Medicine and Psychiatry* on eating disorders in a global context. It sought to provide anthropological responses to clinical questions about the low rates of treatment success (Keel & Brown, 2010), the high rates of treatment ‘dropout’ (Fassino et al. 2009), and the modes of managing enduring eating disorders (Touyz & Hay, 2015; Treasure, Stein and Maguire, 2015). Among the contributions, Musolino, Warin and Gilchrist (2018) examine ambivalence toward help-seeking in Southern Australia, focusing on narrations of what they call ‘triggers’: encounters with food and other social stimuli that prompt women with disordered eating to re-engage in restrictive or binge-purging practices. The authors argue that culturally embedded gendered desires to deny or fulfil particular embodied longings (e.g., for the intensity of the binge or the lightness of the empty body) are fundamental to understanding why people do not seek help, and their frequent oscillation between recovery and relapse. Ambivalence toward recovery is a common experience also for those undergoing treatment – and Lavis’ (2018) paper, which focuses on British inpatients’ experiences, examines how patients mobilize practices of eating and not eating to cultivate their relationship with anorexia during

treatment. The attractiveness of disordered eating, argues Lavis, lies not in the maintenance of an emaciated body, but in the desire for ongoing illness, with anorexia experienced as a 'safe space' that allows sufferers to 'live through distress' through a 'viscerally felt shield' from the outside world. Similarly, Eli (2018), in her analysis of Israeli patients' narratives of their eating experiences, argues that people with eating disorders 'strive for liminality' – actively seeking an ambivalent being through eating disordered practice to survive oppressive familial, institutional, and social conditions. Eating disorders, Eli suggests, work as a long-term way of surviving-in-the-world amidst structural vulnerabilities and social suffering.

This body of literature strongly suggests that enforced treatment cannot work. On the other hand, the increasingly celebrated principle of respecting patients' choice seems to be equally detrimental given the intricacies of the conditions in question (cf. Mol 2008). In this context, respecting patients' choice about treatment will not help, as it is likely to lead to chronicization or death. It thus becomes fundamental to explore how treatment may be approached ethically in both anthropological analysis and clinical practice. On this matter, a second strand of literature on treatment has usefully drawn attention to how inpatient facilities in the US, Mexico (Gremillion 2003, Lester 2007, 2014, 2019), Canada, Australia and the UK (Warin 2005) are characterized by settings of care, dynamics of surveillance and treatment practices that unwittingly reproduce the very dynamics that sustain eating disorders, making treatment fail. All these three elements – these authors suggest – are based on a notion of patients' 'self' as lacking in self-discipline, whose problems can be solved by addressing 'the mind'. Still, 'the body' is at the centre of treatment, seen as an uncooperative appendage that needs to be constantly under control.

Gremillion's (2003) ethnography of an eating disorder clinic in the US contains another interesting – if underestimated – point. Among other things, she analysed the dynamics between the members of the treatment team – what she calls the 'therapeutic family' (ibid.:119) – and the patients. 'Affectionate caretaking' was considered a crucial 'natural' feature that professionals had to possess, but at the same time it was perceived as potentially risky, thus requiring staff members to learn to keep a distance through 'minimal mothering' (ibid.:120). Otherwise, they risked 'overnurturing' patients and generating harmful effects (ibid.:121-127). Staff members in her field site could explain very well how maternal attitudes could lead to over-involvement or punitive behaviours, but less easily what constituted a good nurturing attitude (ibid.:149-153). A balance between 'involvement' and 'detachment' was seen to be needed, but just where the 'right' balance lay was not clear;

reaching it was known to require time and constant practice. Lavis, Abbots and Attala's (2015) work on the entanglements between eating and caring also invites reflection on this 'slipperiness' of care – on how it is framed both as an innate ability and as something to be learned through training (ibid.:5-7).

In fact, there has been little attention paid to the professionals in anthropological accounts of eating disorder treatment, other than to point out how well-intended clinicians make sense of their care within systemic failure, and end up colluding with the structural limitations of the treatment apparatus within which they work. Lester (2009, 2017, 2018), for example, explored how clinicians strive to provide the best treatment for patients within the constraints of managed care in the US, which requires quantitatively measurable treatment goals. All these works converged into Lester's (2019) recent monograph – the product of twenty years of ethnographic research in a private eating disorder treatment centre, coupled from a certain point with her own clinical work as a counsellor, and informed by her personal struggle with eating disorders from early adolescence into young adulthood. Here Lester argues that eating disorders are not simply a way for people to manage 'the abject' – what they find most difficult and frightening – as anthropologist Warin had argued (2010) – but are also 'a means for seeking connection' (Lester 2019:23). Moving on from her previous framing of eating disorders as 'technologies of the self' (Lester 1997), here she proposes to see eating disorders as ways of extending an ethical demand to others, and re-frames them as 'technologies of presence' (Lester 2019:63): as tools that people employ to make themselves seen and responded to in the world. She thus calls for paying attention 'to how professionals care' when facing what appears to be a nearly impossible situation, consisting of patients who often do not want to receive treatment, their families in crisis but still resistant to change, and a healthcare system that downplays the kind of clinical expertise that seems to help. She examines how such a situation generates contradictory ideals of recovery and paradoxical notions of the 'healthy subject', thus producing frictions and 'roadblocks' – within a sense of constant precarity due to the system of health insurances requiring quantifiable and predictive evidence of treatment success. Her ethnography is therefore ultimately about how professionals *understand* practices of care when 'care' and 'harm' are deeply intertwined, and about how they *make sense of* treatment in the face of such systemic failure – which often leads to more sickness and to death (ibid.:xvii,xviii). Exploring notions of 'manipulation' in the clinic, Lester offers a critical analysis of the multiple ontologies of eating disorders that shape the lived experiences of patients and clinicians, arguing that

clinicians unwittingly end up assimilating the political-economic logics of US managed care into their ontologies of eating disorders, thereby constructing everyday realities of clinical practice that provide ethical space for the withdrawal of care.

This literature has tended to paint a picture based on a binary conception of success or failure: treatment that should succeed by saving patients' lives and supporting long-lasting recovery fails to do so. What I try to do in this thesis, instead, is to take a step back and examine the difficult care work that is done within the less-than-ideal context of a public treatment centre in Italy, by considering patients' views in interaction with those of the other actors involved in treatment, and by exploring the kind of care that these encounters can generate – the alliances between patients, professionals and family carers that are made and unmade in the process. In doing this, I aim to move forward the anthropological discussion of eating disorder treatment by purposefully focusing on the grey areas between 'failure' and 'success', and on how, when difficulties arise and things seem to be failing, professionals try other ways to make their interventions work, generating novel forms of care as they do so. In this way, besides the anthropological literature on eating disorders, my research necessarily draws from and aims to enrich the literature on care more generally.

Ethnographic literature on care

One inspiration for this thesis is Annemarie Mol (2002)'s work on atherosclerosis in the Netherlands, which examines how various medical and non-medical practices 'do' bodies and diseases differently according to their disciplines and technologies, but also how these different constructs are made coherent through specific therapeutic activities. Starting from this notion of the 'body multiple' and the 'disease multiple', here I ask how the multiple 'bodies' and 'eating disorders' of patients and professionals are coordinated during treatment. How do patients shift from being moral agents to being patients with a mental disorder to be explained and managed (cf. Antze 2010)? What are the everyday 'ritualizations' that continually create and recreate 'clinical reality' (Lester 2009:374)? In my work, I also respond to Mol's call to add an exploration of how the work of coordination is or can be done 'well' – which is, the question of 'the good' (Mol 2002: 165,166). My thesis is an attempt to offer one example of 'the diverging and coexisting enactments of the good in medical practice' (ibid.:176,77) by examining how the multiple dis-eases and bodies that circulate within and outside the eating disorder treatment centre are coordinated with the aim of

providing ‘good care’. In this sense, I follow the approach that Pols (2015:82) calls ‘empirical ethics’, as I explore the different and sometimes conflicting notions of ‘good care’ *within* care practices, by analysing the ‘goods’ that carers and patients strive for, the values and norms they implicitly or explicitly shape, and the ‘bads’ they want to avoid (ibid.83). This places ethics *in* the world of those we study, as a part of everyday practices (ibid. See also Brodwin 2013).

From Mol’s later work on what she calls ‘the logic of care’ (2008), I take her approach of avoiding the distinction between ‘care’ – mostly used to refer to activities, such as washing or feeding, that are done to make daily life more bearable – and ‘cure’ – used for interventions that should ideally heal people from a disease – as in practice the two overlap. In an eating disorder treatment centre, specifically, things that would be framed as ‘care’ – feeding, listening – are seen to be the very key to the ‘cure’. Therefore, like Mol (2008:2), I will use the term ‘care’ to refer to all kinds of practices going on in the treatment centre, although, we will see, there are different forms of care emerging from different situations. Furthermore, as in her work on diabetes (ibid.), I take the specificities of care for eating disorders as the focus of why it is important to disentangle ‘care’ from an immediate assumption of ‘kindness’, and to be open to including in ‘care’ practices that might otherwise seem to have more to do with ‘force’ and ‘coercion’ but which, upon further scrutiny, reveal themselves as requiring a lot of active effort from patients (ibid.:7). A particular kind of affection is expected from staff members of eating disorder treatment units, and yet they are required to perform treatment practices that can also seem antithetical to caring. The necessarily ‘harsh’ aspects of their job are seen to impede ‘connecting’ with patients, and vice versa (Gremillion 2003:144,145). The complicating factor is that the receivers here of the necessary daily activities of intrusion, surveillance and coercion tend to be high achievers, successful academically and professionally, and apparently capable of making competent decisions in all aspects of their life, apart from those regarding their own nutritional intake (Giordano 2005:1; Kendall 2011:2). This makes the work of care even more difficult. My thesis will thus explore how patients’ desire to remain ill is managed by professionals so that they can go beyond the binaries of ‘patient choice’ vs. ‘enforced treatment’, and ‘cure’ vs. ‘treatment failure’; and the ethical implications of this challenge (Lavis 2016:73). Through what tools do professionals insist and *manage* to insist when patients refuse to eat?

Here I depart from Mol’s approach in that I do not wish to separate out ‘good care from messy practices’ to distil its ‘pure logic’ (Mol 2008:10). Instead, I want to stay with the

messiness of what she calls ‘real life’ (ibid.), to show how much one can learn from its complexity. I also build on Mol, Moser and Pols’ (2010) suggestion that in care practices the knowledges, technologies, bodies, people and daily lives involved need to be continuously ‘tinkered with’. By suggesting that professionals tinker not only with food, but also with family, I will contribute to a specific understanding of their notion of ‘tinkering’, as the tinkering that we will see happening here is also aimed at *relationships* of care.

On this matter of attention to the family, from Mattingly’s work (2010) on hospital care for children with incurable conditions in the US, I have been influenced by a focus on ‘what is at stake’ in daily life for all those involved in the healthcare encounter – patients, families, professionals: what matters to them, how this changes over time, what their struggles are (ibid.:29). I also take Mattingly’s idea of bodies emerging as a ‘border territory’ in the health care encounter (Hahn 1985:97-98, cited by Mattingly 2010:12), and her observation that apparently trivial activities occurring within clinical spaces become ‘significant experience’ in the continuous creation of motivation for recovery, with the aim of turning patients ‘from passive recipients of care to active participants in their own recovery’ (ibid:13,19).

Mattingly’s notion of ‘healing as a battle’⁵ (ibid.:62) is very relevant to my field site: whereas in her work the patient’s ‘body’ is the battlefield, in the case of eating disorders, we will see, the battlefield is mostly located in ‘the mind’, with the ‘body’ being seen as the recipient of the battle’s collateral effects. However, in both cases the patient is conceived as having heroic qualities and responsibilities that are fundamental to win against the illness (ibid.:65). Finally, from Mattingly’s latest ethnography (2014a), I follow her attention to the temporality of ethics and projects of care (ibid.:39,40), and her observation that ethical practices are situated in the specific constraints of practical action, and therefore have an experimental and risky character (ibid.:379,384). We will see how eating disorder treatment is a case in which professionals’ own moral becoming ‘depends crucially upon the experience of acting in circumstances that are fraught and uncertain, where it often seems impossible to find any best good that is worth acting upon and stakes are high, but where, nonetheless, action must be taken’ (Mattingly 2014b:484; see also Kleinman 2010:23,24).

More specifically, my work will be in conversation with other ethnographic works on care in mental health services: Brodwin’s ethnographic study (2011,2013) of a U.S. agency of Assertive Community Treatment (ACT) helpfully examines the uneasiness experienced by

⁵ This military metaphor in medicine dates to the nineteenth century. It came into wide use in the 1880s when bacteria were identified as the agents of disease (Sontag 1978:66).

professionals as they must juggle between ensuring their severely mentally ill patients' 'autonomy' while at the same time not abandoning them, and the complexity of caring for patients who do not respond to treatment (Brodwin 2011:192,201). Similarly, in her ethnography of psychiatric services in Greece, Davis (2012) looks at the ethics of responsibility in care for mental illness and I share aspects of this focus. With Myers (2015), who worked in a mental health clinic in the US, my thesis also shares attention to what the process of recovery 'requires' from patients and professionals every day, and what helps and hinders them in this process (ibid.:10).

Within the literature on care and mental health, what could be called 'anthropologies of mental health and domestic worlds' (Bradley and Ecks 2018:570) have been a fundamental source of inspiration and comparison. Buchbinder's (2015) account of a chronic pain clinic for children in the US, Bradley's and Ecks' (2018) analysis of the relationship between family life and hair-pulling disorders in the UK and the US, Chua's (2011) work on how the South Indian State of Kerala addresses what is seen as a modern epidemic of suicide in children, and Pinto's (2011,2014) ethnography of mental health treatment in North India, have variously shown the intricacies between mental health and kinship, and how medical practice engages in kin work by seeking to define the appropriate mechanics of kin care. They have also contributed to challenging the supposed boundaries between a 'domestic' sphere of kinship and a 'public' sphere of work (see McKinnon and Cannell 2013). In arguing that treatment practices for eating disorders in my field site turn kinship care into a therapeutic tool for the professionals, this thesis will draw on and go beyond works that, by looking at kinship in practice, have usefully explored the ambivalent and potentially harmful side of kinship (e.g. Carsten 2019; Das 1995; Lambek 2011; Pinto 2014) and have highlighted how kinship can be framed as a source of mental distress and at the same time a vehicle for remedy (Bradely and Ecks 2018; Buchbinder 2015; Chua 2011).

Anthropological research on child rearing will also feature in the conversation (e.g., Lancy 2014; Mezzenzana 2020; Ochs and Izquierdo 2009; Otto and Keller. 2018;): when looking at treatment for eating disorders, one cannot avoid exploring notions of childhood, parenthood and adulthood, and how specific notions of 'dependence' and 'autonomy' figure in mental health settings (cf. Lester 2019). Does (a mentally healthy) adulthood require overcoming one's dependence on others? How do ideas about appropriate forms of adulthood and dependence take shape in treatment?

On these questions, McKearney (2017,2018) has written about the complexity that professionals working in *L'Arche* – a Christian community that cares for patients with ‘cognitive disability’ in the UK – face when it comes to respecting their ‘independence’ (as in Brodwin 2013) and to assigning ‘responsibility’ for acts of resistance to care. He suggests that responsibility is here distributed ‘across selves’ (Laidlaw 2013), including ‘the ill self’ of cognitive disability, allowing healthcare workers to stay ‘detached’ from frustrating behaviours. This seems to occur with eating disorders too, when professionals blame treatment resistance on ‘the eating disorder talking’ (see Lester 2017). To what extent and in what ways is the notion of an externalised mental disorder that ‘takes over the real self’ of the patient employed by professionals to interpret non-compliance as the result of either ‘calculating manipulators’ or ‘vulnerable invalids’ (Lester 2009:376)? And in turn to justify care practices that would seem to go against patients’ will? More widely, how does this way of assigning responsibility relate to Strathern’s (1988,2018) notion of ‘partible persons’, as ‘potentially partible minds and bodies’? Is this a way of conceiving actions as the way people select – or are incapable of selecting – one of their ‘multiple compositions’? As noted by Strathern, the notion of a ‘partible self’ anticipates the possibility of ‘partition’ of one or more of its parts. How does this relate to the work of making the disordered part of the self ‘go away’ through treatment?

Anthropological literature on Italy

Given the location of my field site, this thesis inevitably engages with some ethnographic works on other aspects of contemporary Italy, and aims to expand in particular the sparse anthropological literature on a) Italian kinship (see e.g. Barbagli and Kertzer 1990; Leira and Saraceno 2006; Saraceno 2015), b) the interplay between kinship and treatment for mental health conditions (e.g. Bernini 2004; Giordano 2011, 2018), and c) the specific forms that so called ‘relational’ labour takes in the country (see Muehlebach 2011, 2012, 2013). As for ethnographic accounts of eating disorders in Italy, the only literature existing is an anthropological study on disordered eating in Southern Italy (Cheney 2013) which – in line with much of the anthropological literature reviewed in this Introduction – describes how women transform gendered relations of kinship and power through practices of not eating, and how such practices allow women to craft locally meaningful moral selves (see also Cheney, Sullivan and Grubbs 2018). There is also one doctoral thesis in anthropology that

examines the complexity of the ‘multidisciplinary, interdisciplinary and transdisciplinary’ treatment model in an Italian residential facility (Molinari 2017:129), and that helpfully draws attention to its underfunded public healthcare context (ibid.:115-120).

Other theoretical inspirations

From the wider theoretical literature in anthropology, I draw on different strands of work. From Laidlaw (2013) and Lambek’s (2010) ‘ordinary ethics’ I take the recognition that human beings cannot avoid speaking and acting with ethical consequences, evaluating actions, caring, but also being aware of failure to do so. In my research, I thus move between what professionals feel is ‘the ought’ and what they can do and therefore ‘is’ (ibid.:4,6).

Latour’s (2004:209) notion of ‘learning to be affected’ and becoming ‘articulate’ in a profession is helpful to explore how professionals in eating disorder treatment ‘learn (not) to be (too) affected’. Similarly, I follow McDonald’s (2014) call for attention to this and to making ‘the body’ the object of ethnography rather than the language of analysis. I note ‘the bodies that are acquired’ (McDonald 2014,2018) by eating disorder professionals that enable them to see scientifically the ‘bodies’ of patients; and I look, too, at how patients *acquire* specific ‘bodies’ through clinical interactions. In sum, I look at their ‘mutual articulation’ (McDonald 2014: 130).

Anthropological literature on the relationship between food and kinship is also key to this thesis. Carsten (1995:223), for example, has suggested how among the Malays on the island of Langkawi, receiving and giving food is fundamental to the process of becoming a person and participating fully in social relations as kin. Similarly, Amazonian ethnographers have suggested how through commensality indigenous people engage in processes of ‘familiarization’ (Fausto and Costa 2013; Vilaça 2002). Drawing on this work, we will see how in the eating disorder treatment centre, not only food is a substance of kinship (Carsten 1995, 1997) – kinship is also a substance of feeding.

Finally, my research draws on and contributes to that strand of anthropological literature which, in the face of the current conceptual priority given to ‘relationality’, reconsiders the potential of ‘detachment’ and its value in specific settings, recognising that ‘engagement’ and ‘detachment’ are interwoven in complex ways (Candea 2015:1,14). Following Anderson

(2001), I will explore the aims, forms and effects of multiple practices of detachment in this eating disorder treatment centre in Italy.

My work will thus include storytelling about the activities of healthcare workers – how they perform and experience their caring work, their intentions, their concerns. One aim will be to understand the occasions when there are perceived tensions with patients and ‘within themselves’ – ‘moments of moral breakdown’ (Zigon 2007:138) – and to point out the different ways in which professionals try to act for the best, advancing theories on the ethics of care. The thesis will thus look beyond ‘suffering’ (see Robbins 2013) and beyond ‘failure’ (see Carrol et al. 2017) – at how ‘the good’ is strived for in the difficult world of eating disorder treatment.

Overview of the thesis chapters

I begin in Chapter 1 by introducing the field site and its history. Here I trace the history of how ‘eating disorders’ became a problem in medicine and gradually in psychiatry in Italy, and how treatment developed accordingly. I then zoom in on the treatment centre where I conducted fieldwork, locating its approach within such developments, and introducing its ‘inhabitants’: patients, professionals, interns and volunteers. I explain my research methods and my role in the field as researcher and volunteer, and some of the ethical implications of such roles.

Chapter 2 introduces the fundamental tension of the thesis, by asking: what are ‘eating disorders’ about? I suggest that patients’ practices can be seen as one of many expressions of contemporary self-shaping projects (cf. Lupton 2016), but that patients’ framings of those practices speak a great deal to the *relational* aspect of such projects – i.e., to how these people’s self-projects are about selves in relationships. I then shift to how professionals, on the other hand, construct patients as having a ‘disorder of the self’ which leads to certain ‘dysfunctional symptoms’. Notwithstanding this tension, both parts seem to be saying that eating disorders are not ‘really’ about food; instead, food emerges here as the vehicle of a distress that has something to do with relatedness. Professionals ascribe symptoms to an entity that is at the same time *external to* and *within* ‘the person’ of the patient. This results in patients being framed as having complicated and fractured ‘wills’ – the ‘will of the real person’ and the ‘will of the disorder’ – making the seemingly coercive measures of treatment an act of professional care.

Although food, ‘the body’ and ‘weight’ are seen as the vehicles for a distress located ‘deep in the mind’, Chapter 3 shows how food is put at the centre of treatment practices and is temporarily turned into a purely scientific ‘nutrition’ – because of the ‘urgency’ that malnourishment is seen to generate in the materiality of patients’ bodies. The chapter thus shows how the structure, knowledges, and everyday practices of treatment aim to create ‘healthier bodies’ and ‘healthier minds’ in patients – by gradually substituting patients’ self-care projects with a definition of health that is jointly constituted by psychotherapists, psychiatrists, nutritionists, endocrinologists and educators. In this way, patients who are defined by professionals as ‘resistant’, ‘ambivalent’ and ‘manipulating’ are turned into ‘aware’, ‘authentic’, ‘motivated’, and ‘responsible’.

Since eating disorders are seen by professionals as markers of ‘things gone awry in family relations’, Chapter 4 and 5 show that the work of transforming the patient is felt to succeed only if the patient’s family is transformed, too. In focusing on how professionals tinker with kinship care by trying to channel its ‘dysfunctional’ aspects into ‘functional’ aids towards recovery, Chapter 4 goes beyond exploring the potentially ‘dark side’ of kinship to suggest that kinship here becomes a therapeutic tool – albeit a difficult one to use.

Chapter 5 explores one of the instances in which the transformation sought in patients and their families does not seem to happen. It suggests that treating ‘preadolescents’ with eating disorders – a recent and increasingly prevalent phenomenon in Italy and elsewhere – puts into question the very paradigm of treatment, because children fail to undergo the desired steps deemed essential for therapeutic transformation. This impasse, we will see, forces professionals to try other ways of treating children.

Chapter 6 covers another kind of cases in which the transformation sought in patients and their families is seen not to happen: ‘chronic’ patients show that sometimes the patients’ and the professionals’ diverging constructions of the eating disorder keep clashing. The chapter looks at how professionals experience and deal with the limits of their own care, and suggests that ‘chronicity and ‘comorbidity’ put into question two of the pillars that constitute the very logic of their treatment model: family-based care, and framing the eating disorder as a part of the patient’s self that can be dispensed with. Both cases of ‘preadolescent’ and ‘chronic’ patients thus further show how tinkering with family is difficult work. These chapters suggest, however, how even when treatment ‘doesn’t work’, failure generates further

relational work and novel forms of care, making an argument for looking beyond ‘failure’ and for considering, instead, its productive aspects.

The conclusion, finally, brings the chapters together by illustrating how the thesis, sitting at the intersection between anthropologies of science and biomedicine, and anthropologies of ethics, kinship and care, enables us to think more about the complexity of bodies and diseases, and of food and kinship.

Chapter 1

Into the Field

Introduction

You can glimpse the distinctively orange walls of the sixteenth century villa hosting *Il Giardino*¹ (literally ‘The Garden’) from above and below, whether you are ascending or descending from the little grey coloured town in central Italy where it is based. Just what goes on within the walls of this villa is not obvious. Descending from the town centre, perched on a hill overlooking a river bank, one might guess that there is a large garden within its walls, as centuries-old trees reach over the top. Sometimes, especially in spring and summer, one can hear distant voices of girls coming from within. At times they are chatting, at times crying, at times laughing, and at times – it would seem – acting.

What happens within those walls is closely connected to a much more recognisable and prosaic space, just ten minutes’ walk from the villa as you continue to descend towards the ancient walls of the town: the local Health Centre. Only by reading the plaque placed on the front door of the villa can one make the connection: ‘Residential Facility for Eating Disorders *Il Giardino*’ is written under the name of the respective local health unit² and the name of a local charity fund. Similarly, if one goes to the Health Centre further down the road, one can read that the third floor hosts the ‘Eating Disorder Day-Service *Il Giardino*’, offered by the same local health unit. Seemingly different spaces are thus brought together for apparently the same ‘thing’ – that is, ‘eating disorders’. A reader of Mol (2002) might ask how eating disorders are ‘done’ by the people brought together here – patients, their families, and professionals. These are questions that this thesis attempts to address, by looking at what happens in these spaces of care, in this specific town in central Italy.

In what follows, I introduce the field site and its history. Whereas in the Introduction I reviewed some of the international literature on ‘eating disorders’, here I trace a brief history

¹ The name of the treatment centre has been invented by the author, and some of its identifying features omitted, to maintain the anonymity of its inhabitants.

² The Italian National Health Service (*Servizio Sanitario Nazionale*) was set up in 1978. The central government controls the distribution of tax revenue for publicly financed health care and defines a national statutory benefits package to be offered to all residents in every Region—the ‘essential levels of care’ (*livelli essenziali di assistenza*). The Regions are responsible for organising health services through local health units, which deliver primary care, hospital care, outpatient specialist care, public health care, and health care related to social care.

of how ‘eating disorders’ emerged in medicine and gradually in psychiatry in Italy, and how their treatment developed accordingly. I then zoom in on the treatment centre where I conducted fieldwork, locating its approach within this history and introducing its inhabitants. The second part of this chapter outlines my research methods, including my role in the field as researcher and volunteer, the implications of this double role, and the way I dealt with the specific ethical issues I encountered.

A history of ‘eating disorders’ and eating disorder treatment in Italy

As we have seen in the Introduction, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) seems to create ‘eating disorders’ as the same object everywhere, within a ‘one medicine fits all’ project. As some medical anthropologists have suggested (e.g., Kleinman and Good 1985; Kleinman 1988; Martin 2007), such an approach – which suggests ‘mental illnesses’ and each such illness unrelated to context – is within the optic of a scientific medicine that divests itself of the local, social or cultural (McDonald 2015). Asserting sameness or continuity over time and space for any illness, including ‘eating disorders’, is problematic. As noted by the Italian psychiatrists and psychotherapists Ruggiero and Prandin (2003:154), a great deal of biomedical and psychological research on eating disorders has been produced in Italy. Well before the DSM framing, several ‘pre-psychiatric’ conceptualisations (Ruggiero, Prandin and Mantero 2001:293) can be found of people displaying the eating patterns that are now classified under such a diagnosis. Anthropologists might feel that they cannot easily assert that we are dealing with the ‘same thing’ – but medical definitions and historiographies seek to do that.

The thirteenth century physician and philosopher Pietro di Abano (1958) is reported to be the first Italian scholar to frame the restricted eating and excessive thinness of a woman in what we might now see as medical terms. In his paper, only published in 1958, he reported the case of a 30-year-old woman in Normandy who had allegedly not eaten any food since the age of eighteen. In the sixteenth century, the anatomist and surgeon Alessandro Benedetti (1533) and the physician Simone Porta (1551) described cases of fasting girls, trying to give medical explanations. Porta described the famous case of a German woman in terms of what has since been called ‘a true early case of anorexia nervosa’ (Ruggiero, Prandin and Mantero 2001:293): as restricting food from early childhood, having always been very thin, unwilling to eat regularly, often vomiting after meals, and being ‘manipulative’ – i.e., constantly

promising to eat later. Porta explained these characteristics as the consequence of ‘dyspepsia’, a condition of impaired digestion.

With the ‘Enlightenment’ we first see those same behaviours – now categorized as illness – associated with ‘*voluntary* starvation’: the Italian physician Jacopo Bartolomeo Beccari (1745), in his review and discussion of ‘the miraculous nature’ of starvation, concluded that long periods of starvation could be observed not only in Saints, but also in people suffering from what were then called ‘melancholia’ and ‘hysteria’. The first Italian description of anorexia in recognisably modern psychiatric terms was by Giovanni Brugnoli (1875) – considered the father of neuropsychology in Italy (Cubelli and Nichelli 1990) – in the same years that the famous accounts of Lasègue (1873) and Gull (1874) were published in France and England respectively. Brugnoli reportedly ignored their papers, and, differently from them, in his description of the women observed, he stressed that the matter was not lack of appetite: in fact, he wrote, those women *did not* lack appetite, and yet actively refused food. This made their restricted eating not a symptom of another medical disorder, but the central feature of an ‘independent neurotic disorder’ due to a ‘psychological dysfunction’ (Brugnoli 1875). His paper also featured descriptions of ‘overactivity’, binge-purging behaviours in the night, and the effects of the condition on the family (ibid.).

In the early twentieth century, Italian studies on eating disorders mainly belonged to the field of neurology. This was because in Italy, until the 1970s, conditions that were seen to have to do with the ‘nervous system’ included in the same category of ‘neuropsychiatry’ both issues ‘of the mind’ and issues ‘of the body’. As in other countries, ‘cachexia’ (ongoing loss of skeletal muscle mass) due to Simmonds’ disease (a chronic deficiency of function of the pituitary gland that leads to atrophy of the viscera, resulting in emaciation and death if untreated) was sometimes lumped together with the thinness now associated with anorexia nervosa into what was called ‘young pituitary thinness’ (See Galdi et al. 1936; Dogliotti 1936). Starting from the late 1930s, many psychiatric studies talking of ‘anorexia nervosa’ were published in Italy, mostly focusing on differentiating anorexia from Simmonds’ disease (e.g., Ottonello 1937, Accornero 1941, Dotti 1950). Among these, Accornero (1941) had a central role in ‘psychiatrizing’ anorexia. He first introduced a conceptualisation of anorexia nervosa as sharing some features with schizophrenia – such as ‘flat mood’ and ‘lack of reality testing’ – but with such features being restricted to body size and eating. He therefore called anorexia a ‘monosymptomatic psychosis’. Other authors adopted this conceptualization in the following years (See Baraldi 1952; Basaglia 1959; Martinotti 1953; Rossini 1959), stressing

the importance of studying ‘the psychological problems’ of the patient. Such an approach can also be found in the first developmental model of the internationally renowned psychiatrist Mara Selvini-Palazzoli (1963, 1965), who described anorexia as a monosymptomatic psychosis with a ‘psychotic ego functioning’ regressed to the ‘oral stage of development’. As we have seen in the Introduction, in a later phase of her career she came to see anorexia as ‘a disorder of the whole family’ (Selvini-Palazzoli 1978): she described recurrent patterns observed in ‘disordered’ families and involved them in patients’ treatment through interventions aimed at revealing the ‘pathogenic links’ between the eating behaviours of the patient and the behaviour of her relatives³.

Until the 1980s, three main kinds of treatment were thus available in Italy for eating disorders: family psychotherapy, individual psychotherapy, and inpatient treatment in general medicine wards for patients with life-threatening conditions (Dalle Grave 1996). Family psychotherapy was offered by a few specialised centres – mostly private – whereas public services offered non-specialised individual psychotherapy, psychiatric counselling and general medical treatments, with no integration or sequencing of treatments (Ruggiero, Prandin and Mantero 2001:296). In the 1980s and 1990s, public specialised inpatient units started appearing, introducing new treatment principles and guidelines (*ibid.*). In particular, cognitive-behavioural therapy (CBT) became the preferred psychotherapeutic approach for eating disorders in Italy, drawing on parallel developments in other countries: the British psychiatrist Fairburn (1981) had developed cognitive behavioural treatment for bulimia nervosa in the UK, while the Canadian psychiatrist Garner and the American clinical psychologist Bemis (1982) proposed a cognitive approach for anorexia nervosa, all of these based on adaptation from cognitive theory as applied to depression. CBT generally included three stages of treatment that lasted for about five months: the first one, to achieve ‘control over eating’ by consistently eating regular meals and snacks; the second one, to ‘identify and modify dysfunctional thoughts, beliefs, and values’ related to body size and shape, self-image, and mood, which were seen to affect eating behaviour; the third, to maintain improvement through ‘cognitive restructuring’ (*ibid.*). In Italy, the psychiatrists Guidano and Liotti (1983) proposed a slightly different model in which the core feature of anorexia was seen as a ‘deficit in cognitive structures’ related to ‘personal identity’. The most popular ‘cognitive’ treatment model for eating disorders in Italy was the ‘integrated model’ put forward by the psychiatrist Dalle Grave and colleagues (1993), who developed the so-called

³ See Selvini-Palazzoli (1978).

‘lenient approach’: they changed the strict behavioural programme of CBT to allow for ‘more flexibility’, reassurance about ‘weight phobia’, ‘psychoeducation’, and ‘nutritional restoration’ organised by a nutritionist ‘trusted’ by the patient – with food presented ‘as medicine’ within a process of ‘mechanical eating’. In this approach, psychotherapy was offered mainly *after* so-called ‘nutritional restoration’ had been achieved. The emphasis was on establishing ‘an alliance’ with patients to enhance their capacities, with the aim of fostering ‘autonomy’ and the greatest practical degree of ‘independence’ from the eating disorder (ibid.:297).

As noted by some scholars who reviewed the ‘evolution’ of eating disorder treatment (Marks 2019), by the 1990s a considerable multidisciplinary and multinational group of professionals specialised in eating disorders had emerged internationally, resulting in the foundation of the Academy for Eating Disorders in 1993. The year 2001 witnessed the first annual meeting of The International Conference on Eating Disorders in New York City, where the latest research in the disciplines of neurobiology, cognitive neuroscience, genetics, and psychopharmacology also started circulating, contributing to shifts in understandings of eating disorders and their treatment (Marks 2019). As it will become clear in the thesis chapters, the professionals working in my field site are involved in this ‘internationalisation’ of eating disorders: many of them read journals, attend and participate in national and international conferences, and collaborate with colleagues working in countries such as the UK and the US. One could therefore say that they enact international theories and treatment, which is why the reader will at times encounter statements that might seem to ‘generalise’ eating disorders and their therapies. It will therefore be helpful to bear in mind, while reading the chapters, that the ‘facts’ professionals refer to in their work of diagnosing and treating patients have become international facts through their construction as such in international networks, including publications in journals and conferences. We have seen in the Introduction, and will see in more detail in the following chapters, how through the DSM anorexia and bulimia nervosa have become international diagnoses, and how therapies developed in response to these diagnoses have become international treatment through the assemblage of scientific facts⁴ that standardise ‘healthy bodies’ and ‘healthy minds’. Nevertheless, we will see that there are some Italian specificities in the way eating disorders are conceived and treated here. Most obviously and visibly, in the food that patients are given

⁴ See Candea 2018:215.

– but also in matters related to the relational aims of treatment and the relationship with the family.

In line with developments in medicine elsewhere, recent national guidelines in Italy (ISS 2012) now recommend ‘evidence-based treatment’ over ‘theoretical knowledge’, and that treatment should be ‘multidisciplinary’ – in tune with the ‘multifactorial aetiology’ of eating disorders – but tackling the ‘disordered eating behaviours’ first (Ruggiero, Prandin and Mantero 2001:297). Family therapy for eating disorders in Italy is therefore largely a component of wider multidisciplinary therapeutic programmes that also look at ‘individual psychological and biological aspects’ (ibid.). Such complex treatment, however, is hardly available to all those who would be considered in need of it, as we will see in the next section.

The current state of treatment services in Italy

The current landscape of eating disorder treatment services in Italy is all but rosy. Within an epidemiology felt to be the same as in other European countries, Italy has seen a rising prevalence of eating disorders from the 1980s and the 1990s (Garghentini et al 2003:168). In 1998, the Italian Health Ministry published specific guidelines for the treatment of these conditions (Ministero della Sanità 1998), calling for an organizational model with four different but integrated levels of treatment that patients can access depending on the severity of their condition, and through which they can move depending on whether they ‘improve’ or ‘worsen’: outpatient services as the first level of treatment; the day-service or semi-residential treatment as a more intensive intervention, with assisted meals; admission to hospital if the patient’s condition is critical; and rehabilitative admission to a non-hospitalized residential facility for a period of three to five months.

However, the Italian National Health Service has not kept up with the guidelines of the Health Ministry. A number of surveys carried out by the Health Ministry itself since 2008, which converged in the creation of an ‘online eating disorders map’⁵ that traces all existing public services for eating disorders available in the country– together with continuous reports

⁵ See <http://www.disturbialimentarionline.it/mappa-dca>.

of lack of services in the national news (e.g. Ruggiu 2016; Palazzo 2020)⁶ – suggest that treatment coverage is patchy throughout the country, and can generally be regarded as poor, especially in the South (see also Garghentini et al. 2003:168). For the more than 3 million people who have received a diagnosis in Italy, there are few dedicated facilities, causing a continuous migration towards private residential structures, non-specialized hospitals and psychiatric clinics, not only from the poorest Regions of the South, but also from the Centre and the North.

The Region where I conducted fieldwork was among the first ones to develop a complete network of public services for eating disorders, following the national guidelines. Today, the centre I worked in is the reference point for many others elsewhere. The centre's approach was born from the Clinical Director's view of 'cure' as 'not only therapy', but also as 'attending to patients with all their experiences and suffering' (personal communication). This approach to mental health services was the result of the transformations of the Italian healthcare system in the 1970s, which peaked with the closure of psychiatric hospitals in 1978 under 'Law 180', thanks to the critical psychiatry movement led by the psychiatrist Franco Basaglia. Basaglia had called for a new understanding of 'the sick' and their treatment, and in turn for different spaces of care (see Foot 2015).

The treatment centre – how it came to be

During fieldwork, I was lucky to get to know Franca, President of *Supportiamoci* (literally 'Let's Support Each Other'), the centre's Association for patients' relatives. Now a sturdy woman in her seventies, in her fifties and sixties Franca had played a key role in the birth of the treatment centre, and had worked there as a coordinator and nurse for some years before retiring. She still comes to *Il Giardino* twice a week, for the weekly staff meetings and for the weekly meetings for patients' relatives. On these occasions, she never fails to show up during patients' lunch, playing the role, she says, of the 'caringly insisting grandma'. She is a living archive of the treatment centre, and clearly enjoys telling foundation stories and other anecdotes of 'when things worked properly'.

⁶ One of these newspaper articles denounced the death of a 20-year-old boy from a town in Northern Italy, as having been 'killed by anorexia and by law' because of the 'unacceptable system of care' for eating disorders (See Palazzo 2020).

One hot morning at the end of July 2018, Franca told me the story of how the treatment centre came to be. Back then – it was 2001 – she was working as a Head Nurse in the children’s ward at the local hospital, when an 11-year-old girl was admitted with a diagnosis of pneumonia. The girl refused to eat and was always crying. She would eat very little and extremely slowly, cutting food in tiny pieces and sometimes hiding it. The staff called on the now Clinical Director – who at the time was working in the Department of Psychiatry of the main town in the Region – for a psychiatric consultation. She concluded that it was ‘a severe case of anorexia nervosa’. As soon as the diagnosis was clear, together with a psychologist, a nutritionist, the paediatrician and the dieticians of the hospital, the psychiatrist organised an ‘integrated therapeutic programme’ to be carried out within the ward. This was the first case, Franca remarked, of a ‘multidisciplinary treatment team’ that was based on the recommendations of the national guidelines, which called for ‘continuous communication between different experts and for a holistic view of the patient’. Holistic here meant attending to ‘the body’ and ‘the mind’ of the patient at the same time, Franca explained. In the same year, the Health Department of the Region had formed a group of experts to elaborate Regional guidelines for those who worked with eating disorders. During the editorial phase of the guidelines, it was noticed that the substantial increase in the demand for care in the Region was met with an extremely fragmented and hardly accessible response. Patients and their relatives had to build their therapeutic path on their own, with a lot of effort and confusion, by putting together the different aspects of treatment. The challenge was therefore to build a therapeutic path that was complete, differentiated by the levels of severity of the disorder but at the same time integrated, and most of all accessible.

Soon – Franca told me – the staff working in the children ward realized that the treatment programme, which was giving ‘good results’, could be applied to other girls. They thus started working in a more structured way at the hospital, creating a day-service for evaluating and treating patients. A whole hospital ward was dedicated to this aim. The newly created treatment team started providing ‘assisted meals’ – i.e., meals under the ‘surveillance’ of at least two professionals – after Franca noticed that a group of cats would regularly gather under the windows of the ward, happy to receive the food that ‘rained from the sky’ during mealtimes. The toilets of the ward were closed for two hours after meals to prevent patients from purging. Gradually, protocols and rules were set for each element of the programme, and all the professionals involved started intensive training and supervision with the renowned psychiatrist Dalle Grave, who had developed the ‘lenient approach’ of CBT for

eating disorders. Thanks to the presence of staff members used to working in a children's ward, it was possible to admit patients as young as 10-11 years old, something unthinkable in most treatment centres at that time, and still uncommon today.

By the end of 2002, the hospital where Franca used to work was hosting outpatient services for eating disorders, the day-service, and hospitalization for life-saving interventions. What was missing – the Clinical Director felt – was a space *outside* the hospital for the implementation of a rehabilitation programme offering a continuous form of care without the side effects of long-term hospitalization. This was eventually made possible by a local charity fund, which administered a sixteenth century villa in the town centre. The fund enthusiastically embraced the idea of converting the building for this new health need, and in May 2003 the residential facility *Il Giardino* opened. In 2011, as a consequence of the centralization of health services, the local hospital was closed and moved to a new larger hospital in a town nearby. The ex-hospital was converted into a Health Centre, of which the third floor has been dedicated since 2012 to the day-service for eating disorders, and to outpatient services. Patients requiring hospital admission have, since 2011, been re-directed to a specialized ward of a hospital in another town one hour's drive away.

Il Giardino and its inhabitants

The first thing that struck me as soon as I entered the residential facility of *Il Giardino* was the run-down and yet welcoming atmosphere. Upon entering through a big wooden door, one finds oneself in a dark and humid lobby. Walking up some stairs, the smell becomes one very different from the mouldy smell typical of most old buildings in the town centre, whose narrow alleys do not let the sun warm them. It is a distinctive smell of fried onions – something that one would not expect in an eating disorder treatment centre. This is because the first floor of the building is inhabited by a *Casa Famiglia* (literally 'Family House') hosting a small community of women with cognitive disabilities, who really like cooking with fried onion as the basis of their meals. Their cat, Pepper, who often sneaks out of their apartment into the communal garden, offers occasions for interaction between patients and his owners, who all enjoy running after him. After years of cohabitation, these neighbours have learned well the key rule imparted to everyone new to the treatment centre – including

new patients, professionals, interns, volunteers, and the anthropologist: ‘No talk about food’⁷. They repeat it like a mantra any time they hear someone breaking it.

On both sides of the entrance to the *Casa Famiglia*, several doors open up to spaces dedicated to receiving the public, and to coordination and administrative activities. The *front office*⁸ is where volunteers, interns and professionals take calls from prospective patients or their families, organise medical visits, manage waiting lists, and write reports on patients’ progress and discharge letters. From the *front office* one can access the consulting room – where visits with the doctor and the psychiatrist, the daily ‘pharmacological therapy’ and the much-dreaded weekly weight monitoring happen. Both rooms are surrounded by shelving units that contain the necessary material for compiling patients’ files, and where files of discharged patients are kept for records. Another door opens to the ‘administration office’, which also functions as the office of *Il Giardino*’s Coordinator. Here a smaller shelf contains the current patients’ files. On the right-hand side of the flight of stairs there is the largest room of the building, reserved for weekly staff meetings, supervision meetings and support meetings for parents. Equipped with screen and projector, sometimes it is also used for patients’ group activities and for the training of new interns. From this large room, one can access the nursing station on one side and the Director’s office on the other.

Another flight of stairs leads to the garden entrance: a glassy door overlooking a large green space surrounded by 300-year-old holm oaks and hedges that are seasonally covered with flowers. If one keeps walking up the stairs instead, one reaches the second floor – the residential space for patients – only accessible to professionals, interns, and volunteers. At the top of the stairs, turning left, one finds the door of the toilet reserved for staff, and the opening of a slightly elevated L-shaped corridor along which a series of doors open to patients’ bedrooms, with windows overlooking the garden. Laundry services, a locked storage room, and two shared bathrooms are also there, with ‘shower shifts’ written on white sheets attached to the doors. From the end of the corridor, a narrow flight of descending stairs leads to the dieticians’ office and to a smaller, back access to the building, reserved for staff and admitted patients. The rest of the floor is where patients spend most of their time. Right across the top of the stairs, after crossing a bright hall decorated with pictures, drawings and letters written by patients who have been discharged, a locked blue door hides behind it the most dreaded space of the building: the *Sala Terapia* (literally ‘Therapy Room’), where

⁷ More on this in Chapter 3.

⁸ Professionals use the English term ‘front office’ to refer to this space, which is why it is in italics.

patients eat their lunch and dinner. On the right side of the hall, a large living room called ‘relaxation room’ is decorated with paintings and enlightened by three large windows. It features a big table surrounded by chairs in the centre – used for drawing, writing, board games and other leisure activities – two large sofas, an armchair, a piano and a TV. At the two opposite sides of the living room, two light blue wooden doors open to other rooms: on one side, to the smaller ‘therapy room’ and the kitchen, reserved for eating breakfast and snacks, but otherwise closed to patients: here it is where professionals eat their meals, before or after patients, depending on their commitments. All these rooms feature high ceilings, terracotta polished floors, and antique wooden furniture. On the other side of the living room, another light blue wooden door leads to ‘the little gym’ – the only room that has been recently refurbished for the aim of hosting ‘body activities’: dance-movement therapy, drama-therapy, yoga, and meditation. This is testified by the new parquet floor and by the most mysterious feature of the whole building: a locked mirror⁹. On this floor, the air is stiff and warm, and carries the smell of patients’ food – continuously prepared and re-heated through the day.

The frantic movement is what catches the eye here – or better, the juxtaposition of two different kinds of frantic movements. One is that of professionals, who spend their days moving up and down the floors, from one task to the next – having to juggle between patients’ demands, those of patients’ parents, and those of the Clinical Director. They hardly manage to stop for a couple of minutes here and there, in the safe space of the kitchen. The centre employs a multidisciplinary approach that is based on the coordination of thirty professionals – the vast majority being women¹⁰ in their thirties and forties, except for the Clinical Director and two others who are in their 50s and 60s. The staff include two psychiatrists – one of whom is also the Director – a doctor nutritionist, an endocrinologist¹¹, six psychologists – of which two are also psychotherapists – two dieticians, three nutritionists, a dance-movement therapist, two philosophical counsellors¹², five educators, a

⁹ This is the only body-length mirror in the whole building, employed for a specific therapeutic activity that I will introduce in Chapter 3.

¹⁰ Of the whole treatment team, only two psychotherapists, one psychologist and one nurse were male.

¹¹ Endocrinology is a branch of medicine that, in the language of biochemistry, studies the role of hormones in regulating bodily functions, and which provides treatment when – as it is often deemed to be the case for people with eating disorders – hormone levels become ‘unbalanced’. For a brief history of the emergence of endocrinology as a medical science, see Welbourn 1992.

¹² Philosophical counselling is a contemporary movement in practical philosophy. Developing since the 1980s as a profession but since the 1950s as a practice, philosophical counsellors usually have a PhD or at least a

social worker who acts as Coordinator, two nurses, and three healthcare assistants – plus an Administrator who deals with bureaucratic matters. On any given shift, there are three professionals and a nurse assigned to the ‘residential part’. Their work is supported in a fundamental way by a substantial number of young interns and volunteers, whose stay in the centre is organised in morning and afternoon shifts, paralleling those of professionals, and usually lasts for six or twelve months. For simplicity of expression, I often group together all the carers working at *Il Giardino* as simply ‘the professionals’ or ‘the treatment team’ – as distinct from ‘the patients’ – in the pages that follow, unless the persons in question belong to only one of the sub-categories just mentioned, in which case I use the name of their specific professions.

The other kind of frantic movement is that of patients. About 16-18 patients – virtually all girls and women¹³ – inhabit the residential space on the second floor of the villa. Their frantic movement can often be observed in the garden, and sometimes up and down the stairs between the two floors. During my stay, patients were aged 10 to 58 years old, with the vast majority between 15 and 30 years old. In line with the relatively recent recognition in the clinical literature that eating disorders do not affect – at least not anymore – only people from privileged backgrounds (cf. Gard and Freeman 1996; Mitchison et al. 2014), patients’ socioeconomic situation was quite varied: it ranged from patients whose families owned multiple properties and spent their holidays in fancy hotels around the world, to patients whose families could not afford to cover the costs of a trip from a different Region to visit them during weekends. Since the treatment centre is public, patients do not have to pay for treatment, but some of them have to pay for rented accommodation once they switch to the semi-residential phase of treatment.

Differently from that of professionals, patients’ frantic movement is not driven by tasks to do – at least not by tasks imposed by someone else. Their movement is instead seen to be driven by ‘a compulsive urge’ to keep moving in order to ‘burn calories’ and ‘lose weight’, professionals explained. Even when they are sitting on the sofa or on a chair, or when they

Master in philosophy, and offer consultation services to people who look for a philosophical understanding of what are seen as social or mental problems. Philosophical counselling at *il Giardino* is offered as a group activity to patients and patients’ parents. It fits with and expands the centre’s ‘holistic approach’ – attending to the ‘existential aspect’ of the eating disorder, alongside the medical and the psychological (more on this in Chapter 2).

¹³ During fourteen months of fieldwork, only two male patients – 14 and 19 years old – were admitted, in different periods of time.

are standing against a radiator to keep themselves warm, patients are rarely completely still: there is always at least one leg frantically moving up and down, or from side to side. Only a very few patients can be observed staying still, but this usually means – professionals say – that they feel extremely unwell and down.

The day-service facility has a very different feel to it. ‘It used to be the surgical ward – each room was an operating room’, Franca had told me. Situated in a wing of the third floor of what is now the Health Centre – where services ranging from vaccinations, blood tests, maternal and child health are offered – the day-service consists of a long and wide corridor with light-coloured linoleum floor, enlightened by a series of large windows, making the space much brighter but at the same time colder than the residential facility. Windows occupy the right-hand side of the corridor, overlooking an internal courtyard in disuse that patients use to smoke cigarettes. On the other side of the corridors, six lilac doors open onto the different rooms of the facility: the *front office*, which also works as a weekly staff meeting room; the dining room, from which professionals can also access the kitchen; the relaxation room, where patients spend most of their time between meals and therapeutic activities; the consulting room, where visits with the doctor and the psychiatrist, and the weekly weight monitoring happen; the group activities room; and the ‘little gym’ room.

There are fewer people moving around here, partly because there is a smaller number of professionals working here, partly because patients who arrive at this stage of treatment – I am told – ‘have learned’, more or less, to ‘keep their compulsive exercise at bay’¹⁴. Fifteen professionals, plus some interns and volunteers, work in this facility, some of whom also work in the residential facility. However, the bulk of the work and most shifts are carried out by three figures in the ‘psy’ disciplines – two psychotherapists and one psychologist – and three figures in the ‘nutri’ disciplines – two nutritionists and one dietician. For every shift, only two or three professionals are present, plus an endocrinologist or a psychiatrist in some morning shifts, although the number of patients admitted is never below 12. Another difference is that patients here tend to be older: since it is a day-service, they need to be at least 18 years old in order to live in a rented apartment or in the housing offered by the charity fund. During my stay, most patients were in their twenties, a few in their late teens and their thirties, and a handful in their forties and fifties.

¹⁴ We will see how in Chapter 3.

Being a researcher and volunteer – the ethics of doing clinical ethnography

My relationship with *Il Giardino* – which includes both the residential facility and the day-service facility – dates to January 2014. Back then, I was frantically looking for a ‘field site’ where I could experiment with fieldwork for my MSc in Medical Anthropology. I was writing a thesis on patients’ experience of eating disorder treatment, and while surfing the internet I came across a video about a treatment centre in Italy. In the video, I was caught by the emphasis that the Clinical Director placed on wanting to create ‘a space of care and not just of cure’, something that seemed to be lacking in most patients’ accounts (e.g., Hendricks 2003) and according to the ethnographic studies of treatment facilities that I had encountered (Gremillion 2003; Moulding 2003; Warin 2005, 2010; Malson 2008). I thought that the centre might have offered an interesting counternarrative, and I was curious to explore what ‘care’ meant there. I wrote an email to the Clinical Director, introducing myself and explaining what I wanted to do. Five months and an ethical approval later, I was there doing my first five weeks of fieldwork. During that very brief stint of MSc fieldwork, I established good relationships with the treatment team and – quite predictably – left with more questions than answers. When I contacted the team again asking whether they would be willing to have an anthropologist around them for the much longer period that PhD fieldwork requires, they replied as enthusiastically as the first time. As a result, I spent fourteen months between the beginning of July 2018 and the end of August 2019 doing doctoral research in the residential and semi-residential facility of *Il Giardino*.

As an anthropologist wanting to conduct research in a clinical space, I was particularly fortunate, because obtaining access to and taking a role in such settings is usually difficult, even in one’s country of origin (Zaman 2004:2026;2008). This is both because hospital authorities and medical practitioners tend to resist analysis by social scientists – partly due to the latter having often engaged in ‘doctor bashing’ (McKinlay 1977:495 cited in *ibid.*); and because such settings are only accessible via ethics committees where a clash between medical ethics and ethnographic methods often causes problems (van Ginkel 1998:260; Oeye, Bjelland and Skorpen 2007; Bell 2019). I was therefore very lucky to find a Clinical Director who was open to and interested in what an anthropologist could ‘reveal’ about the implicit working of their treatment practices.

The Director quickly authorized my project, assuring me that my presence would not cause any distress to the patients nor to the staff, since they were all ‘used to have people around

coming and going' – by which she meant interns, volunteers, and professionals from other centres who come for training. However, I was aware that my presence would be different from that of the other visitors, because of the key role that some form of 'participant observation' still plays in anthropological research. In fact, even when access is obtained, any participatory aspect poses special issues in clinical settings. Some (e.g., van der Geest and Finkler 2004:1999; Vermeulen 2004; Wind 2008) argue that unless the anthropologist is a healthcare professional where s/he conducts research, fieldwork in a clinical setting is not really 'participatory', because the researcher is not allowed to participate in the 'work' around which the social life of the clinical setting is centred – the information circulating being seen as too complex and/or sensitive to be shared with the ethnographer (Vermeulen 2004:2072). Fieldwork in clinical settings does not fit well with older assumptions of 'participant observer'. Wind (2008) has proposed 'negotiated interactive observation' as a more appropriate way to describe ethnographic fieldwork in these settings. Anthropologists seem to have found a role in these spaces as analytical commentators, context-givers, or suppliers of 'ethics' – which is one way that the 'social' reappears alongside the objectivity or detachment of medicine (e.g., McDonald 2015,2017). Indeed, not 'participating' in one of the existing roles is seen by some as desirable (Tanassi 2004:2055) because not belonging to any of the power groups makes everyone 'feel free to talk', and more willing to do that (Van Dingen 1998:281; Barret 1996:xviii).

One might rightly observe that anthropologists can have problems everywhere with any form of participant observation., and methodologies have changed accordingly. Nevertheless, the additional ethical approval process typically requested by a clinical site can bring these difficulties more into the open. Wind's (2008) description of what ethnographers do in clinical settings as 'negotiated interactive observation' cannot be generalised. For my fieldwork, I did not have the role of a patient, nor of a healthcare worker, but I still participated in some acceptable and useful ways. In both facilities, I had the double role of 'visitor researcher' and 'volunteer'. Volunteering – and the related assumed will to 'give something back' in the form of time, skills and material help – seemed expected in a setting that was constantly understaffed, and where going through the 'volunteer stage' was fundamental for anyone who wanted to access potential paid employment opportunities in the future. Indeed, most of the other volunteers were not retired people helping in the treatment centre as an 'extra activity' during their free time (cf. Muehlebach 2013). They were mostly students and young professionals for whom 'volunteering' was part and parcel of their

training, and a fundamental way of building connections that could enhance their job prospects. It seemed impossible for them to think of being hired without ‘having given something’ to the treatment centre first. Similarly, for me, obtaining access to a world that would typically be foreclosed to social scientists required an exchange in kind. This exchange in kind turned out to be one of the most precious and useful tools for my fieldwork access.

Thanks to my role as a volunteer, I did not simply observe, but also helped the staff with several tasks. Still, I had to occupy a position in the available power dynamics of the centre to ensure that I was welcomed. Because the treatment centre was public and part of a teaching institution within the National Healthcare System, students in medicine, psychology, nutrition and nursing were carrying out their research studies and undergoing internships at the time I was doing fieldwork. I thus learnt about the world of the treatment centre from professionals, as they had learnt whilst interns. I was placed by professionals in the same category as ‘interns and volunteers’ for the organisation of shifts. Within team meetings, I would sit next to interns on ‘their side’ of the table. To gain access to the various activities of the treatment facilities, I had to go through their same ‘gatekeepers’ – the Clinical Director and the Coordinators of the facilities. Although I did not quite fit into their existing categories, I thus gradually learnt to dwell (Ingold 2000) in their community of practice.

I spent most of my days at the residential or at the day-service facility, helping staff members with supervising meals and with other daily tasks¹⁵, and participating in patients’ various group activities – including psychological group sessions, drama therapy, dance-movement therapy, meditation and nutritional group sessions¹⁶. My typical day would start at 9 a.m., when patients were finishing breakfast, and end at around 8 p.m., after their dinner. I attended all the weekly staff meetings, during which psychotherapists and nutritionists would present their respective patients and discuss their ‘case’ with the rest of the treatment team. During these meetings, the staff would sit together, discuss the situation and progress of every patient, and take decisions for next steps as well as for discharges and new admissions.

Every Saturday morning, I attended the weekly support meetings for families, where patients’ parents and other relatives would ask questions, talk of their doubts and difficulties, and learn from each other’s experiences. Among other things, this allowed me to explore how

¹⁵ These included accompanying patients to medical visits outside the treatment centre, accompanying the youngest ones to school when they were granted permission, and listening/talking to patients in moments of crisis when professionals were busy.

¹⁶ More details on these activities in Chapter 3.

skills used by professionals to manage interactions with patients are ‘transferred’ to family members, and to what extent they differed (cf. Treasure 2010:4). Apart from this, weekends were mostly free from structured activities and were reserved for visits or permits to go home if the conditions of the patient allowed it. I could therefore observe different dynamics from the weekdays, and I had more time to spend informally with both the patients and the staff, chatting, doing puzzles, watching movies and playing board games.

The monthly ‘supervision meetings’ for the treatment team were another precious occasion for learning: during these meetings, one ‘case’ of a ‘particularly difficult’ patient is presented by the team to an experienced psychotherapist who does not work in the treatment centre, with the aim of receiving feedback from an ‘experienced but fresh, uninvolved eye’.

One morning per week, I managed the *front office* of the residential facility, performing administrative duties and attending to patients’ relatives’ needs and worries. In the last months of fieldwork, I was given permission – with the agreement of patients – to attend first visits and individual nutritional sessions. Attending these was useful for gathering material regarding a) local notions of what it means to be ‘ill’ or ‘healthy’, b) the ways and instruments used to assess this, and c) what kind of action is expected according to the result of the assessment. Finally, outside the treatment centre, I attended several events and professional conferences on eating disorders that happened in the country. These were a precious opportunity to gather material on families’ and professionals’ experiences ‘on the ground’ in a wide number of treatment centres, to learn more discourses about eating disorders and enrich the topics that came up in my daily work.

My involvement in all these activities meant that I was seen as a kind of ‘hybrid’ by my interlocutors – between researcher and volunteer, between volunteer and professional, or in any case a liminal figure floating in the space between patients and professionals. Cleo, a patient, put it this way: ‘I wouldn’t know how to classify you. I think of you as someone outside the boxes of this place: you are not a patient, you are not a professional, you are not an intern...you are just Giulia, and you just belong here’. Patients knew that I was an anthropologist doing research and not a professional in their terms, but my role as a volunteer meant that I often seemed to assume the role of a professional: during meals for example, if patients showed ‘dysfunctional behaviours’ such as separating food from the seasoning or cutting food into too tiny pieces, I was expected to make them notice what they were doing and make them eat everything ‘in the right way’. Moreover, very early on during fieldwork I

was entrusted by professionals with the capacity to give patients things that they could only obtain from a professional, such as water or keys for the laundry, and patients would come to me to ask for things as they would do with any other professional. Nevertheless, I was much closer to patients and spent more time with them than any professional did. Patients in the semi-residential facility – who mostly spent their weekends walking around the small town – would sometimes bump into me and invite me to join them for a walk, play board games, or go to the cinema. On these occasions, they did not treat me as a professional, but as someone of about their age who was also spending her free time on her own and might want some company. They would often openly complain about professionals or tell me ‘dysfunctional things’ they had done that they would not disclose to professionals, confident that I would keep silent as I was not ‘one of them’.

On the other hand, professionals seemed to want to ‘protect me’ from patients: I was often advised not to spend ‘too much time around patients’, especially outside the treatment centre, for my own ‘mental health’; however, nobody ever told me that I should refuse patients’ invitations when patients mentioned my presence in their weekend outings, reported at the ‘welcome group session’ on Monday mornings. It seemed that the boundaries that professionals had to maintain with patients – it would have been inappropriate for a professional to join patients for an outing in the weekend, unless this was framed as a therapeutic activity – did not apply to the anthropologist. On the contrary, I was even thanked by a psychiatrist one day when she learnt that I had offered to spend a Sunday afternoon with Lisa, a patient at the semi-residential facility who was going through a particularly tough time, and for whom lonely weekends were especially difficult. The psychiatrist told me that it would have been good for Lisa to spend time and talk ‘with a girl of her age, but who is not ill’. In that moment, I was stripped of both my professional roles – what counted seemed to be my closeness to the patient as a fellow human being, of the same age and gender. Nevertheless, this did not mean that professionals never saw me as ‘one of them’ – in fact, they mostly did. Since my presence in the centre went much beyond my shifts as a volunteer, I was seen by professionals as someone closer to them than to interns and other volunteers, whose shifts were shorter and whose responsibilities were less onerous.

Sometimes, professionals seemed aware that they were being observed by a potentially judging anthropologist. At the beginning, when they would make jokes or ‘act silly’ – something that I soon realised might be fundamental ‘work’ to prevent the atmosphere of the centre from becoming ‘too heavy’ – one of them would suddenly stop and say things like:

‘We should stop, there is an anthropologist with us!’ and everyone would laugh and compose themselves. Gradually, once professionals understood that I could be trusted – perhaps because I had seen enough of that world to be understanding of their behaviour – they stopped applying obvious filters with me. If there was something that they were worried about, they would just tell me explicitly: ‘...But this, don’t write it in your thesis!’.

In fact, it did not take long for professionals to feel completely at ease with my presence, to invite me to join them for lunch in the centre, and later to invite me for dinner at their place – sometimes even offering me to stay for the night. They talked about patients or about their personal issues in front of me – or to me – as they would do with other colleagues. A few months into my fieldwork, I was added to the WhatsApp group of the professionals working in the day-service facility, and I was invited more than once to events and parties organised by the Clinical Director or by other professionals. For my birthday, I received the same ‘treatment’ reserved for any professional working there – but not for interns or volunteers – and I received a gift from the whole treatment team. The same happened when my fieldwork ended, and I had to leave. With some professionals, I developed close friendships that last to this day, and that were a fundamental source of company and support during fieldwork.

My involvement with patients and professionals, and with their practical day-to-day life, meant that at some point during fieldwork I did not simply have multiple roles, but also multiple aims, not always reconcilable. Being caught in the vortex of practical things to do at the centre, sometime with urgency, and in the welcoming social life of professionals and patients outside the centre, often resulted in doubts about whether I was doing research. Was ‘keeping an analytical eye’ on everything that happened enough – or indeed possible? In a recent piece, Bell (2019) has noted how the multiple forms of relationality that characterize ethnographic fieldwork are often presented in terms of the tension between ‘participation’ and ‘observation’. These contradictory qualities of ethnographic research are frequently glossed under the label of ‘detached observer and participant-friend’ (Rynkiewicz and Spradley 1976: 126). As observed by Bell (2019:11), the concept of the ‘dual role’ was first designed to address the situation of clinician-researchers conducting a study on their patients (e.g., Churchill 1980), where the dual role was not seen as intrinsically unethical, but as a phenomenon to be carefully managed. Similarly, many social and behavioural sciences construct research relations with heavily managed expectations concerning ‘contact’ with research participants. The ‘undesigned relationality’ (Bell 2019) in the research can seem to be ‘a noise distorting reliable, objective results’ (Lederman 2013:599,600). The underlying

positivism in this is evident in that relationality becomes tied to ‘truth’ and ‘trustworthiness’, and ‘rapport’ serves to generate ‘data’ (Bell 2019:14). Instead, ethnographic fieldwork is predicated on the anthropologist learning about an unfamiliar social world by developing practical competence in the aspects of daily life that are enabled by relationships cultivated over time. The multiple roles of ‘anthropologist’, ‘friend’, ‘student’, ‘apprentice’ etc. are thus all equally ‘real’ (Lederman 2017).

Conducting fieldwork in a clinical setting problematises participation not only in terms of the roles that one can, as an ethnographer, assume, but also in terms of the extent to which anthropologists can ‘understand the other’ just because they practise ‘participation’ (Hastrup 1993:732; Wind 2008:85,86). When pain and suffering are involved, one should be particularly cautious about any seemingly participatory achievements (van der Geest 2007:12), even if one feels that one’s background makes one particularly ‘familiar’ with a specific world.

De-familiarising a familiar field

Before starting fieldwork, I was aware that my field site would feel familiar: many patients and staff members were of my age, and we shared similar backgrounds. This was not simply because I was a 26-year-old Italian woman, who was born, had grown up and had lived in central Italy for most of her life¹⁷, but also because I have a history of living with an eating disorder myself – a biographical point that, I later discovered, I shared with some of the professionals. I was diagnosed with anorexia nervosa when I was 12, but I was young enough and ‘caught’ early enough that two years later I could say that I had ‘recovered’. I was not admitted to any inpatient facility – although at some point I was threatened with it – managing to limit treatment to regular outpatient psychotherapy sessions and medical visits. Mine was therefore a ‘success story’, thanks to the fact that a) I was spotted by my family and brought to treatment just a few months after my ‘disordered eating behaviours’ had started; b) I was young enough that treatment could be more easily imposed on me; c) I was living in a large town with a good outpatient treatment service; and d) my family had the means to pay for a private psychotherapist who could see me twice a week in the most acute

¹⁷ Since I conducted fieldwork in Italy – and in Italian, my ‘mother tongue’ – I had to do a significant work of translation when analysing and writing up, with all that that entails for any ethnography.

phase – something unthinkable in public services. All these factors contributed to making my recovery much smoother than the majority of those I encountered during fieldwork.

The fact of having suffered from an eating disorder was at the same time helpful and tricky. It was helpful because, remembering well the experience of anorexia, I already had a sense of how to behave with patients in a way that would not (even unintentionally) harm them or make them feel uncomfortable – I knew the ‘typical things’ that most people who live with an eating disorder do not need to see or hear, but that people who are not familiar with eating disorders often show and say. It was also helpful because I knew patients’ ‘irrational logics’ – the ‘manias related to meals, expressions of absurd thoughts regarding the body, weight and eating’ (Deiana 2012:64) – well enough to avoid feeling overwhelmed by them. On the other hand, the risk of taking things for granted was always present. I therefore had to do a constant work of ‘de-familiarizing’ myself from the discourses of my field site. However, I do not think that these issues have been a problem for my ‘research outcomes’. As Latour (2004:19) points out, the distance that one should achieve is not that between the observer and the observed, but ‘that between the contents of the world before and after the inquiry’. Nor it is the fact of having suffered from an eating disorder that gives any more ‘authority’ to my research, as moments of recognition or empathy cannot be proved right or wrong (van der Geest 2007:9). Nevertheless, as every anthropologist, in carrying out fieldwork I was never neutral nor irrelevant – I spent more time with certain people, and in writing I privileged their voices. The ‘undesigned relationality’ (Bell 2019) that characterizes every ethnographic fieldwork thus came to shape the boundaries that I drew for my field site.

A note on delimiting the field site

Delimiting my field site (cf. Candea 2007) might have seemed a straightforward task: the physical space of the treatment facilities could be seen to delimit the space of the field itself. However, as with ‘the village’ (ibid.:175), hospitals and clinics have shifted from being seen as ‘cultural islands’ in which a global biomedical model keeps ‘what happens inside’ apart from the social world surrounding it, to being seen as domains that reflect and reinforce dominant social and cultural notions and values (van der Geest and Finkler 2004:1996). This position contends that clinical ethnographies can therefore open a window to the social and cultural world (the ‘mainland’) in which the hospital or clinic is situated (ibid.:1998). In fact, the longer I spent doing fieldwork, the more I realised that the field spilled outside the

physical space of the treatment centre in many directions: to patients' temporary accommodations in town; to patients' family homes; to professionals' houses; to the restaurants, cafes and shops where 'good enough' patients would spend their free time during weekends; to professionals' conferences around the country. In sum, 'nothing was out of bounds, and no time was off-duty' (Candea 2007:174). Moreover, the very physical space of the treatment centre was itself less bounded than one might imagine: the residential and semi-residential facilities were in different parts of the town, and two additional facilities offering hospital beds were located in a different town altogether. Patients and professionals circulated among the four facilities, sometimes even within the same day – and 'ethnographic material' would keep happening simultaneously in all these locations. So how to delimit the field?

In my case, some practical barriers, and the role of volunteer that I inhabited alongside that of researcher, helped me to impose some boundaries to the ever-spilling field. These challenges also worked as a constant reminder that what came to be my delimited field site was not part of a totality that 'awaits to be discovered', but 'a contingent window into complexity' (Candea 2007:178-179). For example, I had 'arbitrarily and knowingly excluded' (ibid.:175) the space of hospital wards because of practical and ethical considerations: the hospital was located in a distant town that was nearly impossible to reach by public transport, and patients admitted there were at immediate risk of dying. Making patients and already overworked professionals spend additional energies interacting with an anthropologist just did not feel right. I thus decided to gather information about what happened in that space through conversations with professionals and patients whom I met in the residential and day-service facilities, but who had spent time in hospital wards. On one occasion, however, I found myself in a hospital ward for two days, when a patient of the residential facility had to be suddenly admitted to hospital and volunteers were needed to supervise her meals. In that case, the physical boundaries I had drawn for my field site did not hold, as my interlocutors asked me to cross them. Their practices made the hospital an inevitably relevant part of my 'field site'.

Navigating research ethics

The AAA and the ASA codes of ethics have always been my point of reference, but in the complexity of its everyday practices, conducting ethical research also requires being reflexive and critical of one's own project, and of anthropology itself (Caplan 2003:2,27). Given the

nature of my research, a few points required specific attention: research participants included professionals, family carers and patients diagnosed with what are classified as mental conditions. However, these conditions do not affect the capacity to take informed and responsible decisions. On the contrary, people with eating disorders are seen to be very ‘intelligent’ and ‘mature’ (Giordano 2005). In this light, all participants were thus capable of deciding whether to take part in my research or not, as confirmed by an authorization letter that I obtained from the Clinical Director¹⁸. That letter also specifies that when patients under 18 are admitted, the treatment facilities obtain informed consent from parents regarding the possibility that patients will be involved in research.

My research was felt to be in line with the treatment centre’s ethical guidelines and did not require approval from a local ethics committee, as it did not involve the use of invasive procedures¹⁹. Although the centre had given me formal consent to work there as a researcher, I knew that this was very different from obtaining the consent of every person. Following the Director’s advice, to ensure participants’ ‘informed consent’ I introduced myself and the research that I intended to conduct on arrival – first to the treatment team, during a weekly staff meeting, and right after that to patients at the beginning of a group activity. I distributed the relevant information sheets and made myself available for any question. I did not approach potential participants individually to invite their participation, since this could have been perceived as a form of coercion. Being Italian and having lived in Italy most of my life, all communication and information was provided in Italian²⁰. I sought oral consent from patients and professionals to observe and participate in group activities (group therapy sessions, meals, outings, staff meetings, etc.), and written consent for the ‘interviews’ that seemed to be expected. I made explicit the aims of the research to them: a descriptive study of professionals’ experiences of treating people with eating disorders, that sought to analyse the difficulties encountered and the way carers cope with them. Later on, I realised that a key dimension of treatment was seen to be the work of family carers, so I also introduced my study to patients’ relatives at the beginning of a weekly meeting for families, and sought oral consent from them to attend every meeting.

¹⁸ Evidence that the Clinical Director has granted permission is attached in the Appendices, with a translation in English and with any identifying information blacked out (see Appendix 1)

¹⁹ This would not have been the same in the UK.

²⁰ Samples of the information sheets and of the informed consent form are attached in the Appendices, translated in English (see Appendix 2).

Participants were recruited for interviews after they expressed interest and showed that they fully understood what their participation involved. At this point, they were given two copies of the informed consent form to sign so that they could keep one for further reference. This form included details about the voluntary nature of the study and the participant's right to withdraw at any point, without being penalised or questioned about their reasons. Finally, I continually re-negotiated consent throughout the fieldwork in informal ways. I did not conduct formal interviews with parents, since their time in the treatment centre and in town was very limited and had to be spent with the counsellors and with patients. However, I managed to talk informally to several parents on different occasions. I conducted only eight formal interviews with patients – purposefully excluding those under eighteen. Early on I realised that I was gathering a lot of material about patients' stories and experiences by simply listening to them during group activities and by chatting with them informally; more structured interviews seemed to evoke a performative attitude and framings that perhaps they were expecting me to hear. Moreover, many patients were already quite distressed and tired by the work they had to do in the treatment centre, and I did not want to add further stress. Therefore, I focused my attention on professionals. Patients' interviews and all other conversations were not recorded.

All the interviews with professionals were recorded, however; this seemed expected, as interviews themselves seemed to be expected from professionals. Interviewees included the Clinical Director, the Coordinator of *Il Giardino*, the President of the Association for parents, two medical doctors, the second psychiatrist, five psychologists, two psychotherapists, four nutritionists, two dieticians, three educators, one nurse, four interns in psychology, and two interns in nutrition. A few other professionals had volunteered, but their tight schedule made it impossible. However, throughout fieldwork I had the chance to ask questions and engage in discussions with all professionals through casual conversations over meals or coffee, and while helping them with tasks. Most of the material was gathered in this way.

Any recorded interview has been transcribed, and then the tape wiped clean. All personally identifying information has been removed from the transcripts. Transcribed interviews were coded with recurring themes and analysed together with the other material collected in the form of field-notes. I coded the material by myself. I thought that since this was my first proper ethnographic research, I needed more 'lived' immersion in the material, something that a software could not have provided. All material became 'data' safely stored on the

university network and password protected. Data stored on my computer and hard drives have also been anonymised²¹.

Since it was not feasible to obtain formal consent from every person I saw and interacted with without causing major disturbance to the facilities' daily activities, I addressed this issue by: (1) introducing myself and my research on arrival, and whenever a new patient was admitted or a new staff member was employed; (2) asking permission to observe/participate at the start of each group activity; and (3) not using a tape-recording device except during interviews with professionals, and after having received written informed consent. When introducing myself, I asked those who were not willing to participate in any way in my research to later approach me individually and let me know, but this never happened.

I always relied on the clinical judgment of the staff and the comfort level of patients in determining the appropriateness of participating in any activity and conducting interviews. Conversations with both patients and professionals did touch on sensitive topics, and might have caused some distress. Whenever I noticed that this happened, I immediately stopped and asked if they preferred to interrupt the interview or switch to another topic. However, in virtually all cases participants were willing to continue talking. I constantly tried to balance my ethnographic curiosity with the potential consequences of my activities – both for participants and for myself. This also implied that I had to be careful about the ways in which I established relationships with participants. Setting 'boundaries' with both patients' and professionals' requests was a continuous exercise, which was necessary to define the scope and limits of my role in the field, besides being an interesting source of ethnographic enquiry itself.

²¹ I kept updated with the debates concerning the EU's General Data Protection Regulation that came into force on 25 May 2018, and with concomitant updates to the Data Protection Act in the UK and in Italy, making sure that my research practices conformed to the changes in legislation.

Chapter 2

‘It’s not about food’: eating disorders as disorders of the self

Introduction

It is an unexpectedly chilly morning in early June 2019, and I am walking to the residential facility. The five-minute walk from my flat is usually very quiet, but today I find cars stuck in line one after the other. As soon as I get closer, I see a red car blocking the way in front of the entrance to the facility – with two people standing just outside, talking to someone in the car. As I reach the doorway, I bump into the nutritionist Irma, who greets me with ‘Oh thank God you are here Giulietta, today we really need help. It’s one of those days that you want to forget. Look at what I have to do...’. Irma then moves closer to the red car and starts talking to the person inside – I can see now that it is a young girl, twelve or maybe eleven years old. She is holding tight to the car seat. I infer that the other two adults standing near her are her parents. ‘Come on Carlotta, let’s go up. The drawing group is starting in a bit, it will be fun’ – Irma tries to convince her. But Carlotta keeps shaking her head. At that point, the girl’s father enters the car to get his daughter out. Carlotta starts screaming that she does not want to go ‘there’ – while she is being released from the rope attached to her seatbelt, which had reportedly been necessary to prevent her from trying to jump out of the car during the trip. Carlotta’s father takes her out by force, and then drags her into the residential facility – all the way up the stairs to the second floor, with the help of the nutritionist Irma. Carlotta’s mother follows them. She is tearful and keeps repeating: ‘If mummy and daddy leave you here, it is to help you; we can’t help you at home’.

By the time Carlotta’s parents manage to leave, it is lunch time. Carlotta refuses to eat, and when she is told that she must eat at least part of the meal before she can leave the dining room, she says an unconvinced ‘OK’. Then she sneakily hides some of the food in her tissue and some under the plate, and throws some more on the floor. Observing her from the back of the room, standing next to me, Irma looks worried: ‘Most patients do this at the beginning...but it is striking that she does it at such a young age. She already knows all the tricks!’. In fact, one of the key skills that I had to learn for my role as volunteer – one that all interns and professionals working here must learn – was ‘training my eye’ to spot patients’ tricks to hide food during mealtimes: ‘It is stronger than themselves at this stage, they can’t

help it. That's why we have to control them from above, like vultures', Irma continues. Three more 'vultures' are walking around the tables in the dining room, stopping when they notice something that should not happen – too much tomato sauce or oil on a napkin, too many bread crumbs on the tablecloth, too much fruit cut away while peeling it ... the list could go on. Patients' aims are apparently always the same – newcomers like me are taught by Irma and her colleagues: 'reducing the number of calories¹ ingested, to reduce weight gain'.

What is here classified as an 'eating disorder' seems – to an external, untrained observer – to have to do with eating, food, calories, and weight. As we will see in this chapter, however, both patients and professionals – although in different ways – seem to agree on one aspect: 'It's not about food'. If eating disorders are not about food, then, what are they about? In this chapter I will attempt to provide an ethnographic answer to this question. The answer, we will see, depends on who gives it: patients and professionals have different theories of their 'eating disorder', but even within the two groups, different understandings circulate of what is going on, and produce specific effects. Illuminating these differences, and the complex effects produced by their circulation and encounter, will bring to the fore the difficulty of caring for people with eating disorders.

First, building on existing ethnographic literature on patients' experiences, I explore how patients at the treatment centre frame their eating disorder as a 'self-care' project. We will see that patients' practices can be seen as one of many expressions of contemporary self-tracking practices. Australian sociologist Deborah Lupton (2016) has recently given an account of the purposes of those who get involved in self-tracking, exploring the assumptions underpinning contemporary self-tracking practices and the ways in which notions of the self and the body become challenged and negotiated. The first section of this chapter similarly examines how and why people are interested in 'self-tracking' – but through what is classified in medicine as an eating disorder – and what purposes they aim to achieve in doing so. Building on Lupton, I will further suggest that these self-tracking and self-shaping practices show strongly the *relational* aspect of such projects – i.e., how these people's self-projects are not about 'bounded selves', but about selves in relationships, especially kinship relationships.

¹ The 'calorie' was first defined in 1824 by the French physicist and chemist Clément as a unit of heat energy in studies of fuel efficiency for the steam engine. The American chemist Atwater introduced the 'Kilocalorie' in 1887, to measure the potential energy from food to support human labour (Hargrove 2007). In the world of eating disorders, food becomes 'calories' and persons become the morally charged numbers of their 'weight': the lower the numbers, the more praised the food/person is.

I then shift to how professionals, on the other hand, construct patients as having a ‘disorder of the self’ which leads to certain ‘dysfunctional symptoms’². By exploring the multiple ways professionals conceptualise the ‘eating disorder’, its causes and manifestations, I suggest that symptoms are ascribed to an entity that is at the same time *external to* and *within* ‘the person’ of the patient. This results in patients being framed as having complicated and fractured ‘wills’ – the ‘will of the real person’ and the ‘will of the disorder’ – and therefore as inevitably ambivalent and resistant to treatment. This framing makes it not only acceptable but also a professional duty to intervene, even if through somewhat coercive measures. We will see how, during the patient’s assessment preceding admission, what might be seen by patients as self-improving practices and experiences (Lupton 2016) is framed by professionals as pathology. This pathology is diagnosed and treated through a careful tracking of the patient’s ‘body’ and ‘mind’, performed by biomedicine and the psychological sciences respectively.

At the end of the chapter, I look at what kind of therapeutic relationship can be – and eventually is – generated by this particular encounter between patients and professionals, and what role ‘lies’ and ‘trust’ play in the encounter. We will see that there is a key tension in this relationship, a tension between coercion and responsibility; but we will also see that the tension generated by the encounter of patients and professionals’ diverging constructions illuminates what those constructions have in common: eating disorders, both parts seem to be saying, have something to do with relatedness.

Patients’ ‘eating disorder(s)’

The whole disorder is a constant envy for a chimera that can never be reached.

Lisa, 26

I opened the Introduction to the thesis with a vignette (see p.1) in which a 19-year-old girl recently admitted to *Il Giardino* described the behaviours that had led to her diagnosis of anorexia as a way of ‘mastering oneself’, with treatment apparently ‘ruining’ all her efforts. In the opening of this chapter, we saw a 12-year-old girl being taken to *Il Giardino* by force.

² For an account of how patients in the UK and Australia report being constructed as ‘eating disordered patients’ by professionals, see Malson et al. (2004).

Both vignettes indicate that patients accessing the treatment facility usually do not go there ‘spontaneously’, out of ‘their own will’. Patients are often brought to treatment by someone else – mostly by their parents, sometimes by their partners or spouses – and with considerable effort. The father of a 15-year-old patient summarized the process vividly during his first weekly group meeting for parents: ‘At that moment, I felt like an executioner who for the good of his daughter brought her to a place where she didn’t want to go, so that she could recover from a condition in which she says she feels totally fine’. However, as Lisa’s quotation at the beginning of this section suggests, things are more complicated than that.

In the thesis’ Introduction, I traced how anthropologists in recent decades came to take seriously ‘patients’ experiences’ of eating disorders, focusing not only on the practices medically seen to characterize these conditions, but also on the patients’ moral reasoning behind them. Lester (1997), as we have seen, proposed to analyse anorexia through Foucault’s (1986) notion of ‘technologies of the self’ – outlining how bodies, in what she calls ‘the West’, are seen as the material vehicle for an ‘internal self’, and how restriction of food, invested with meanings about dependency and nurturance, is therefore used to communicate autonomy (Lester 1997:486). Foucault’s scheme of self-formation processes – which Lester draws on – considers four elements: 1) the part of oneself that is the object of work – ontology; 2) one’s position in relation to one’s ideals – deontology; 3) the practical form that the self-forming activity takes, including techniques and activities – ascetics; and 4) the way of being that one aims to achieve – teleology³. Following Lester, the ontology in anorexia is thus not simply the body, as it would first seem, but the whole ‘self’ *through* the body. The self that is pursued is a self-restraining self, in which ‘reason’ rules over ‘emotion’ and the enjoyment of food. This reason/emotion dichotomy, with the emotional and sensuous ranked together, is common in the US and beyond, but perhaps especially so in Europe. The anorexic’s ‘food obsessions’, ‘compulsive exercise’, and ‘militaristic regimenting’ of her life thus have more to do with changing the self and communicating its new attitude, rather than with becoming slim (ibid.485). However, Lester argues, at a certain point the bodily practices take over and lead to ‘a compulsively single-minded focus on the body’, while the theoretical self-project fails (ibid.:485-488).

Similarly, we have seen how Gooldin’s (2008) account of an eating disorder unit in Israel suggests that hunger, which involves physical pain and suffering, is experienced by patients

³ See Foucault 1986[1984] and 1997, as outlined in Laidlaw 2013:103,104.

as an enjoyable ‘hyper’ feeling of self-mastery, which becomes an embodied ‘medium of selfhood’ for a ‘heroic way of being in the world’ (ibid.:282,290). In these patients’ experiences, the eating disorder is not a problem, but a deliberate attempt to reshape the self as a moral way of living in the world (Eli 2012:2). These studies strongly suggest that eating disorders go well beyond issues of body weight and shape: rather, a ‘moral practice of deprivation’ seems to be part of a complex form of ‘self-care’ that takes dominant ‘healthism’ imperatives to their extreme, paradoxically bringing people to self-sabotage (Lester 2014:249).

The fact that people’s project ‘fails’, however, does not seem to reduce the strength with which they hold on to it (see Lester 2014:248,249). But to what extent can one contend at this point that their determination is the consequence of an ‘autonomous will’ stemming from a ‘reflective self’, as Gooldin (2008) would put it? What is not clear is if and how this perception changes through different phases of the illness and of its treatment. Gooldin does not address the issue, whereas Lester briefly mentions that anorexics in later phases of their illness ‘realise’ that ‘obsessive bodily practices’ have taken over. Indeed, at this point many do seek treatment (Lester 1997:487,488).

Most patients admitted to *Il Giardino* reported that ‘at some point’ they did feel that they ‘had lost control’ over the illness. Even patients diagnosed with ‘restrictive anorexia’ – which, among eating disorders, has been reported in the medical literature as the one epitomising pure and total control (on account of the absence of episodes of ‘loss of control’ typical of bulimia and ‘binge-purging’ anorexia) – interestingly framed their restrictive behaviours as belonging to the realm of ‘loss of control’. One exchange that happened in the semi-residential facility, during a psychological group session, is illustrative here: although of very different ages, the two patients involved had both been diagnosed as suffering from anorexia since adolescence, alternating periods of ‘pure restriction’ and periods of ‘binge-purging’ anorexia. They thus claimed to be able to reflect on both ‘kinds’ of eating disordered behaviour. During the session, 26-year-old Lisa was trying to convince a younger patient – still in her adolescence – that associating her current restrictive anorexic behaviour with ‘complete strength and control’ and her feared bulimic behaviour with ‘loss of control’ was unfounded: ‘The force of restriction is only an illusion’, she said, ‘because when you reach the point where someone has to scrape you off the floor with a spoon, you are not very strong. One feels strong only at the beginning.’ Loredana, aged 56 and now classified as a ‘chronic patient’, promptly intervened to support Lisa’s point: ‘Exactly, because even in

restriction you lose control, you keep restricting and restricting, losing more and more weight...and you can't stop'. This realisation – Lisa and Loredana continued – was what had brought them to treatment. At this point Marzia, a 32-year-old patient who had been diagnosed with bulimia when she was 16, remarked that she had also found herself unable to control the behaviour that until a certain point had had a positive role in her life, leading to ambivalent feelings towards it:

[The eating disorder] is a protection from the external world, but only at the beginning. At the beginning it's like an escape route, or a mask to call for attention – and then suddenly you find yourself unable to live without it. So you want and don't want to be helped at the same time (Marzia).

In these cases, it was patients themselves who had decided to ask for help through treatment. This is typically the case with people who have been dealing with an eating disorder for quite a few years, and who have experienced the negative impact of the condition on their lives. Although worried, Lisa, Loredana and Marzia had been keen for the moment of admission to arrive, because they had realised that they could not live with such a disruptive condition anymore. The premise of admission in these cases is different from that of a teenager who is dragged to the treatment centre by her parents, or of an adult who is admitted straight after being hospitalised and yet keeps doing everything she can to avoid being fed. The kind of work that needs to be done and can be done in treatment is also very different, as we will see in the next chapters.

As in Mahmood's (2011) study of pious women's self-cultivation in Egypt, the ethnographic material presented by Lester and Gooldin, together with the views of those patients whom I have cited here, suggest that reflective projects of self-cultivation can paradoxically end in their own curtailment (cf. Laidlaw 2013:150-167). In a similar way, the result is the elimination of the very capacity for reflective decision-making that allows the self-cultivation path in the first place. However, patients here *are* often reflectively aware of the problem with their self-project, but they cannot act otherwise without feeling a moral failure (cf. Lester 2014:245).

In her recently published monograph, Lester (2019) has argued that eating disorders are not simply a way for people to manage what they find too difficult and frightening – as the anthropologist Warin (2010) had put it – but are also 'a means for seeking connection' (Lester 2019:23). She thus suggests switching from framing eating disorders as 'technologies of the self' (Lester 1997), to seeing them as 'technologies of presence' (Lester 2019:63) – as

ways of extending an ethical demand to others by making oneself seen and responded to. The notion of ‘technologies of presence’ resonates well with the way the patients I met talked about their eating disorder. Certain refrains kept coming up, and pointed to the relational function of the eating disorder as opposed to any exclusive focus on a bounded ‘self’:

What is the limit between dependence and independence in the disorder? Between visibility and invisibility? Because everything seems very contradictory to me: you want to be invisible, but you want to be seen; you want to be independent, but you need help and you end up asking for help. Why does one want to be independent – not to be dependent on anyone – and then end up being dependent on everybody? (Mara, 19)

However, something more seemed to be going on in some of the patients’ accounts. Although many patients framed the eating disorder as a way of ‘regressing from having to take responsibility for one’s life’, and of going back to ‘a state of dependence in which the whole family has to act in function of you’ (Cristina, 20), many also framed it as a paradoxical act of family care whereby ‘the illness also works to distract other family members from their own problems, which might be even more painful for them to deal with’. The ‘utility’ of the illness, as they called it, was seen to be not only for the person who gets ill, but for the whole family. It was, in the words of the psychologist Sara, a ‘relational utility’. Another patient confirmed that her parents would probably have divorced by now if it had not been for her illness: ‘The utility has been that of keeping them in a coalition to help me fight against my illness’ (Marzia, 32). In other cases, the illness had a relational utility in that it freed patients from the burden of caring for other family members without causing major family rifts. This was the case of 56-year-old Loredana, who had to look after her single mother for most of her life: ‘In a sense, the illness is a way to be free. I am free not to care for others, because I have the documented justification of the illness’. Here we see how for these patients, not only is the eating disorder a self-care project that extends beyond their ‘individual’ and ‘bounded’ ‘self’ by placing ethical *demands* on others, as Lester (2019) would put it; sometimes, it is also about *contributing* to keeping the family together by making sure that its focus is on the patient’s illness, and therefore away from issues that might threaten the family unity.

What we might call ‘patients’ theories’ of the eating disorder – the ways patients understand, experience, construct and ‘do’ (Mol 2002) their condition – professionals call the ‘egosyntonic nature’ of eating disorders, a phrase indicating that the behaviours, values and feelings stemming from the disorder are in harmony with the needs and goals of the patient,

and therefore partly ‘wanted’ and ‘desired’ by the patient (Lavis 2016:69). Whatever the name, this necessarily results in a deontological problem for professionals: Carlotta’s nutritionist Irma reported feeling ‘in great difficulty’ every day that Carlotta had to be taken to *Il Giardino* by force⁴, and often told me and her colleagues that she did not know what to do: ‘Should I send her back home where she doesn’t eat anything? How can I do that? She really doesn’t want to stay here...but it is clearly because we force her to eat’. Ascribing Carlotta’s refusal to stay in the facility to ‘not wanting to eat’ – hence to ‘the symptom of her eating disorder’ – made Irma decide that keeping Carlotta in treatment, even if against her will, was the right thing to do. In the next section, we turn to the different ways in which professionals in this treatment centre talk of the ‘eating disorder’ and of its relation to ‘the patient’s self’ – and suggest what ties them together.

Professionals’ ‘eating disorder(s)’

It’s in the head that we must eradicate the eating disorder [touching her temple].

Educator Flavia

One Saturday morning in January 2019, I am attending the weekly meeting for parents, in the big room on the first floor of the residential facility. The mother of a 16-year-old patient who has been recently admitted talks of her difficulty in understanding her daughter’s problem ‘as the expression of mental distress, as you say here’. The father of another patient nods: ‘I find it difficult too. I would like to understand...is this disorder a matter of genetics? Or is it more like a cold and a flu, and you get it from a virus, or a bacterium? Does it come from inside or outside? I wonder what bad thing I might have done to deserve this punishment...’. At this point, the counsellor leading the session – directing her gaze to those who had spoken – answers that the question of ‘where the disorder comes from’ is an interesting one, as ‘there isn’t a clearly identified external cause that one could address with an antibiotic’. Unlike for other diseases, the counsellor continues, ‘there is nothing that one can see or touch’ that could be held responsible for causing it. Genetics⁵ – she specifies – can play a role, but another component is also necessary ‘to activate’ the illness, and this is

⁴ The youngest patients are admitted to the residential facility with the difference that – at least for the first weeks of treatment – they return to their family house to sleep, so that admission is not ‘too traumatic’.

⁵ For more on the ‘genetics’ of eating disorders, see Trace et al. 2013.

usually something ‘in the environment, often in the family’. ‘Nature’ and ‘culture’ seem to be both playing a role here. ‘This isn’t an organic disease’, she concludes, ‘and yet, unlike other mental illnesses, it has an evident impact on the body. It is a mental ailment that speaks through the body, through food. Therefore, it is also about food, but it doesn’t end in food’.

During another meeting, a few months later, the same counsellor finds herself having to address a couple of parents’ anxieties about ‘the very long time’ that their daughters seem still to be needing to get better, after two and a half months in residential treatment. The counsellor replies poignantly that she is surprised that they speak of two and a half months as if it were ‘a very long time’:

It is a long time, but it is also a very short time if you think that the disorder took years to structure itself inside your daughter. Your daughters have taken the road of the disorder with the same determination with which a person whose house is burning sees only the window as an escape route. Even if you show them the door later, it is improbable that they will use it, because they already know where the window leads them. They don’t know where they will end up if they go through the door...

From these examples, we can start seeing how the ‘eating disorder’ is constructed in this treatment centre. The centre has a disease conceptualisation of the eating disorder as a severe psychopathology, as something within the realm of illness to be treated within medicine. The ‘seed’ of the disorder is seen as being located ‘inside ourselves’ – ‘genes’, ‘temperament’, ‘emotional vulnerability’ – but the triggers that make someone develop the disorder, that ‘activate’ the disorder, are seen to come ‘from outside ourselves’, including ‘traumas, complex family situations, the social environment...’. ‘We can’t detach things from their context’, summarises one counsellor. This aspect is highlighted during weekly meetings for parents, who are generally anxious to know the reason why their daughters are ill, and who would clearly feel better if they only knew there was ‘some scientific explanation’ – ‘faulty genes’ is among the favourite – which would lessen their sense of guilt at the thought that something they have done might be at least part of the cause. However, the characterisation of ‘eating disorder’ in professionals’ discourse reveals a much more complex picture, wherein the eating disorder is framed in several different but intersecting ways.

First, the eating disorder is conceived – mostly by endocrinologists, nutritionists and dieticians – as a ‘disease that has to be treated’, with its ‘symptoms’ mostly linked to malnutrition. Addressing the problem therefore is seen to necessarily imply re-feeding the person, without which psychotherapy is pointless. In the most severe cases, patients come to

the residential facility straight after a hospital admission. As the psychologist Marta – who had previously worked in the hospital ward in the nearby town – explained, hospital admission is needed as a ‘life-saving admission’ for patients who have virtually stopped eating and drinking, and are held to be at immediate risk of dying because their organs have started ‘shutting down’. Treatment in the hospital mainly consists of ‘refeeding’ patients with nutrition bags connected either intravenously or through a nasogastric tube⁶, in order to return them ‘to a physical condition away from that immediate risk, and that would make them more accessible psychologically’. Even in these conditions, some patients still try to resist treatment, by taking out the tubes or by ‘walking compulsively’ in their rooms: ‘In those conditions you can’t work on motivation or awareness...it is more a matter of support and containment’. The idea here is that if a patient’s body is too depleted, it is impossible to do any psychological work because the mind is possibly not working properly. The endocrinologist of *Il Giardino* often repeated that one must remember that ‘the brain is an organ, which needs nutrients to function properly’: patients could not do any ‘mental work’ in extreme states of malnourishment. The endocrinologist here points to the corporeality of the mind: psychological work cannot take place without nourishment of the body/brain, which seems necessary to allow the will to exist: ‘You don’t have a mind at all if you don’t eat’.

Quite early on in my fieldwork, the same endocrinologist told me about a research project that she was involved in with an American clinician, to study how explaining to patients the ‘Adapted-to-Flee-Famine Hypothesis’ (see Guisinger 2003) would affect patients’ motivation to treatment. This is an evolutionary construction of the condition, whereby the distinctive symptoms of anorexia – restricting food, denial of starvation, and hyperactivity – are seen as ‘adaptive’ mechanisms that facilitated ancestral nomadic foragers leaving depleted environments. According to this hypothesis, ‘genetically susceptible individuals’ who lose too much weight may ‘trigger’ these archaic adaptations. When I asked the endocrinologist how one would explain to patients the presence of their self-reported obsessive thoughts (telling them to move and exercise) in light of this evolutionary theory, she told me – as a matter of fact – that patients’ obsessive thoughts ‘are not thoughts that belong to them; those are thoughts generated by a malnourished body that goes into blackout’:

⁶ Nasogastric intubation is a medical process involving the insertion of a plastic tube through the nose, past the throat, and down into the stomach.

Knowing this is helpful to patients, because it helps them feel less guilty. It also helps us not to ascribe too much responsibility to them for not being able to stay still. If one makes them understand that thoughts come from the brain, which is an organ, they will also understand that if the organ is not nourished properly, it goes into short circuit.

In the endocrinologist's construction, 'hyperactivity' is a 'biological collateral effect of malnutrition, not related to patients' will – even if it *starts* as will'. The fact that 'it starts as will' but eventually 'is not related to will' anymore is then crucial for professionals' understanding of the ethical complexity of treating eating disorders.

A similar construction of the eating disorder can also be observed in a recurrent group activity for patients led by one of the nutritionists, which focuses on the 'Minnesota Study'⁷. This was a starvation-rehabilitation experiment that took place in the US between 1944-1946 to understand, the nutritionist explains, 'what happens to the body and the mind in a state of severe malnutrition'. The study reported that healthy people who were (voluntarily) led into semi-starvation displayed changes in eating-related behaviours also found in people with eating disorders – e.g., eating very slowly, becoming obsessed by food, etc. The volunteers also experienced a strong sense of guilt when eating, and in the 12 weeks of re-feeding they seemed to have lost a sense of control over their appetite. Finally, what were framed as the emotional and psychological changes that the volunteers experienced during the restriction phase were seemingly 'identical' to those found in people with eating disorders – including marked depression, irritability, intense preoccupation with thoughts of food, decrease in self-initiated activity, loss of sexual drive and social introversion. The content of this research is presented by the nutritionist as 'proof that all these behaviours and symptoms are consequences of malnutrition, not of personal matters'. It is these 'biological symptoms' – the nutritionist insists – combined in complex ways with 'psychological aspects', that determine the persistence of an eating disorder: 'This is why we insist so much on nutritional rehabilitation – so that we can eliminate all the stuff that is caused by malnutrition, and then access the deep causes of the disorder for that specific person'. Talking about the other changes found in the study volunteers – and in those with eating disorders – the dietician would typically report that among cognitive changes 'there are no alterations of intellectual activities, but a reduction of the capacity to focus, of comprehension, critical thought and vigilance'. Scientists of nutrition thereby provide an ethical ground for intervening against patients' will: although patients' intellectual activities may remain untouched, other

⁷ See Keys at al. 1950.

‘elements of cognition’ that are deemed fundamental to making competent decisions regarding their health – namely critical thought and vigilance – are framed as being affected.

A second – more psychologically-informed – construction is that of the disorder as a ‘symptom or symbol of something else’: as the external form that ‘inner mental distress’ takes. The counsellor leading the weekly meetings for parents keeps reminding parents that: ‘It’s not symptoms that need to be at the centre of our attention; it’s the suffering behind the symptoms that needs to be at the centre’. The psychotherapist Mauro, on a similar note, would often repeat during group sessions at the semi-residential facility that, through his years of experience, he had concluded that these patients’ illness was the result of ‘people moving away from things they have known for a long time. What is left unsaid has to get out from somewhere. On a smaller scale, it’s the same mechanism whereby when I keep stuff inside that I would like to say, my throat may start hurting’. In fact, one of the most common complaints on the part of patients is that their families do not understand that ‘it is not only about eliminating the symptom’ – about eating or not eating what they want – but also ‘about changing inside’. Parents are reprimanded for not understanding that ‘an internal change is inevitable in the fight with the external symptom’. These complaints are related to professionals’ theory of eating disorders as being the result of a ‘mismanagement of emotions’ – whereby ‘suppressed emotions’, especially anger, inevitably ‘emerge’ in the form of eating disorder symptomatology. For the symptoms to recede, patients need to give voice to their emotions.

Linked to this ‘emotions mismanagement’, the eating disorder is thirdly framed as a ‘paradoxical act of self-care chosen by patients to deal with problems that they feel they cannot manage’ (Clinical Director): in a situation in which – perhaps due to family issues or traumas – patients feel they are not in control of anything, but are at the mercy of events that keep hurting them, they ‘choose to control the only thing they feel they can control: the food that enters their body, and the shape that their body takes. That, at least, has to be perfect’ (psychotherapist Teresa). Since this self-care practice ends up harming patients – at least in the eyes of others – a fourth construction makes the eating disorder ‘an almost conscious request for help’, whereby ‘the disorder might be functional to make things around us and relationships change’. This is felt to be especially the case for patients who ‘have been parenting their own parents, rather than the other way around⁸’ (psychotherapist Valeria).

⁸ More on this in Chapters 4 and 5.

Although the eating disorder is seen by professionals as ‘a dysfunctional’ request for things to change, there is also the notion that it can be transformed into a more constructive ‘protest’. During a group session, the psychotherapist Michele seemed to echo Lester’s (2019:63) theory of eating disorders as ‘technologies of presence’ when he suggested to patients that one could ‘read the eating disorder as an act of protest, perhaps due to a perceived lack of empathy on the part of others’. He defined the eating disorder as ‘a protest that aims at the wellbeing of a relationship’ and therefore as ‘a potentially constructive protest, if one allows it to become an explicit expression of that need for empathy’.

Finally, the eating disorder is commonly framed as a ‘disorder of identity’: in this framing, the eating disorder gives a person who does not know who she is an illusory answer, ‘becoming an indivisible part of the patient’s self’ (Clinical Director). During a weekly meeting for parents, the philosophical counsellor explained that some people are ‘more emotionally vulnerable’ than others, and that this is necessary – if not sufficient – for someone to develop an eating disorder: ‘One is not born with emotional vulnerability, but one can develop it within one’s identity’. The counsellor specified that this phrase referred to the possibility of being hurt by external things: ‘the eating disorder settles where there are these fragile cracks. It is a glue that keeps the pieces of the person together, but that makes the person rigid, because the glue stiffens and stiffens, until the person breaks into pieces’. Patients themselves often remark that their greater, ‘excessive’ sensitivity vs. others has provided a fertile ground for the disorder; that ‘people who are not so sensitive’ do not develop eating disorders. This kind of discourse would especially come up in the context of group discussions about patients’ histories – not uncommonly characterised by acts of bullying or heavy criticisms of their body shape and eating habits, coming from schoolmates, siblings or other relatives, and even sports teachers and doctors. In this sense, the counsellor explained, ‘the eating disorder is not a problem for them, but a solution. A patient once told me that the illness for her is like a pillow: all the things that used to hurt her, now hit the disorder’. On another occasion – this time during a group activity with patients – the same counsellor brought a passage from Rilke’s ‘Letters to a young poet’, which she presented as perfectly depicting the eating disorder. In her reading of the passage, the disorder is seen as a ‘guest’ that enters ‘inside people’ through sadness, and changes them without them noticing it: ‘We are alone with that alien thing that has entered into ourselves; [...] the new thing in us, the added thing, has entered into our heart, has gone into its inmost chamber and is not even there anymore – it is already in our blood’ (Rilke 1962:64). The counsellor’s association

visualizes the eating disorder as an external negative element that slips into people and ‘makes a nest inside their identity, by giving the illusion of helping to keep them whole, but only to gradually take over their thoughts, desires and behaviours, up to the point of literally destroying them’.

Parents and professionals alike employ this last framing that externalises the disorder. During support meetings, parents commonly express the worry that when their daughters are at home for weekends, they find themselves ‘following the requests of the eating disorder too much’. It is notable here how parents talk of ‘following the requests of the disorder’, not of their daughters. Parents with more years of illness experience would routinely point out how they had gradually learnt ‘not to give too much space to the disorder’ and to keep doing what they liked, especially if they had other children, because otherwise it would be ‘like letting the disorder win’. Nutritionists often express their frustration at the fact that whatever addition to the meal plan they propose, some patients always manage to ‘twist it according to what the disorder says’. Psychotherapists feel proud when they feel that their patients realise that ‘the things they say they do “to feel better”, they actually do to make the eating disorder survive’ – apparently suggesting just ‘how fused and con-fused they are with the disorder’.

In this world, then, ‘eating disorders’ are not really about food, nor about the body. Food, eating, and bodies are just ‘the tools’, the ‘vehicles’, of a ‘mental ailment’. Since they are the ‘tools of the illness’, and deeply affect ‘the body’ – which has to be preserved if one hopes to ‘work on the mind’ – an extensive part of treatment has to do with food, eating, and bodies. This is highlighted by the amount of time dedicated to ‘nutritional therapy’, ‘nutritional group sessions’, ‘cooking labs’ and ‘mirror exposure therapy’, as we will see in the next chapter.

Fractured selves, fractured wills?

The professionals’ constructions of the eating disorder affect in particular ways how patients and their behaviours are acted upon during treatment. Professionals construct patients with eating disorders – how they think, what they want, how they act – as the result of an external controlling agent ‘which took over their mind and body through malnutrition’. Patients are thought to be ‘not themselves anymore’, even if they feel they are. Common military metaphors characterize the eating disorder, as ‘an alien monster who divides and conquers both the patient’s self and her family’, and patients in treatment become ‘ED warriors’. This is one way in which professionals explain the complexity of dealing with these patients: ‘This

monster made patients assume behaviours that don't belong to them'. Externalizing the disorder seems to help professionals and parents to avoid assigning full responsibility to patients for what they do or say, and to legitimate actions of their own that seem to go against the patients' will: 'The disorder takes over your daughters' self, [...] it takes up half of their brain, so it generates a constant internal battle during treatment' (endocrinologist). In this framework, going against the patients' perceived will is just a way to 'help them win the battle'.

It is not only professionals who frame patients as being 'invaded by ill thoughts' (nutritionist Marta); patients themselves perceive their wills or selves as 'fractured' and 'multiple', reporting that in many instances they don't know 'who to listen to'. Sometimes this makes patients delegate choices to trusted others, as 19-year-old Marina told us one Monday morning during a welcome group session at the semi-residential facility:

This weekend I went for pizza with my boyfriend and a couple of friends, and I let my boyfriend choose my pizza. I realized my brain was starting racing on its own, so I decided to make him choose for me. And he didn't choose an easy one, he chose the pizza with salami! I wanted to strangle him at the beginning, but he told me I was ready for this, and it all went OK.

Marina specified that one useful thing she had learnt in treatment was to rely on others to choose foods when she felt that her brain 'goes nuts, on those automatic thought patterns'. Here, delegating choice becomes a way to fight against 'the eating disorder talking'.

However, this strategy does not work for everyone. During a welcome group session on a Monday morning, Assia – a 21-year-old patient admitted with a diagnosis of binge-purging anorexia – reported being 'afraid of herself' when 'that ill part takes over', since she felt that nothing or nobody could stop her, including her parents' attempts to lock the bathroom door when she was at home: 'I don't recognise me in those moments. I don't understand how that person can be me. Because I also feel pleasure in that moment'. At this point, the psychotherapist Mauro objected, in an interesting turn away from the dominant notion of eating disorders that we have just explored: 'But it's not something other than yourself, like in a dissociative personality disorder. It is always *you*, it is a part of yourself that wants to say something'. Mauro continued and explained: 'But if we don't let that part speak to us, if we don't give an emotional representation of what causes us anguish and suffering, we end up as if we were possessed by something, as if this thing came from the sky, opened our mouth and

made us binge and vomit'. In a follow-up conversation on this point, Mauro explained to me that he saw the eating disorder as the result of 'aspects of ourselves that we have always kept silenced and that demand to find space within ourselves'. With time, he explained, these aspects 'take shape within ourselves in a violent way' and make us do whatever they want: 'When patients say they hear "like an external voice", it is actually an *internal* voice, it is that part of themselves that they don't recognise because they have always refused to be in contact with it!' (original emphasis). Unlike the case of conditions in which the illness is seen as more clearly 'something that is not you', the fracturing set out by Mauro makes the work of treatment more complicated, in that the aim cannot be to 'eliminate completely' the cause of the illness, because part of that is integral to the patient's self.

Nevertheless, externalising the eating disorder seems to be the prevailing discourse in this treatment centre. Drawing a line between 'the disorder' and 'the person' seems necessary for professionals to do their job effectively by opposing the patient's view of the eating disorder as a 'self-care' project – but also to experience their job as ethical, as the educator Flavia explained to a group of parents:

Sometimes I am very harsh with your kids. You cannot know how difficult it is to maintain this harshness when they get angry or start crying. But one must think that when one is harsh, one is being harsh with the illness, not with them as persons. And I tell them exactly this, that what I am imposing on them is against the disorder, not against them.

In her ethnography of eating disorder treatment in the US, Lester (2009) suggested that by talking about some patients as having traits of 'borderline personality disorder', clinicians frame 'subjects' whose eating disorder appears impossible to treat. This makes them feel OK when insurance coverage is denied because they cannot provide the required proof of treatment effectiveness. In this way, practitioners re-frame unbearable choices by creating 'a blindness to the existence of conflict' (Sturm 2004:107) Professionals working at *Il Giardino* seem to be doing something similar, but not necessarily when they have to make sense of not being able to treat particularly difficult patients. They do it for everyday acts of care that require going against patients' will. Framing the eating disorder as an externalised agent that fractures patients' will justifies seemingly coercive acts. In this way, professionals manage to go beyond the binaries of 'patient choice' vs. 'enforced treatment', and 'cure' vs. 'treatment failure' (Lavis 2016:73).

The idea among professionals that eating disorders are 'disorders of the will' means that someone other than the patient has to function as a temporary, 'prosthetic' will during

treatment (cf. McKeanery 2017). In the next chapter, we will see that, once patients have been given the instruments to become aware that their self has been taken over ‘by the will of the eating disorder’, they are held responsible, in light of this awareness, to trust their carers and follow what they are told if they want to get better. The expectation is that patients – still ill – could and should actively de-part from the ill part of their self. This expectation is reflected in professional frustration at dealing with so-called ‘false patients’ – false not in the sense that they are not ill, but in the sense that they do not seem ‘authentic’. ‘These patients are apparently very compliant with treatment’, I was told, ‘...and then magically they don’t gain any weight, and it turns out that they stay up all night walking up and down their rooms to burn calories’. These patients are defined as ‘manipulative’, as they do everything they can in order ‘not to change a gram’ (nutritionist Irma).

In her account of psychiatric services in Greece, the anthropologist Davis (2012:65) characterizes ‘diagnosis’ as ‘a fundamentally moral activity’, especially in that it proceeds ‘according to the rules of a game played for truth [...] whereby the responsibility to tell the truth weighs on therapist and patients alike, tough in different regards and measures’. In the case of eating disorders, diagnosis and the related ascription of what is called ‘focal incompetence’ – focal in the sense that it relates only to the ‘nutritional’ sphere patients’ life – allows the professionals to cope with the moral unease of enforcing a form of care on patients whose behaviour suggests that they do not want it. As will become clear later in this chapter, this problem does not disappear after admission but is always in the background during treatment. We will see how it is professionally navigated, and how, in Davis’ (ibid.) terms, ‘the game played for truth’ extends well beyond the moment of diagnosis to the whole duration of the therapeutic relationship.

Assessment, diagnosis and admission: creating the eating disordered patient

In order to be admitted, prospective patients need to undergo a ‘first visit’ which consist of an assessment performed by a doctor, a nutritionist and a psychologist. During this initial assessment, the biomedical and psychological sciences create an objective reality of ‘eating disorder’ and ‘patient with eating disorder’ through the use of numbers and specific measurements. First, the patient is asked by a nutritionist and a psychologist what she thinks ‘the issue’ is, and when the first ‘problems with food’ started. The patient is asked to give an account of her ‘nutritional story’, and then an account of the ‘family and social aspects’ – i.e.

what was going on in the patient's life 'at the relational level' before and when symptoms started. The attention on separating, but at the same time correlating, these two aspects of 'the eating disorder' is notable, and in the next two chapters we will see how they are addressed in treatment. After this double account, a doctor assesses the physical, nutritional state of the patient by checking her Body Mass Index (BMI), by looking at the results of blood tests which patients are required to bring to the first visit, and through a general medical examination. The BMI is a number obtained by dividing a person's weight in kilograms by the square of her height in metres. It is used in biomedicine to categorize people as 'severely underweight' (under 16 kg/m²), 'underweight' (under 18.5 kg/m²), 'normal weight' (18.5 to 25), 'overweight' (25 to 30), and 'obese' (over 30). BMIs under 20 and over 25 have been associated with higher all-causes mortality, the risk increasing with distance from the 20–25 range (see also Di Angelantonio E. et al. 2016)⁹. A patient's BMI is here a key metric in the monitoring of their health and progress, and is constantly updated in their files, following each weekly weigh-in. But the BMI is also one of the factors that determines patients' diagnoses in the DSM. It therefore constitutes a patient's very identity as 'anorexic' or 'bulimic' – a metric in what the Canadian philosopher Ian Hacking calls 'making up people' (Hacking 2006) – and their suitability (or lack thereof) for accessing the different levels of treatment. Residential treatment is recommended for patients whose BMI ranges between 14 and 18. Below 14, hospital treatment is recommended, as the patient is considered at immediate risk of death. However, in practice the lack of hospital beds for patients with eating disorders means that sometimes patients are admitted to *il Giardino* with a BMI of 12 or 13. Similarly, blood tests tell professionals about the 'hidden' damage that malnutrition

⁹ Efforts to define a practical index of 'relative body weight' began in the US soon after actuaries started reporting increased mortality among overweight insurance policyholders. In 1903, the Society of Actuaries and the Association of Life Insurance Medical Directors of America defined being 'overweight' as weighing more than the average for insured people of one's own age, height and sex (see Hacking 2006). These efforts culminated after World War II, when the relationship between weight and cardiovascular disease became the object of epidemiological studies (see Eknoyan 2008). From these studies it was concluded that the best index was the ratio of the weight in kilograms divided by the square of the height in metres – an index that had been described in 1832 by the Belgian mathematician, statistician and sociologist Quetelet. Studying human growth, he had concluded that besides the peaks occurring after birth and during puberty, people's weight increased as the square of their height. This was thus known as the Quetelet Index until 1972, when the American physiologist Ancel Keys re-termed it Body Mass Index (see Keys et al. 1972). In 1998 the World Health Organisation defined being overweight as having a BMI of more than 25. 'Underweight' was defined as below 18.5. Ian Hacking (2006) takes the invention of the BMI as an example of how statistics scientise bodies: he suggests that sciences 'make up people' through their 'engines of discovery', such as statistical analyses, that are thought of as having to do with 'finding the facts'. In this sense, before the invention of the BMI, 'underweight' or 'overweight' persons did not exist, as people could not experience themselves in that way.

has supposedly caused to patients' bodies: they are used to assess the risk that the disorder poses to patients' lives, and which level of treatment is therefore advisable. A physical medical examination complements the tests to assess the 'visible damage done to patients' bodies by malnutrition'. Doctors look for 'lanugo' (soft, downy hair on the patients' body, seen as the body's strategy of protecting itself against heat loss associated with extreme thinness), swelling and other signs of bad circulation, curvature of the spine, and 'abnormally low' blood pressure and heart rate¹⁰.

The apparent diagnostic objectivity of metrics reappears when the patient is then asked to fill in several standardised, itemised questionnaires that, together with a psychological assessment done through conversation with a psychologist or psychiatrist, are supposed to measure 'the intensity of the obsessions typical of eating disordered patients'. During the psychological assessment, the person is asked to report the experience of distress, and the standardised, itemised questionnaires seek to translate patients' experience into quantifiable symptoms. Mental illness is thus imagined as distinct disorders that can be detected through questionnaires and then tackled through tailored treatment. The idea underlying these tests is that, even in the absence of severe visible consequences on the body, the presence of recurrent thoughts and worries about one's body shape and food can predict the insurgence of 'dysfunctional behaviours' which eventually lead to 'concrete consequences'. The tests are also administered to rule out any other reason behind loss of weight and restrictive behaviour towards food. Obsessive thoughts are thus placed as the 'core psychopathological nucleus' that defines when a patient is 'an eating disorder patient'.

¹⁰ Lock and Nguyen (2010:32-54) have noted how the notion of risk in medicine emerged as a result of statistical metrics introduced in the nineteenth century by the new disciplines of epidemiology and public health. Drawing on historical and ethnographic works, they have suggested how deviation from the norm became disease, but also how risk stratifications emerged. As they note, it was only when an investigative approach to the interior of the body based on anatomy took hold in the early nineteenth century that arguments about the relationship between normal and abnormal biological states were debated. A fundamental development, they suggest, came about when bodily variation started being defined in terms of deviation from a statistical 'average': once the material characteristics of individual bodies were described and quantified, they were then assessed against 'normal values' established by statistical surveys of 'healthy' populations. On the other hand, statistical metrics made the notion of risk fundamental to discern factors external to the body that contribute to disease, revealing a tension that, they say, has been present from classical times in European medicine: that between an internalizing discourse in which disease is socially decontextualized; and an externalizing discourse that emphasizes familial, social and environmental influences. We will see in Chapter 3 how the tools and measurements of biomedicine and the related notion of risk are employed not only to construct the eating disordered patient, but also as a fundamental treatment strategy.

An additional element that needs to be assessed for admission is ‘motivation for treatment’. Patients are asked why they think they need admission, how they feel about it, and what their ‘intentions’ are. Ambivalence regarding admission is expected and seems to be what defines the ‘standard’ patient who needs admission. However, complete lack of awareness of having a problem that needs to be addressed with treatment – something that is not uncommon – is viewed as indicating that the patient may not be ready to undergo residential treatment.

The numbers constructing and derived from the BMI, the blood tests, and the standardised, itemised questionnaires administered on assessment and then again on admission, together with the medical examination and the talk-based session with a professional, contribute to constituting ‘the eating disordered patient’, becoming fundamental parts of what are seen to be patients’ very selves (cf. Koopman 2019). Ambivalent motivation becomes one of those fundamental parts. The following and last section of the chapter addresses the first step through which patients’ and professionals’ views are brought into dialogue, in professional attempts to engage with the patients’ ‘inner world’: constructing the therapeutic relationship.

Constructing the therapeutic relationship: building trust through lies

The pleasure of the disorder is the pleasure that you might receive from a secret lover. The problem is that you miss it as you might miss a piece of yourself, even if it brought you very close to death. We need time, we need to trust and rely on other people.

Loredana, 56

Trust in professionals is not something that is there or not there, but something that is achieved *during* treatment. A few months after Carlotta – the patient who had been tied in the car and brought to the treatment facility – was admitted, her therapist reported that her parents were alarmed because they did not see ‘much progress’, especially in terms of weight gain: ‘It’s true that her progress is slow, but let’s remember that she arrived screaming that she didn’t want to stay. We didn’t give up on her and she is finally starting to trust us’. When someone voiced that Carlotta was probably making herself vomit after the meals, one nutritionist said that she did not think Carlotta was vomiting – perhaps she was doing something else, like spitting in the toilet some food that she did not swallow: ‘I have been following her outside the toilet with my ear on the door, and I couldn’t hear anything’. Others did not seem convinced, so the endocrinologist proposed to do a blood test ‘to verify that’: excessive vomiting over a prolonged period of time, the doctor later explained to me, leads to

excessive loss of water and electrolytes from the body, especially sodium, potassium, calcium and magnesium. Expelling the gastric acid contents can also lead to an increased blood pH and a low level of potassium. Medical science is again a tool to ‘discover the truth’, which is here both corporeal and moral. It is not a question of just detecting an organic pathological phenomenon – it is about detecting what the patient might be hiding during treatment.

The first thing that a professional must do to be able to work ‘in cooperation’ with patients is to ‘*agganciarli*’, a term used to indicate the process of ‘catching’ patients’ interest and ‘make them realise we can help them’. Until this happens – the logic goes – patients will not trust the professionals and will not be honest about how treatment is going, whether they are managing to follow rules and recommendations, or what they find difficult. The therapeutic relationship is seen to be based on this trust-building process, which takes time and requires sustained truth-telling from both parties. However, as the discussion about Carlotta’s suspected behaviour suggests, even once the patient trusts professionals, trust is not necessarily mutual. What could be seen as an invasion of privacy – placing one professional ear on the toilet door – seems to be so necessary at this stage that it does not require explanation. Patients are assumed to lie because – professionals say – ‘lying is part of the illness’, it is ‘almost a symptom of the disorder’. Patients, their relatives and friends confirm this: during the peak of the disorder, ‘it is all about lies, since the eating disorder can only be sustained through lies’¹¹. Patients had to lie when asked if they had eaten, when, and what. They had to lie when explaining why they were always missing social gatherings involving food, or why they had to run away immediately after eating, to purge in secret.

Responsibility for lying – as responsibility for hiding food or for compulsively exercising – is therefore ascribed to the eating disordered part of the patient’s self, which makes patients almost ‘physically incapable’ – in the philosopher Williams’ sense of the term (see Laidlaw 2013:153) – to do otherwise. Thanks to this framing, patients’ lies are not taken personally by professionals. ‘Being lied to’ and feeling ‘manipulated’ is tolerated and accepted as ‘a matter of fact’ when working with eating disorders. This does not mean that being lied to never feels frustrating to professionals, especially when it makes them feel they have to act ‘as the police’. The moment a patient starts ‘opening up’ and ‘being honest’ about her difficulties is marked as a conquest by professionals, and is taken as a sign that the patient is ‘really willing to recover’, and that the therapist has done a good job.

¹¹ Cf. Warin 2005.

Professionals not only maintain a sceptical stance towards patients' truth-telling; they also themselves occasionally lie to patients – on the grounds that 'when treating people with eating disorders, especially the most difficult cases, you *have to* lie sometimes'. This typically includes the extent of patients' weight gain, or what is inside their meals, or the quantity of what they eat: 'Otherwise, they risk disintegrating. It is not really lying, because you will eventually tell them the truth when they are ready'. As suggested by Arteaga (2018:206) in her ethnography of colorectal cancer treatments in London, what for some is a lie, for others is better understood as 'the pacing of information': 'breaking news step by step' is seen by professionals as necessary for what they frame as patients' 'emotional well-being'. Although lying to patients is not standard practice in the eating disorder treatment centre, when it happens, it is 'for the best, because the patient could not have handled the truth'. Some professionals strongly disagree with this way of working, arguing that it risks destroying the relationship of trust on which everything is built: 'If they find out that you lied to them, that is when you lose them for good'. This last position is usually that of psychotherapists, who – nutritionists point out – 'are not those who have to tell patients how much weight they have gained every week and increase the composition of their meals'. Psychotherapists – nutritionists seem to imply – do not understand how delicate and difficult their task is, and how easy it is 'to generate a crisis and risk a drop out'. Here professional lies are justified by the idea that certain truths sometimes might not be appropriate for a patient (cf. Fainzang 2002:129).

In the world of this treatment centre, it seems, both parties start from the premise that the other may be lying at some point. Patients too are often suspicious of what they are told by professionals, especially at the beginning. As noted by Davis (2012:65,72,110) about the patient-professional relationship in psychiatric services in Greece, since both parties suspect that the other party may be lying, 'mutual suspicion' transforms the 'distancing manoeuvres' of patients' 'self-presentation' and of professionals' assessment and control 'into a more intimate, if antagonistic, relation', because the desire to 'know the truth' helps secure mutual dependencies. Lying therefore helps *constitute* the professional–patient relationship. Patients and professionals in the eating disorder treatment centre endlessly try to ascertain 'what is in the mind' of one another, trying 'to transform the motives, emotion and actions' of the other (cf. Mattingly 2010:47). Ultimately then, what happens after a lie is told and uncovered brings together patients' and professionals' competing views of the eating disorder and of health – an inevitable clash that can subsequently generate confrontation and more intimacy.

In this sense, I agree with van Dongen's (2002:143) suggestion that lying is 'an idiom to talk about a social and an interpersonal conflict', but that its meaning is 'more in the drama than in its social function' (ibid.). Drawing on Turner (1975:27) and on ethnographic material from a psychiatric ward in the Netherlands, van Dongen (2002:143) defines lying as a 'ritual of affliction': the lie signifies suffering, and can turn into more care. Lies for patients at *il Giardino* similarly seem to be paradoxically necessary to 'open up' a space for receiving help. On the other hand, professional lies are expressions of a struggle against an uncomfortable situation in which they do not know how to act for the best of the patient while being fully honest at the same time. Professional lies are framed as 'temporary lies' that are only necessary in particularly delicate phases at the beginning of treatment, and that function to prevent patients' self-discharge. Lies are thus seen to maintain the existence of a therapeutic relationship in which, eventually, lying will not be necessary.

Conclusion

In the same way that Davis (2012:16) claims to understand the patients in her ethnography as 'theorists of the psyche and theorists of relations', I take both patients *and* professionals in my field site as theorists of the 'mind', the 'body', 'relations' and 'ethics'. Similarly, paying attention to the professionals involved, we have seen that Lester's work (2009, 2019) suggests that clinicians' everyday ethics are generated by the clashes between professional ethics and the contextual opportunities to apply them (cf. Brodwin 2008,2013). These clashes generate an adjusted moral talk, whereby clinicians frame some subjects as having an eating disorder that is impossible to treat. Lester's work confirms Zigon's (2007) notion of ethics as not always a conscious domain of choice (as in Robbins 2004) or a matter of 'virtue ethics' (as in Hirschkind 2001 and Mahmood 2005), but as a sometimes-unconscious attempt to go back to the familiar from an uncanny situation of 'moral breakdown' (Zigon 2007:140).

In this chapter, taking Lester's argument further, I have suggested that the professionals working at *Il Giardino* construct a specific 'eating disordered self' as a way of making sense of and making bearable not only the impossibility to treat some patients, and therefore the *failures* of treatment, but also the everyday tasks that contribute to the *working of* treatment. This is because, as we have seen, treatment brings together multiple and diverging 'eating disorders' – which can be simplified as: for patients, a relational self-care project; for the professionals, a mental ailment that by 'working through the body' takes over the patient's

identity. Furthermore, I have suggested that framing their everyday tasks as ethical would not be possible for professionals without a notion of the self as not only ‘multiple’ (as in Lester 2017), but also ‘partible’. Only a partible conception of the self allows professionals to reconcile the tensions inherent in their job: between the stated aim of treatment – bringing patients back to an ‘independent, autonomous and responsible’ state¹², and the demands of clinical work, which include everyday activities of intrusion, surveillance and coercion directed at people who are mostly capable of making competent decisions in all aspects of their life other than their food intake.

We have seen that patients with eating disorders do not present a unified will as assumed by principles of consent at the heart of medical ethics (Petryna 2009, in Pinto 2014:253). As McKearney (2021:159) has noted while writing about the complexity that professionals face when caring for patients with ‘cognitive disability’ in a Christian Community in the UK, without a unified self to relate to, care will inevitably coerce and neglect at least part of the patient. By framing their coercion as directed ‘to the eating disorder, not to the person’, professionals at *Il Giardino* resolve the tension between care and coercion. However, whereas in McKearney’s case carers act ‘ethically’ on the assumption that they cannot know what goes on in the patients’ ‘mind’, embracing that very ‘opacity’ (Robbins 2008:426), here we have seen that professionals seem to manage to act ethically on the assumption that they *do know* ‘what is in patients’ mind’: thoughts and desires ‘determined by the illness’. The notion of an externalised mental disorder that ‘takes over the real self’ of the patient is employed to interpret non-compliance as the result of ‘vulnerable invalids’ (Lester 2009:376), and to justify care practices that seem to go against a patient’s will. This difference may be related to the difference between a reversible ‘illness’ whose mechanisms can be understood through psychotherapy and ‘shown’ by science, and a permanent ‘disability’ which bearers are deemed incapable of articulating. Moreover, the reversibility of the illness in eating disorders means that there is a ‘normal state of health’ that patients can return to.

This difference in the case of eating disorders seems to suggest that responsibility is not only distributed ‘across selves’, as McKearney (2017) put it, but across *parts* of the self. Following Strathern’s (1988,2018) notion of ‘partible persons’ as ‘potentially partible minds and bodies’, patients’ actions are conceived as the way they select – or are incapable of selecting – one of their ‘multiple compositions’. The notion of a ‘partible self’ anticipates the

¹²More on this in Chapter 3.

possibility of ‘partition’ of one or more of its parts (ibid.). As we will see in the next chapter, the aim of treatment here is the ‘partition’ of ‘the disordered part of the self’, which can happen only once it is recognised by the patient as an external agent that has become a temporary part of the self. Ethnographically, seeing patients’ selves as partible allows professionals to frame the ‘internal battle’ that patients feel they undergo during treatment, and the suffering that comes with it, as something temporary – as something that can be overcome and therefore worth struggling for. In this sense, as argued by Pinto (2014:250-253) in her ethnography of psychiatric facilities in North India, in everyday treatment practices the ‘classical ethical grid’ which sees ‘care’ opposed to ‘abandonment’ and ‘freedom’ opposed to ‘constraint’ can often collapse into a grid where care can slip into constraint, and freedom might slip into abandonment. In this chapter, I have tried to show how professionals at *Il Giardino* work hard to navigate that slippage.

Chapter 3

From coercion to responsibility: transforming bodies, transforming minds, transforming selves

Introduction

It is lunch time on a Wednesday at the end of September 2018. I am ‘on shift’ as a volunteer in the day-service facility. Patients are already waiting behind the closed door of the dining room – the so-called ‘therapy room’ – when I open it after I have finished helping Rosa, the social worker on shift that day, to set the table and arrange the food trays. The nutritionist Irma is already inside, next to the table where the tray containing the first course of the meal is ready to be served. Patients take the bowl from their assigned seat and start queuing towards the food, in tense silence. The soft music in the background and Irma’s encouragements are the only audible sounds, although there are eighteen people in the room. One after another, the fifteen patients take the big scoop placed in one of the trays and serve themselves. ‘A bit more’, Irma reminds most patients, making sure that each scoop is a level spoonful by pushing the food down in the scoop with a spoon. Once patients are all served and back to their seats, they are allowed to start eating. Most of them start chatting with one another or with Irma, who is now eating with them, sitting halfway along the long table. The newly admitted patients are quieter and more inquisitive towards the food on their plate. Those who have been admitted for longer eat slowly and carefully, but they seem more interested in the conversation than in the food.

As every Wednesday, the afternoon is centred around ‘group therapy’, led by the psychotherapist Mauro. By this time, I have learnt how to arrange the uncomfortable orange plastic chairs for group therapy sessions into a perfect circle in the dedicated room at the end of the corridor, so that no patient stays hidden from Mauro’s gaze or from that of fellow patients – a panopticon-like structure (Foucault 1991[1975]), one might say, but with no central hidden observer. Instead, the observer analyst sits in the circle together with the patients, as exposed to their gaze as they are to his. I have also learnt that I have to place two different chairs, one for me and one for the psychology intern on shift that day, outside the circle in two opposite corners of the room, marking us as external observers of the group dynamic.

Today Azzurra is invited to start talking, because this is her last group session. After six months of semi-residential treatment, she will be discharged on Friday and will continue her

treatment path here through weekly appointments as an outpatient¹. Azzurra is a 30-year-old woman who has been diagnosed with anorexia ten years ago. During this last group session, she voices her fear of having soon to respect the quantities of her meal plan ‘on her own’, that is, without the constant watchful eye of the nutritionists. At this point Lisa, 26 years old and diagnosed with anorexia, suggests that perhaps Azzurra is scared of ‘taking responsibility’ for her eating: ‘As long as you were here, you were forced to – and therefore you were given the permission – to eat. But when it has to be you who gives yourself permission, then you are scared’. Azzurra seems to agree with Lisa’s explanation: ‘Yes, now I will have to take care of myself. Even if I have the tools to fight these thoughts, I still have the thoughts. One part of me knows what I have to do, but another part still thinks that this food is too much, and that I need someone external to take this responsibility’.

At this point of the conversation Marzia, a patient usually seen as of radiant personality, looks visibly upset. Marzia is 32 and was diagnosed with bulimia when she was 16. Her treatment had until recently consisted of irregular outpatient sessions with several psychotherapists, psychiatrists and dieticians. She had asked to be admitted to the day-service facility after going into a coma caused – it was felt – by the ‘electrolytes imbalance’ due to her frequent binge-purging behaviour. After that frightening episode, in which her boyfriend at the time found her lying unconscious in the toilet and had to rush her to the hospital, she promised herself that she would try ‘to get out of bulimia once and for all’ with a more intensive treatment.

Mauro notices Marzia’s perceptible distress and asks her what troubles her. She reveals that during her last weekend visit at home, her parents told her that she had better recover this time, because one of her uncles had just been diagnosed with stomach cancer ‘without doing anything to provoke it’, they had said. This had really upset Marzia, because it was as if her parents were telling her that she had actively chosen to develop an eating disorder. Many other patients react visibly outraged, saying that those who think that someone can choose to have an eating disorder are either ignorant or very silly: ‘Nobody would do that. One does not “buy” this illness, it just happens’. At this point Josy, 30 years old, points out that although she agrees, there *is* a difference between them and someone with cancer:

¹ Outpatient treatment consists of only coming to the facility for weekly individual sessions with one’s assigned therapists – one week with the nutritionist, then one with the psychotherapist. If everything goes well, after about six months therapists and patient agree to meet less frequently for ‘check ups’, until, if the patient consistently does well for a year or so, she is discharged from outpatient treatment.

We can choose to recover, they can't. Their recovery doesn't depend on their internal strength, will, or motivation, but on medicine and other external things. I am not saying that motivation and will alone are enough for us, but the solution is still in our hands: with treatment, we can understand ourselves and the function that the eating disorder has in our life. Even if it is difficult, we have the possibility to choose to get better; people with cancer don't.

Mauro smiles and nods in agreement, saying something that strikes me for the audacity of the image proposed to a group of girls struggling with bodies getting bigger during treatment: 'Yes, you are like pregnant women, in a way: you will give birth to something at the end of this treatment path'. Patients look startled. Mauro explains what he means: treatment, he says, generates 'something new' in patients, just as a pregnancy generates something new 'starting from your own self, through the encounter with someone else'. The 'someone else' here is the treatment team, and the intended result of the pregnancy is an 'aware, motivated, and responsible self' for patients.

In this chapter I try to trace the course of these patients' metaphorical 'pregnancy', understanding 'the self' as an enactment, in Mol's (2002) sense of the term – that is, as constituted and re-constituted through dialogical, imaginative, interpersonal and institutional practices. What I observed in the group sessions seems to suggest a world in which people are framed into persons with 'selves' that can become 'autonomous' through psychotherapeutic work. Nikolas Rose (1990) has traced the development of psychotherapy as a set of techniques within which the modern self has been formed, suggesting how the world of psychotherapy precedes the person. He has shown how during the Second World War, 'interpersonal relationships' first became recognised as a site of intervention through 'group work'. Rose has also suggested how nineteenth-century philanthropy laid the foundation for the expectation of 'self-regulation' by the individual. This 'regulated freedom' required techniques for introspection and self-government. Human subjects became susceptible to 'reshaping': through psychotherapeutic techniques, individuals could now learn 'self-awareness', which provided them with a way of changing how they operated in relation to themselves and others. This also brought an 'obligation to be free', entailing the right to a sense of 'autonomy' as the capacity to make informed, uncoerced decisions (ibid.).

In the world of this treatment centre, a moral responsibility to get better follows from the possibility to autonomously choose to recover. Once change towards recovery is underway – as the examples cited seem to suggest – it is the patients' responsibility to keep going in that direction. It seems that from the moment of discharge, the responsibility to 'eat properly'

must shift from being shared with the treatment team, to being entirely managed by the recovering patient. But how does this happen? How do patients who are brought to residential treatment by force and who ‘can’t help’ hiding food unless under constant surveillance, get to the point of assuming responsibility for doing – or avoiding – the very things that they were forced to do or avoid at the beginning of treatment? This chapter will explore how patients ‘get there’, by examining how ‘responsibility’ travels through the network of care.

In her compelling ethnography of what she calls ‘failed care’ for eating disorders in the US, Lester (2019) argues that the managed care view of eating disorders as ‘self-inflicted illnesses’ – for which patients are blamed and deemed responsible – makes it impossible for patients to receive adequate care. Framing eating disorders in this way, over-responsibilising patients for their conditions, seems to prevent any kind of health improvement. Here I look at how professionals in a treatment centre in Italy, where there is a very different healthcare system, try to navigate these double binds and make patients ‘treatable’. Here we will see that de-responsibilising patients allows professionals to treat them even if it means coercing them in some instances – and then *subsequently* to assign responsibility to them for recovery.

Anthropologist Vogel (2018a) has similarly traced how what she calls ‘agency’ is configured and redistributed throughout post bariatric surgery treatment for people with obesity in the Netherlands. She suggests that in the clinic’s complex care – consisting of dieticians, exercise coaches and psychologists – the qualities and abilities of the patient’s ‘self’, and the socio-material conditions through which these emerge, are rearranged. This rearranging, she notes, is in her case to an important extent done by the patients, who ‘willingly submit themselves’ to surgeons and psychologists in order to craft themselves differently: ‘Patients make things act on them that in turn make them act in certain ways, and that transform them in the process’ (ibid.:509). In this chapter, we will see that at *Il Giardino* something similar happens, although starting from a very different premise, and in a different sequence: here patients do not actively subject themselves to becoming ‘the subject of intervention – including their material constitution, inclinations and feelings’ (ibid.:511). Rather, the transformation of patients’ minds and bodies is the necessary *starting* point for patients to reach a state in which they will start ‘actively’ subjecting themselves to treatment.

Throughout the chapter, I trace how patients who are defined by professionals as ‘resistant’, ‘ambivalent’ and ‘manipulating’ are turned into ‘aware’, ‘authentic’, ‘motivated’, and ‘responsible’. I describe how the structure, rules, knowledges, and everyday practices of

treatment function as tools to foster such a development, and suggest what kind of bodies - and therein minds - patients acquire through clinical interaction (cf. McDonald 2014;2015:40). This is a process in which, ethnographically, mind and body are two entities – ‘bodies’ and ‘minds’ here are an ethnographic matter, not an analytical device imposed by the ethnographer (ibid.): we will see how professionals work on patients’ minds to create new, ‘healthier’ bodies for them, and how in turn, with a healthier body, patients are seen to be able to acquire new, ‘more autonomous’ minds.

Eli and Lavis (2021) have recently offered a ‘materialist account’ of treatment resistance in eating disorder facilities in Israel and the UK, calling for a reconceptualization of ‘the body in treatment’ and showing how objects and spaces shape, maintain, and ‘trigger’ anorexia. Their work radically opposes ‘patients’ experiences’ to what they call ‘the clinical perspective’, as if the latter did not take into account the former in any way. Here, instead, I will suggest that things are more complex than this binary account seems to suggest, as the treatment team constantly engages with and ‘works on’ patients’ views and experiences, in recognition that ‘change must come from within’. Nevertheless, I embrace the authors’ call for reconsidering ‘the body in treatment’ by understanding bodies as part of a network, and by considering how human and non-human others, including objects and spaces, shape ‘eating disorders’ (ibid). Therefore, in what follows, I look at how the ordering of time and space and objects – especially food – in the facilities of *Il Giardino* contributes to patients acquiring specific minds and bodies (cf. McDonald 2014, 2018). I focus on specific therapeutic activities that cultivate patients’ ‘awareness’ – that is, a new way to ‘see’ the condition they find themselves in, not as something that protects them and makes them feel powerful, but as a form of enslavement from an external force that ‘took over their minds’ and ‘blurred their vision’, both metaphorically and literally. We will see that this external force, as it is then seen, neurologically ‘distorts’ the way patients see their bodies, with thin bodies made fat. This apparent distortion is reconfigured by teaching patients an alternative way of seeing their bodies and the food that nourishes them – a new view of the body as composed of parts that are all equally important, with food providing the necessary building blocks for its functioning.

The therapeutic contract

In Chapter 2, we have seen that patients are often admitted to *Il Giardino* ‘against their will’. I suggested that assigning ‘incapacity to choose’ to the patient’s ‘authentic’ self, subsumed to the will of the eating disorder, is one way professionals deal with the problem of applying care where it is not wanted. Another way they seem to cope with this problem is by requiring patients to sign a ‘therapeutic contract’ on admission². The contract contains information regarding the organisation of the residential facility and establishes ‘the rights and responsibilities’ of patients during treatment, including respecting a long list of rules – e.g., compulsory participation in the weekly group activities; being ‘collaborative’ with ‘nutritional therapy’; avoiding purging and other ‘compensatory behaviours’; avoiding self-harming behaviours; avoiding alcohol, drugs, laxatives and diuretics. In the last section of the therapeutic contract, patients agree to employ four ‘basic techniques of self-control’ to ‘counteract’ their symptoms. These are 1) ‘writing a diary’; 2) ‘doing alternative activities’; 3) ‘asking professionals for help’; and 4) ‘employing re-attribution techniques (by attributing one’s obsessive thoughts to the fact that one is affected by an eating disorder)’. Noteworthy is how the last point is expressed with the use of the passive form – pointing to the notion of the eating disorder as an external force ‘taking over’ the person.

The therapeutic contract functions to give the impression that treatment is ‘voluntary’. However, patients are not expected to observe all the rules from the first day of admission: ‘That would be impossible, or else they would not need admission. Rules function as an ideal to which patients must strive’ (Clinical Director). The ‘voluntary’ ideal seems to contradict the framing of patients as incapable of choosing to undergo treatment – because a contract signed without capacity would have no legal force. One might wonder why patients are asked to sign at the beginning if they are not expected to keep to the code of conduct immediately – i.e., if the idea in the contract is only applied at a point when patients are considered to be regaining their capacity. It is interesting that the complete list of 33 rules is given to patients only *after* they have signed the contract and ‘agreed’ to what it entails. In fact, the contract has mostly a ‘symbolic’ function (Clinical Director). It seems that although the contract has no legal force, it is signed so that, if patients keep resisting treatment, professionals can use it

² Therapeutic contracts have been used to define therapeutic relationships in many psychiatric settings since the 1970s deinstitutionalization that took place in Europe and North America (Davis 2012:217; see also Castel 1981).

to argue that a certain patient is not respecting it and give their place to someone who would 'benefit more'. This is why it has to be signed at the beginning, not when the patient's competence is considered to have returned: it is a kind of hedging against the possibility that a patient will never reach the stage where the professionals consider them 'competent', but will refuse treatment. In fact, sustained dismissal of the rules over time results in the treatment team questioning the patient's 'motivation' for treatment, followed by a week's 'pause for reflection' which could lead to discharge. The waiting list for this public service is known to be long. If a patient is not motivated enough, it is reasoned, her spot could be better used for someone else.

There appears to be something else going on, however – something that has to do with instilling in patients, from the beginning, the idea that they are responsible for how treatment goes, and that, without their collaboration, treatment will not work. In her ethnography of psychiatric treatment in Greece, Davis (2012:217) suggests that where behaviour modification is at the basis of treatment, the contract has the explicit therapeutic aim to 'inculcate self-control and personal responsibility in the patient', whose efforts to meet the terms of the contract are evaluated and reinforced by the treatment team (ibid.:218). Working towards the behavioural goals set by the contract together with the therapist becomes a matter of 'self-control' and 'personal responsibility', with moral responsibility becoming a therapeutic tool (ibid.). In the treatment of eating disorders, the eradication of the 'self-control' deemed typical of the eating disorder is as much a therapeutic aim as the inculcation of a new self-control for recovery. Within the world of these therapists, the aim is to move from a particular external control of the self by the eating disorder, toward a new internal self-control by the patient.

Re-structuring time and space

New patients are admitted to the residential facility in the morning. One nutritionist and one psychologist take care of 'welcoming' the new patient– meaning that after signing the contract and doing the medical visit, there is a brief session with them. Here the patient is introduced to how days are organised into group activities, is given 'a tour' of the facility, and the complete list of rules. The patient is then brought to her room, and by then it is usually lunch time.

Lunch, or ‘nutritional therapy’ as it is called here, is the first encounter that new patients have with treatment: suddenly, the patient finds herself in a large dining room. At the centre of the room there is a big oval table where up to eight patients can sit; at the back of the room there are two square tables, for four patients each; on the opposite side a single table facing the wall is reserved for ‘particularly difficult patients’. Patients are assigned a different seat for every meal, but always trying to keep a disposition such that ‘the most problematic patients do not affect the more vulnerable ones’. There is always music on during meals, to disguise the otherwise ‘unbearable silence’ and facilitate the creation of a cheerful atmosphere with small talk and occasional jokes, while professionals carry out their ‘controllers’ role.

Lunch, like dinner, is followed by a ‘rest period’ of one hour, during which patients are required to stay all together in the ‘relaxation room’ – so that the treatment team can make sure nobody is purging in the bathroom or exercising in their room – and they are allowed only to do activities that can be done while ‘sitting still’: watching TV, reading, writing a journal. In the relaxation room, chairs, armchairs and sofas are thus transformed from pieces of furniture into clinical objects, and become central actors in the fight against the eating disorder (cf. Eli and Lavis 2021): they become the tools of the fight against patients’ ‘compulsive’ urge to move and burn calories – a fight that is hard to win, as most patients can be seen keeping at least one leg constantly moving, even if almost imperceptibly for the observer.

Rules of this kind, as noted by Eli and Lavis (ibid.), foreground ‘the optimization of nutrient absorption as paramount to patients’ temporal, spatial, and bodily routines’. The authors argue that they function to ‘designate food as the treatment for anorexia’, thereby framing anorexia as being ‘primarily in and about the body’ (ibid.). This ‘clinical perspective’, they point out, fails to see that anorexia is not really about the body, but is only enacted *with* the body. However, in Chapter 2 we have seen how if there is one thing in common between the diverging constructions of patients and those of professionals, it is that ‘eating disorders are not really about food and the body’, but about issues of relatedness enacted ‘*through* food and the body’. In fact, at *Il Giardino*, making patients rest all together in the same room after a meal is also framed as a way to prevent patients from ‘being alone in the most difficult moments of their day’. Staying surrounded by others, distracted by TV or a book or knitting, is supposed to ‘tone down the obsessive thoughts’ about the meal just eaten and the need to move to ‘burn it off’. It also allows professionals to see if someone is going

into ‘a crisis’, and to intervene by bringing her to a separate room to talk. It is not only about ‘surveillance’ and making sure that ‘nutrients are absorbed’, but also about care.

After the first meal, the new patient is officially part of the facility, and will follow the stream of activities that constitute ‘therapy’. ‘Therapy’ in the residential facility can be imagined as a carousel onto which patients jump. Here I am thinking of one of those modern carousels which instead of being populated only with horse-shaped mounts, include a variety of mounts with different animal and non-animal shapes. Several group activities structured around five meals per day constitute the rotating circular platform of the carousel. Individual weekly sessions with one’s assigned psychotherapist and nutritionist define the shape and motion of each patient’s ‘mount’: each patient, in fact, has a personalised path in terms of ‘the psychological work’ they do, and the ‘meal plan’ that they have to follow, with adjustments made in the course of treatment depending on ‘progress’. Whereas the rotating circular platform keeps spinning in the same direction and at the same speed, each mount on the rotating platform has its own different motion: a horse might move up and down, a giant teacup might spin in the opposite direction.

Time is structured and categorized in a particular way in this facility. Patients shift from a situation in which – before admission – their days ‘revolved around the endless and meticulous process of preparing and consuming and expelling food’, with all the rest ‘receding into the background and time losing its shape’ (Lisa, 26), into a situation in which half-hours, hours, days, and weeks are categorized into different ‘therapeutic activities’, including mealtimes. Individual weekly sessions with one’s assigned therapists can happen at any time, depending on professional shifts and duties. But aside from this, days in the residential facility are heavily structured. Every Monday morning, patients receive a ‘weekly planner’, which lists the group activities that will happen every day, always following this structure:

- 8.00-8.30: psychopharmacological therapy
- 8.30-9.00: breakfast
- 9.00-10.00: individual sessions
- 10.00-11.00: first group activity
- 11.00-11.30: mid-morning snack
- 11.30-12.30: second group activity
- 12.30-13.30: lunch

- 13.30-15.30: time for resting/studying/reading
- 15.30-16.30: third group activity
- 16.30-17.00: afternoon snack
- 17.00-18.00: fourth group activity
- 18.30-19.00: psychopharmacological therapy
- 19.00-20.00: dinner

After dinner, patients are ‘free to do what they want’, which typically includes making phone calls, watching a movie with the educator on night shift, or playing board games. All patients are ideally supposed to be in their rooms at 11 pm. Saturdays and Sundays have a less structured schedule, with group activities ending by lunch time on Saturday, and the rest of the weekend left ‘free’ for patients to receive visits from relatives and friends, or to go out for their weekly permits.

Not only time, but also space is ordered for patients in a specific way. This ordering of space has to do with what are seen to be the specificities of eating disorders. In her ethnographic research on eating disorder treatment in Canada, the UK and Australia, Warin (2005) has shown how for people who live in shared houses, the bedroom becomes the single space for storing, preparing, eating and expelling food. These reconfigurations of space allow people to avoid the surveillance of others, eat what they choose, hide food and purge. Inpatient treatment – Warin suggests – tries to prevent these behaviours, but the single bedrooms at the basis of hospital programmes unwittingly reproduce the very configurations of space that support them as eating, sleeping and expelling food happens in one conflated space (ibid.:104). In her conclusion, Warin (2005:109) called for more attention from both clinical and academic worlds to residential programmes that position themselves in contrast to hospital-based treatment. Here I want to take up her call, expanding her analysis with attention to the ordering of space in the residential facility of *Il Giardino*.

At *Il Giardino*, rooms and areas that might have a role in ‘reinforcing the symptoms’ of eating disorders are either forbidden to patients or their usage is strictly regulated. The kitchen – where food is stored and prepared – is a ‘red zone’ for patients. One of the first things I had to learn when I started fieldwork was that every time I left the kitchen and nobody else was there, I had to close the door and lock it, always hiding the key in a cupboard where every member of the treatment team, but no patients, would be able to find

it. The dining room is also a red zone outside mealtimes, and its door is carefully locked at the end of every meal. Toilets and bathrooms are another ‘space of risk’: in life before admission, patients would access them to purge what they had just eaten, but also to ‘exercise in secret’, ‘obsessively check their bodies’ in the mirror, and weigh themselves. There are no scales in the treatment centre, besides the one in the doctor’s office where medical examinations and the weekly weight monitoring happen. Equally, no mirrors are to be found in the facility, except from small mirrors fixed high on the walls of toilets and bathrooms, so that the only part of the body that they can reflect is patients’ faces. For a while, I was told, toilets were indeed kept locked for an hour after every meal. At some point, however, the treatment team decided to try and keep them open, ‘trusting patients’ that they would respect the rule of staying in the common room for one hour after meals. Keeping toilets unlocked mostly meant, I was told, shifting the responsibility for avoiding compensatory behaviours onto patients: ‘If they make themselves vomit, it will come out in their weight monitoring’ (nutritionist Irma). Patients’ bedrooms are not locked, but patients are not supposed to spend much time there during weekdays. This is meant to ‘prevent them from exercising compulsively’, but also ‘from isolating themselves at vulnerable moments’. Similarly, access to the garden is not prevented by any physical barrier, but the limited time for its use – which includes ‘legitimate things’ like smoking, reading, and sunbathing, but also ‘dysfunctional ones’, like ‘rounds of compulsive walking’ – is specified in the list of rules that patients have to follow. Patients in a particularly severe state are often told they cannot access the garden until they have reached a safer weight. Nevertheless, many patients routinely retreat into their rooms or disappear, to then be found walking in the garden.

One might wonder why an understaffed treatment team spends so much time running after patients, risking that they do things that seem to counteract their treatment, and knowing that that indeed often happens. I would suggest that this ‘loose’ ordering of space functions not only to ‘fight’ the symptoms of the eating disorder, as in recognition of the iatrogenic effects that Warin (ibid.) has noticed in hospital inpatient settings; it also has to do with an ‘instillation of responsibility’ in patients, seen as a key ingredient for a long-lasting recovery – as if the treatment team were preparing patients, from the start, ‘to deal with a world in which toilets, bedrooms and gardens will not be locked’ and in which ‘self-control will have to come from within themselves’ (educator Teresa). The kitchen and the dining room are exempt from this work of responsabilisation because they are conceived as having a different quality: they are seen less as a source of ‘temptation’ for patients to engage in ‘dysfunctional

behaviours’ – i.e., bingeing on the food stored in the kitchen or prepared in the dining room – than as a source of ‘exposure to phobic elements’. Most patients, it is held, would not dare eat the food in the kitchen: they would be ‘too scared to be caught’; the danger, instead, is perceived to be in patients ‘seeing all that food’ – and the calorific content written on the packages that are carefully removed before serving it to patients – and inevitably having ‘crises of anxiety’ which could compromise treatment and result in self-discharge.

Psychopharmaceuticals

When ‘dysfunctional thoughts’ are felt to be ‘out of control’ – and to make it impossible for patients to think about anything else, causing severe anxiety and lack of sleep – psychopharmaceuticals such as antidepressants, mood stabilizers and tranquilizers come in to literally transform what is in patients’ minds. Around half of the patients are prescribed one, or often more than one, psychotropic medication. Twice a day the nurse on shift rings a bell, and patients who have a prescription go to the room dedicated to medical visits. Here, psychopharmaceuticals are given to patients one by one, under the watchful eye of the nurse, who checks that pills and drops are swallowed.

Convincing patients to accept psychotropic drugs is not easy work, because of the popular association of these drugs with their side effect of ‘weight gain’. The psychiatrist ascribes this difficulty to a ‘lack of information’ – since many new psychopharmaceuticals do not have that effect. Many patients also express the worry that when they start taking medications, the thoughts and behaviours they would have during treatment would be ‘due to the drug’ they are taking, expressing a fear of not being ‘in control’ of their thoughts and actions anymore. In the face of these patients’ fears, psychiatrists respond by pointing out that patients’ thoughts and actions are ‘*already* out of their control’ because they are controlled by the eating disorder. Drugs are thus framed as external but benevolent agents that can help patients regain *real* control of their thoughts and actions:

Of course patients are still themselves: drugs cannot eliminate dysfunctional thoughts or make them take decisions; they can only lower the intensity and frequency of obsessive thoughts, so as to make space for *other* thoughts, and make patients capable of accepting help by respecting the rules – exercising less, eating properly...

Here again we are in a world in which an intervention that is external and somewhat imposed on the patient is deemed necessary to counteract the effect of another external and

coercive agent – the eating disorder. This external intervention endowed with therapeutic power seems to be surprisingly accepted by patients once their ‘irrational fears’ are deconstructed by a trusted professional: most patients happily queue to receive their pills or drops, and many look forward to those two moments of the day.

Coercion, awareness and responsibility

The four group activities happening during the day vary depending on the professionals on shift, and have different aims: facilitating patients’ understanding of ‘the meaning’ and ‘function’ of the eating disorder in their life (psychological group therapy); stimulating patients’ ‘expression of emotions’ and ‘connection with others’ (dance-movement therapy, drama therapy, poetry); ‘informing patients’ (nutritional groups); ‘cultivating awareness and motivation’ (motivational group, objectives group); facilitating patients’ ‘re-connection with their body’ (yoga, meditation, ‘body relaxation’); or simply keeping patients ‘busy’ and ‘away from their obsessive thoughts’ (knitting, gardening, literature). All group activities have a strong didactic aspect, also expressed by the term ‘educators’ that is used to qualify the professionals who lead them. In many of those activities, the resemblance to educational settings is noticeable. Most patients have notebooks and take detailed notes, asking for clarifications when they do not understand. Educators often leave patients ‘homework’ for the next session. As if marking the resemblance with school, the beginning of every therapeutic activity, including meals and the administration of medications, is signalled by the ringing of a bell placed in the living room.

Awareness and motivation for treatment are cultivated through all these activities, but most explicitly during ‘psychomotivational group sessions’ – in which psychologists and educators ‘make patients see’ all the disadvantages of having an eating disorder, and what patients are losing by sticking to it. These sessions are typically structured around a patient who volunteers to explain the reasons behind her desire to interrupt treatment and go back home. Most patients ascribe their desire to go home to the fact that at home ‘one is free to do what one wants’ and has ‘control over one’s life’, whereas in treatment ‘one feels constantly coerced’. The professional monitoring the sessions then starts asking the patient what she was free to do at home, ‘concretely’. This typically pushes patients to ‘recognise’ that the freedom they felt they had was actually very limited, often consisting only of deciding what one would

or would not eat. Patients are thus put in front of what these professionals see as the ‘illusion of freedom that the eating disorder gave them’.

Special group sessions are organised by nutritionists to further ‘unmask’ this illusion. These sessions are meant to show patients that the nutritional rules imposed by the treatment centre – experienced by patients as coercive – are nothing compared to the ‘imprisonment of the internal tyranny that they have imposed on themselves through the eating disorder’ – and that these new rules function as a way to gradually break the rules imposed by the illness, with the aim of regaining some ‘true freedom’. The idea is to make patients understand the rationale behind the rules of the treatment centre by making them more aware of the rules ‘imposed by the eating disorder’. The clinic is thus constructed as a world in which the ‘rules of the eating disorder’ and the ‘rules of the treatment centre’ fight against each other. The coercion imposed by the treatment team here is thus framed not as something against freedom, but as an unpleasant necessary step *towards* freedom – and therefore as a feature of care.

Most rules are in fact related to the symptoms of eating disorders: avoid talking about food, calories and weight at any time; avoid tight clothes and clothes that expose ones’ skinniness; avoid exercising; avoid comments on food during meals; avoid hiding food and cutting food into tiny pieces, and so on. Through these rules – aimed at stopping ‘feeding the eating disorder’ – the nutritionists encourage patients’ ‘normal self’ to emerge. As part of this effort, the first and most evident aim of nutritional rules is to ‘re-teach’ patients ‘what and how to eat in a normal way’. This can range from how one properly sits at a table, to how much one cuts different foods before bringing them to the mouth, to how one chews food, or peels fruit. The resemblance with parents teaching the same things to young children is stark³. But there is more going on. At an ‘individual’ level, the aim of many of these rules is not simply to correct ‘abnormal’ behaviour because it makes patients ‘absorb less food’ and therefore not gain weight. The ‘ritualistic behaviour’ of the eating disorder is seen to have another negative function, expressed by the adjective ‘dysfunctional’ that is usually associated with it: it is ‘the only way’ that patients have found ‘to manage their deep anxieties and unresolved issues’: accessing that ‘depth’ is framed as fundamental to recovery, but it can only happen if the dysfunctional behaviours are reduced, and ‘crises’ do happen.

Finally, respecting nutritional rules is framed as a matter of responsibility towards other patients. A constant refrain from nutritionists to patients is that they should not be cutting

³ More on this in Chapter 4.

pasta during meals, because they risk ‘contaminating’ others who perhaps are doing their best to avoid the same behaviour, undermining their recovery. One might note the dominance of corporeal medicine and of the language of infectious diseases seeping into other realms: behaviours are depicted like viruses, and the eating disorder as not only ‘affecting’ but also ‘infecting’ patients’ thoughts and behaviours. A sort of collective responsibility to heal seems to be present, perhaps not too different from the one most typically found in discourses about infectious diseases. With infectious diseases, the imposition of care – be it prophylaxis, isolation, treatment of the symptoms – is justified and legitimised by a ‘disease’ that threatens the social body, placing a collective responsibility on affected individuals. I would argue that, although in a different form, patients in treatment for eating disorders are constructed as having a collective duty to heal, even if their conditions are not ‘infectious’ in the strict sense of the term. Professionals are always very explicit that ‘you don’t get an eating disorder like you would get a flu’ when they reassure worried parents that they do not have to worry about their daughters ‘passing the eating disorder on to their other children’⁴. However, the language that professionals use is exactly the language of infectious diseases when it comes to patients ‘contaminating one another with their dysfunctional thoughts and behaviours’. I would thus suggest that the kind of collective responsibility cultivated in patients is not – as in the case of infectious diseases – directed towards ‘healthy people’, but towards fellow patients, those who are already ill. Patients are rendered responsible towards one another as if the struggle against the eating disorder were a collective struggle that required unity in the face of a common, external enemy who is now ‘inside themselves’.

‘Nutritional rehabilitation’

Mealtimes therefore become times of ‘nutritional rehabilitation’ here, because in the world of normality that the treatment team seeks to reassert, patients’ pathological control over food needs to be ‘de-activated’. Patients are guaranteed that ‘the composition of meals’ is balanced and proportionate to the needs of their ‘severely compromised organism’. Here we see that food becomes scientised, as patients are given ‘what is required for their body to function’ (endocrinologist) – the ‘nutrition’ that one needs to stay alive. Underlying this notion is the idea that there is a correct amount of ‘nutrients’ needed by the human body to maintain health

⁴ When patients’ siblings are also diagnosed with an eating disorder, the ‘cause’ is never ascribed to the already ill sibling, but to the fact that ‘there is clearly something wrong in the family system’. More on this in Chapter 4.

(Cuj, Grabinsky and Yates-Doerr 2021:3). By framing food as ‘nutrition’, in a scientific discourse, professionals try to detach food from the (supposedly problematic) relationality in which it was enmeshed before admission: this detachment is a process of abstracting food from the social – a process that allows professional attention to physiology and turning persons into ‘patients’.

At mealtimes, patients find on the table a sealed plastic package with their name, containing their specific portion of food prepared by an external supplier. Completing the meal means facing four of such packages one after the other: a first course mainly composed of ‘carbohydrates’ – pasta or rice; a second course composed of ‘proteins’ – meat, fish or legumes; a side of vegetables coming with a slice of bread; and a portion of fruit. For a patient on a first day of admission this is usually unsurmountable, and professionals prove themselves flexible after a few attempts. Gradually however, patients are pressured and expected to eat everything that is put in front of them.

In ‘nutritional rehabilitation’, the constant refrain is that ‘food is medicine’. Eating food in sealed packages rather than having ‘normal plates’ – as patients say – contributes to the feeling of ‘taking a medicine’ rather than ‘having lunch or dinner’. Since food is conceived as ‘nutrition’ – as something that works as ‘fuel’ providing the ‘building blocks’ necessary for a depleted organism that would otherwise die – then food ‘*is*’ medicine: in the same way in which paracetamol would be ingested to be able to think about things other than a headache, one has to eat food to act on the symptoms that are due to malnutrition, including the worsening of obsessive thoughts – which prevent one from thinking about anything else. The purpose of this framing – common in eating disorder treatment – is to strip away the ‘pleasure-like qualities’ connected to food and its associations with family commensality, and make it appear as if it were a drug to be taken because the doctor prescribed it. In this way, it is held, patients should ideally ‘feel less guilty about indulging in pleasure’, and ‘less affected by negative emotions related to their family dynamics’ (nutritionist Viola). This rationale was presented to me by all professionals when I enquired about whether they did not find it problematic that most food given to patients tasted – everyone agreed – ‘really bad’. I found it disconcerting that in a treatment centre where patients had to ‘re-gain familiarity with food’, food was evidently of poor quality and badly cooked. Instead – everyone agreed – patients either ‘did not even notice’ – as a result of years of food restriction during which they had excluded most foods from their diet – or, if they noticed, they ‘actually preferred it that way’, as it felt more like ‘a bitter medicine’ that they were ‘really forced to take’. With

time, and especially once they shift to semi-residential treatment, patients start complaining about the taste of the food they are given, and professionals take that as a good sign of ‘progress’. Here we see how in ‘normal bodies’ there is a discrimination of taste: outside the facility, people have acquired bodies in which they have learned to be affected by taste; they have acquired taste that would make that food taste awful (cf. McDonald 2014). Patients who end up in this treatment centre seem to have lost that: their body-selves no longer make those discriminations in taste. Part of their recovery is about re-learning to be affected by it, but in the immediate urgency of residential treatment, in which ‘bodies are at risk’, that is not seen as a priority.

What is seen as a priority, instead, is to work on making patients embrace ‘nutrition science’, but ‘the healthy one’ (nutritionist Irma). This ‘healthy’ nutrition science is used by nutritionists and dieticians to deconstruct the ‘dysfunctional nutritional knowledge’ focused on ‘dieting’ and ‘accelerating metabolism’ that most patients are ‘experts’ in when they reach admission⁵. For example, since food, in the world of the eating disorder, is categorized in the language of calories, in treatment the language of calories is forbidden, and food is categorized – and taught to be seen – in terms of ‘first courses’, ‘second courses’, ‘sides’ and ‘fruit’. If a patient really wants to know ‘how much’ food she is given, quantity is categorized into ‘grams’, never into ‘calories’. ‘Nutritional group sessions’ with the aim of ‘deconstructing the myth of the calorie’ are regularly held by nutritionists, who teach patients that ‘calories don’t exist “out there” in food, but are a social convention that we now know doesn’t even accurately represent what goes on when we eat’ (nutritionist Irma). Instead, a more complex picture of food is presented to patients, in which different ‘nutrients’ (carbohydrates, proteins, fats) are all fundamental to health, and interact with each other and

⁵ The notion of dietary management and of food as ‘nutrition’ emerged out of nineteenth century concerns in Europe with productivity and labour: for governments and employers, the measurement of the calorie presented scientific ‘standards of living’ that contained wage levels while maintaining a productive workforce (Cullather 2007). Science historian Landecker (2013) has pointed out how the industrial metabolism of nineteenth-century biology, concerned with labour efficiency, modelled the body after the factory (see also Rabinbach 1992), in which raw materials are converted into manufactured goods, and pathology is framed as disruption due to broken parts in the machinery. Post-industrial nutrition science, instead, has focused on ‘feedback loops’ between the body and the environment: pathological states are seen as ‘regulatory crises’ of a complex system, whereby the ‘inside’ and the ‘outside’ are deeply intertwined, suggesting that ‘people eat foods, not nutrients’, and that they do so in relational contexts (Cuj, Grabinsky and Yates-Doerr 2021:14). This brief and simplified history highlights how through the development of nutrition science, food has become and keeps becoming a different object ontologically. The science of ‘nutrition’ is influenced by historically and culturally specific aspects that give coherence to its practices.

with a person's specific situation and environment. In this framing, not only the 'quality' of food is as important as 'quantity', but 'complete control' of the processes of 'balancing intake and output of energy' is impossible to achieve (cf. Vogel 2018b:394). Here nutritionists seem to embrace post-industrial scientific understandings of food and bodies which complicate the values embedded in industrial models of metabolism⁶ (Landecker 2011). Nevertheless, typically industrial framings of food as 'building blocks' are constant refrains in their work with patients, suggesting how biomedicine is not a monolithic set of practices and discourses representing 'health according to science' (Vogel 2018b:391).

Vogel (ibid.:397,398) has highlighted how, in the language of calories, bodies are portrayed as machines storing or using energy, and metabolism is black-boxed as the mechanism through which energy is processed and neutralized. Movement is framed as what allows this process, and therefore to reduce one's 'weight'. In this framework, movement and food need to be carefully calculated to know what one is allowed to eat, or whether one undid the 'damage' caused by eating. Both food and movement are to be counted: what matters is the ability to stay in control (ibid.). This kind of reasoning, which patients with eating disorders are seen to have embraced 'at its extremes', is the object of constant 'deconstruction' in the treatment centre. The alternative model proposed by nutritionists, endocrinologists and dieticians, very much as in Vogel's account of treatment for obesity, is an idea of 'metabolism' as a process that ensures the release of energy in the body, as a fire that can intensify or diminish. In this framing, not only is food presented as 'building blocks' – but also as fuel that can feed the 'fire of metabolism': to make one's metabolism 'work better' and 'accelerate' – something that most patients are deeply concerned with – patients are taught that they should eat more, not less. Food, in this logic, is potentially a facilitator and activator of metabolism, and therefore of the possibility to eat more without 'storing fat' (cf. Vogel 2018b: 399). This is because 'the body', patients are told, 'is smart' and 'interprets food scarcity as a famine' (endocrinologist), going into 'energy-saving mode' by 'slowing down its metabolism' to protect itself.

The patients' eating practices before admission, then, seen through this 'healthy nutrition science', emerge as harmful 'excesses of will' that fail to adequately respond to their bodies' 'needs' (cf. Vogel 2018b:404). Whereas counting 'input and output' is completely in the hands of the person, relating to bodies as complex systems implies having to be responsive to

⁶ For more on the history of 'metabolism', see Landecker 2017.

and trusting something other than the ‘self’ (ibid.:402), something seen as fundamental in the path towards recovery, as we will see below.

Food, in this treatment centre, is thus ‘tinkered with’ (Mol, Moser and Pols 2010) not only in the sense that it is scientised and abstracted from the messiness of family commensality, but also in the sense that it is framed in a specific way – supported by a specific form of nutrition science – to achieve what for professionals is a desirable end: to make patients eat. Patients are also taught that, although they have ‘damaged’ their metabolism through months or years of disordered eating, they can still ‘tinker with’ their metabolism by ‘eating properly and regularly’ and making sure ‘all the necessary building blocks’ are there. Patients here do not simply have to learn how to make better decisions for their bodies, but also ‘how to be, and act as, a different eating body altogether’ (Vogel 2018a:517).

On the same day weekly, patients are weighed. Adjustments to the patient’s meal plan are made by the assigned nutritionist depending on whether the weekly ‘weight gain’ is considered enough or not. Nutritionists refer to these changes as ‘a battle to be fought slowly, by tiny victories’. The ‘battlefield’ here is located in the patient’s ‘mind’, with ‘the body’ being seen as the recipient of collateral effects (cf. Mattingly 2010:62). The meeting with the nutritionist is also the moment to agree on weekly permits to ‘experiment with food’ outside the facility. There is a gradual progression of such ‘experiments’. Patients typically start by having the afternoon snack outside, and if these first experiments ‘go well’ – i.e., if patients eat everything and do not have any ‘crisis’ – further and more complex experiments await them: ‘free breakfasts’, ‘packed lunches’, and ‘free meals’ at home or at the restaurant with relatives or friends during weekends. These experiments are meant to test patients’ readiness to be discharged and moved to the semi-residential facility, where there will be less ‘external control’ regarding food. In this phase, patients are asked and expected to ‘put effort’ towards their recovery, and gradually shift from ‘mechanical eating’ (i.e., ‘eating because someone forces you to’) to ‘true motivation in eating’.

However, ‘recovering bodies’ do not automatically result into ‘recovering minds’. After some weeks of treatment, patients often report feeling ‘as if the body keeps going on the treatment path on its own, and the mind is left behind’ – i.e., ‘not accepting the weight gain’ and ‘stuck with obsessive thoughts’. The idea here is that ‘the body’ and ‘the mind’ can proceed at different rhythms, but that this ‘split’ feels alienating, revealing an assumption of a coherent and aligned body-mind axis in a situation of health.

Scientific knowledge as a tool towards recovery

One way in which the treatment team tries to make ‘the mind keep up with the body’ into the process of patients’ self-transformation is by employing ‘scientific evidence’ as ‘a tool of rationality to bring patients back to the level of reality’ (endocrinologist). Scientific facts are conceived by the professional specialists as a powerful instrument that can be employed ‘to debunk the dysfunctional obsessive thoughts of the eating disorder’ (ibid.) and trusted as reliable reference points to orientate oneself when feeling anxious. The science historian Porter (1995) has traced how decisions based on ‘impersonal numbers’ came to occupy a prominent place in democratic societies, as people sought numbers to guarantee ‘objectivity’. Porter describes quantification and the trust in what are seen as objective numbers as a ‘social technology of distance’ (ibid.:ix,49) – and as a sign of ‘weakness’ on the part of the community of practice that promotes it. Weak groups, he argues, turn to quantitative methods to gain strength. In a slightly difference sense, professionals in the treatment centre can be said to gain strength vs. the strength of the eating disorder to the degree that they are able to establish their numbers. What a reading of Porter can suggest is that to succeed in standardizing methods, measurements and calculations is to succeed in stabilizing a community of practitioners, within which it is then possible to exercise judgement.

‘Findings’ of academic articles reporting the details of how ‘the risk of death for underweight people are comparable to those for overweight people’ are routinely discussed with patients during nutritional group sessions. If patients appear ‘distant’ – as if those statistics did not apply to them – nutritionists are quick to remind them that they do not perceive that risk because the eating disorder is ‘affecting’ and ‘infecting’ their mind:

I know that you think this can’t happen to you, that you feel invincible. But it is the eating disorder that makes you feel invincible. Malnutrition affects your cognition, and it makes you unable to recognise this and take the necessary course of action, because your mental space is completely taken over by thoughts about what to eat, how to eat, how to burn it after you eat...But with *your BMIs*, *you are* at risk – *you can see* the data here (nutritionist Isabella, my emphasis).

Clinical tests are another powerful tool used by nutritionists to offer patients a ‘reality check’: the BIA – Bioelectrical Impedance Analysis – is an inexpensive method for measuring ‘body composition’. The instrument, the nutritionist Viola explained, uses electrodes to send a harmless level of electric current through patients’ bodies, which is conducted differently by ‘fatty tissue’ (low in water) and lean ‘muscle tissue’ (more than 70%

water). The BIA thereby ‘measures’ the proportion of ‘body fat’ vs. that of ‘lean body mass’. Patients do this exam on admission, and then regularly every two months, to monitor the changes in their body composition and track their ‘health status’. However, nutritionists agree that the fundamental role of this test lies in its ‘awareness potential’: by ‘revealing’ that in situations of semi-starvation, underweight patients’ bodies are ‘left with body fat’ – since ‘muscle mass’ is the first type of mass to be ‘consumed’ – when patients start re-gaining weight, the test shows that they mainly re-gain muscle mass, which tends to reassure them. Similarly, the Bone Mineral Density Test measures the quantity of calcium and minerals ‘present in the patient’s bones’, as osteoporosis is reported as a common consequence of eating disorders. Patients typically do the test after admission, and then once or twice before discharge. The results of both these tests are powerful allies in ‘scaring patients’ and ‘showing them the *real* and *visible* damage that the eating disorder does to their bodies’ (nutritionist Viola).

Learning to ‘see one’s body’

This matter of the illness preventing one from ‘seeing how one really is’ is perhaps the most widespread and popular ‘belief’ about eating disorders – typified by images and videos featuring girls ‘all skin and bones’ looking at themselves in a mirror and seeing their bodies as fat (see Figure 1).



Fig.1 – ‘Body image distortion’

In professional terms, this effect is called ‘body image⁷ distortion’: the supposed mechanism whereby people with eating disorders, when looking at themselves in a mirror, would not see their bodies ‘as they really are’, but much larger and fatter - especially in the abdomen, buttocks and thighs, deemed to be ‘phobic parts’. This ‘disturbance’, the literature reports, causes significant distress, often persists after otherwise successful treatment, and is a reliable predictor of relapse (See Freeman et al. 1985; Button 1986).

The dance-movement therapist Serena explained to me at length how one’s body image is ‘affected by cognitive, social and emotional aspects, with different parts of the body potentially being affected differently’. If someone tends to be very rigid in their thinking, has a particularly low self-esteem, and is therefore especially vulnerable to the social pressure that praises thin and perfect-looking bodies – which is deemed to be the case with most patients diagnosed with eating disorders – then their body image will reflect all those elements and result in a ‘distorted image’. The ‘dysfunctional behaviours’ of eating disorders are therefore understood as being in part ‘coping mechanisms’ that patients employ to ‘correct the presumed defects they see in their body’. Starting from the 1960s and 1970s, extensive research⁸ has been produced on the ‘body image’ of patients diagnosed with eating disorders, especially anorexia nervosa, and a range of tests have been developed in the field of psychology to ‘measure’ the extent of patients’ body image distortion – which is, ‘how much’ the way they see their bodies differs from ‘reality’⁹. These works all assume a ‘real body’ that can be the object of a more or less correct sensory perception, potentially influenced and distorted by what are seen as cognitive, social and emotional factors, but measurable and quantifiable by science, whose numbers are always to be trusted.

A more recent and currently expanding field of research, highly praised by the endocrinologist of the treatment centre, is that of neuropsychology, which ‘looks at what happens to patients’ nervous system’ through Magnetic Resonance Imaging (MRI) studies. One of these studies (see Sachdev et al. 2008) is the object of regular group discussions with patients. During group sessions, the endocrinologist explains to patients that in the brain of ‘healthy individuals’ a number of regions appear ‘activated’ when they are exposed to images of themselves and others – with images of themselves causing a greater activation of a region

⁷ The Austrian psychiatrist and psychoanalyst Schilder (1935) is considered the father of theories on ‘body image development’, thanks to his work entitled *The Image and Appearance of the Human Body*.

⁸ E.g., Bruch 1962; Garfinkel and Garner 1984.

⁹ See Slade and Russel 1973; Ruff and Barrios 1986; Probst et al. 1995, 1998; Harari et al. 2001.

in the brain called ‘insula’. Patients appear to process images of others in the same way that ‘healthy people’ do, suggesting that there is no fundamental disturbance in their so-called ‘functional architecture of body image processing’ (ibid.:2167). However, when exposed to images of themselves, patients’ brains do not appear to activate the attentional system of the insula, which is thought to suppress ‘the emotional and perceptual processing of the information’. This inactivity is supposed to be at the basis of the failure ‘to correct their self-image disturbance’, and is believed to explain why patients have a ‘distorted view’ of their bodies (ibid.). This material is always presented to patients coupled with an illustration of the MRI scans described in the study (see Figure 2), which – the endocrinologist points out – ‘really show what goes on in patients’ brains’. Patients are told that the disturbance is reversible with weight gain and treatment, as it is more likely to be a consequence, rather than a cause, of the eating disorder (ibid.).

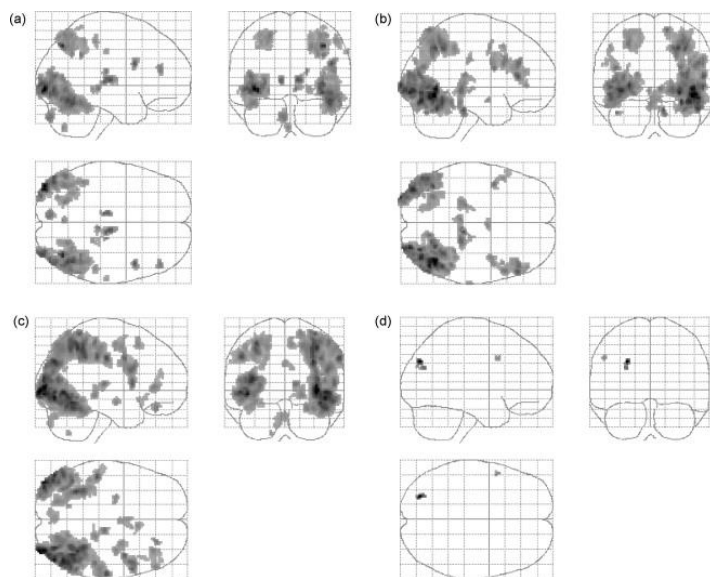


Fig. 2. Similar activation patterns were observed for control subjects and anorexia nervosa (AN) patients: (a) control subjects and (b) AN patients viewing non-self-images. However, very different patterns were observed for comparison subjects and AN patients when viewing self-images: (c) control subjects and (d) AN patients viewing self-images (Sachdev et al. 2008:2164).

Specific therapies aimed at treating this so-called ‘symptom’ of eating disorders have been developed since the end of the 1980s under the name of ‘body-oriented therapies’ (Vandereycken, Depreitere, and Probst 1987), including ‘systematic mirror exposure’¹⁰. ‘Mirror exposure therapy’ is one of the specific techniques employed at *Il Giardino*. It is

¹⁰ See Key et al. 2002; Wilson 1999; Delinsky and Wilson 2005.

based on seven weekly one-to-one sessions with a therapist, who guides the patient through a gradual ‘exposure of the body’ – fully clothed in the first two sessions, then gradually exposing arms and legs by wearing sleeveless shirts and form-fitting trousers, and wearing only bra and underwear in the last two sessions. Before starting the sessions, the patient is given two tests to fill in: the Body Shape Questionnaire (see Cooper et al. 1986) – which measures the intensity and frequency of ‘feelings of fatness’ – and the Body Uneasiness Test (see Cuzzolaro et al. 2000), which evaluates ‘the discomfort with one’s own body image’ (Clinical Director). These same tests are administered to the patient again in the final phase of treatment, to evaluate and quantify the change ‘obtained’ through the therapeutic technique.

The sessions, patients are told, are designed to help them shift from ‘a dysfunctional mind-set’ that focuses on self-criticism, to a ‘more holistic perspective of their entire and unique body’. It is interesting that this is supposed to happen not only by ‘systematic and protected exposure’ guided by the therapist, but also by ‘a change in the language’ that patients use to describe their bodies – ‘from negative, subjective terminology, to non-judgmental, fact-based terminology’. Learning to describe objectively here implies learning to *see* themselves in a different way. During each session, the patient is placed in front of an otherwise locked, full-length, three-way mirror in the room dedicated to ‘body-oriented’ therapies. She is asked to observe her body and assign a level of anxiety from 0 to 10 to every part of her body – from head to feet – while the therapist writes the answers in the first column of a standard form (see Figure 3). The patient is then asked to describe ‘the function’ of each of those body parts, again from head to feet. The functions are sometimes discussed with the therapist, who sits out of view. During these sessions, the patient’s body is thus visually ‘dissected’, systematically, ‘as if the patient was describing it to someone coming from another planet, who had never seen a human body’ (psychotherapist Sara). The patient is asked to refrain from using critical or unkind language, and any positive or negative judgment, but to use terms related to colour, texture, shape, and most importantly ‘function’. At the end of the session, the patient is asked again about the level of anxiety she feels for each body part, with the therapist writing it down in the second column of the form (see Figure 3). Finally, the patient is asked to draw her body as she sees and feels it – with the aim of making her grasp ‘the level of reality’ and follow the ‘cognitive-emotional’ change in the way she perceives her body through the sessions.

Mirror exposure therapy is illustrative of how patients are taught that they ‘cannot trust their mind’, nor ‘the signals sent to them by their bodies’ (psychotherapist Sara) – and of how

treatment attempts to literally change the way patients' minds 'see' their bodies. Patients are taught that the way they see and experience their bodies is a consequence of an externalised disorder that makes their brains function differently, but that this 'distorted view' can be treated and 'removed' by both re-nourishing their bodies and re-training their minds.

| Mirror Exposure | Anxiety level – before | Anxiety level - after | Comments |
|-----------------|------------------------|-----------------------|----------|
| Head | | | |
| Forehead | | | |
| Face | | | |
| Neck | | | |
| Arms | | | |
| Torso | | | |
| Abdomen | | | |
| Hips | | | |
| Buttocks | | | |
| Thighs | | | |
| Legs | | | |
| Feet | | | |

Fig. 3 – Mirror exposure therapy template.

The testimony of 24-year-old Gloria about her experience with mirror exposure therapy is telling of this change:

I experienced [mirror exposure therapy] as a path towards the discovery of my *objective* body image, which is, of my body image *cleaned* from all the *misperceptions* caused by the illness. I was really scared...and instead I eventually *discovered* my body as the external part of myself that allows me to relate to the world. A body composed of many parts – each of them with a specific function, *which is there even without my critical judgment on it*. It was an important step towards learning to love my body and take care of it; towards accepting it as it is and committing to keeping it healthy, so that it can perform all the functions for which I received it (my emphasis).

The day-service facility: a step towards autonomy

We all work with the aim of becoming superfluous, of re-meeting patients outside as strangers. When I meet an ex-patient, I don't say 'hi' nor wave at them unless they do it first, because they have the right not to recognise me, because they don't need me anymore...

Philosophical counsellor Carola

One day in September 2018, during a weekly meeting for parents, Lisa's mother was lamenting the absence of the role of 'family counsellors' in the day-service facility. The family counsellor, as we will see in the next chapter, works in residential treatment as the main channel of communication between the treatment team and the patients' family. Lisa's mother could not understand why this figure was absent in semi-residential treatment, considering that patients were 'left much more on their own' there, with more risks 'to worry about'. The counsellor replied that residential and semi-residential treatment were two different modalities of care: in semi-residential treatment, parents 'have to bear the space of autonomy' that their daughters are slowly re-acquiring: 'In the same way that you taught them how to walk, you have to stand the fear that they might fall'.

Semi-residential treatment, also called day-service, is still an intensive stage of care: patients are required to arrive by 9.30 am, after having had breakfast at home, and to spend the whole day in the facility. Days consist of four group activities separated by the mid-morning snack, lunch, afternoon snack and dinner. Right after dinner, patients are free to leave and go home. The semi-residential facility is open from Monday morning to Saturday after lunch, which means that patients spend half of their weekends 'on their own' – having to 'manage free time' and their meals for one day and a half. The last group therapy session on Saturday – 'the check group' – and the first one on Monday morning – 'the welcoming group' – are meant to reflect on how patients 'experience and manage these spaces of autonomy', which are supposed to gradually prepare patients for 'life outside' once they will be discharged.

The 'autonomy' sought in treatment is therefore of two kinds: first, it is autonomy from the disorder, conceived like an external intruder that has invaded the patient; second, it is autonomy from carers – both from professionals and, as we will see in Chapters 4 and 5, from family carers. Nevertheless, as the next chapters will make clearer, there is not a search for 'absolute autonomy' from other human beings. Indeed, patients in semi-residential treatment

are recommended not to spend weekends completely alone, but to seek the support of their family members, friends or even of fellow patients.

This last option highlights how semi-residential treatment gradually shifts the responsibility to follow the nutritionists' directions onto patients themselves. By spending part of their free time with other patients – and particularly by spending meals together, sometimes even buying the grocery and cooking together – patients create a network that functions at the same time as 'emotional support' and 'mutual control' (psychotherapist Mauro). Meals in the facility also work differently in semi-residential treatment: patients choose what to eat from two options for every course of the meal and serve themselves by using 'the volume' of common kitchen utensils to know 'how much food they need to take', rather than having food already weighed and individually packaged. Patients eat all together at the same large table, and there are no staff members supervising the meal, but only one nutritionist who eats with them (as indicated at the beginning of this chapter).

The didactic aspect in the day-service facility is more dispersed, as if patients indeed start, in this phase, 'responsibilising one another' (psychotherapist Mauro). This is evident in the dynamics of group activities, during meals, and, as I mentioned, in patients' mutual support during weekends. In residential treatment, communication during group activities tends to be dyadic: from professional to patients and back. Here instead, dyadic communication is often paralleled or even substituted by a more circular communication: patients mostly interact among themselves, with the therapist receding in the background and only intervening if necessary. During one group session on a Wednesday afternoon at the end of April 2019, for instance, 29-year-old Alessandra was particularly upset because her request to travel home for a long weekend had been denied. She had been losing weight, to the point that the treatment team were considering moving her to hospital. A long trip by bus on her own was out of the question. She was expecting other patients to sympathise, casting her therapists' refusal as an unjust 'lack of trust'. Instead, several patients told her that although it was understandable that she felt angry and did not feel in danger, she had to trust her therapists, because it was 'scientifically proven' that 'the illness prevents one from seeing how one really is': professionals had a more 'complete' and 'objective' view of the situation. Patients seemed to be accepting, at this point, that they were 'wrong' when they first resisted treatment, and to be gradually embracing the view of the treatment team.

Conclusion

When patients are admitted to residential treatment, the way they ‘see’ their bodies and experience their condition is in stark opposition to the way professionals see them. In this chapter, we have seen that treatment works by gradually substituting patients’ self-care projects with a definition of health that is jointly constituted by the treatment team, partly through the use of numbers offered by the natural sciences. In the progress from residential to semi-residential and then outpatient treatment, patients are thus required to gradually assume responsibility for a kind of wellbeing that is determined elsewhere than in their self (cf. Davis 2012:14,15). For this to happen, a ‘collaborative mode of ethics’ (ibid.) allows someone other than the patient to function as a temporary ‘prosthetic will’ at the beginning, supplying the responsibility that patients are deemed to lack during the first phase of treatment. Some coercion is considered necessary to first deconstruct patients’ ‘pathological’ self-control. A specific ordering of time and space, psychotropic medications, strict rules, and supervised ‘nutritional therapy’ are framed as allowing patients to reach a point in treatment in which their partly re-nourished ‘bodies’ allow their ‘minds’ to be open to listening to the professionals. Only then can patients acquire the tools for a self-transformation that will enhance their health. This happens by exposing patients – through one-to-one and group therapeutic activities – to information and experiences that teach them to see their bodies and condition in the way professionals see them, and therefore to reach a point when they themselves want to ‘abandon the eating disorder’. Once patients are deemed capable of ‘seeing how things really are’ and of choosing to get better, they are given more and more responsibility to do that, while the coercive role of the treatment team proportionally decreases, shifting into guidance. Patients are thus seen to become capable of healthy self-care only after a long and difficult work through which their minds and bodies are transformed.

Chapter 4

‘We are a relational laboratory’: kinship as a therapeutic tool

Our job consists of becoming emotionally involved. You establish some rules of course, a distance. This distance doesn't mean separation, or being far away, but is the space within which the therapeutic relationship can develop. I wouldn't give patients my address, I wouldn't tell them what I do at home. There are some areas in which they must not enter, and one needs to keep them very clear. In other areas, they can enter, and those are the areas that have to do with the therapeutic relationship. One needs to know that they are not friends, nor daughters: they are guests, patients of this treatment centre, and it is this distance that allows us both to speak to one another.

Psychotherapist Mauro (original emphasis)

Introduction

It is a Saturday morning in early September 2018. I am sitting on one of the thirty green plastic chairs at the back of the large meeting room in the residential facility of *Il Giardino*. Every Saturday morning, this room is reserved for the weekly ‘support meeting for parents’. The room is mostly filled with patients’ parents¹, but the meeting is open to ‘any relative who is more or less involved in the care of the patient’. Partners, spouses, sisters and brothers, daughters and sons², grandparents, aunts and uncles also attend, albeit in small numbers. The meetings are open to relatives not only of patients who are currently in residential treatment, but also of those in semi-residential and outpatient treatment, and to relatives of prospective patients.

Today, the meeting is run by the psychologist Carlotta and by the nutritionist Viola. They open the conversation by explaining how group meetings work: this is ‘a collective space’, and ‘personal questions’ regarding specific family situations should therefore be directed, instead, to the assigned family counsellor during individual meetings. Any other question regarding the disorder, the treatment path and daily difficulties is welcome. This introduction

¹ I focus on parents since they were the main non-professional carers of patients in most cases. This is because, also due to the specificity of the Italian context, most patients were still at an age at which they lived in their parental house, even those in their late twenties (see Rusconi 2004); older patients tended to have their parents as their only network of care too, because their social life had shrunk after years of living with a condition that substantially limits social interactions, let alone intimate relationships.

² In the few cases in which patients are mothers, there are specific dynamics related to notions of responsibility for treatment and kinship care in addition to those I examine in this chapter. However, since those cases were a very small minority in the patient population that I encountered, I will address them in a separate paper.

opens the way for a wave of questions on ‘how to deal with meals’ at home. Most parents depict mealtimes as the most feared times of the day – characterised by continuous arguments and ‘battles on every little thing’: a teaspoon of oil, a slice of bread, a spoon of grated cheese. Many parents of prospective patients report that they cannot wait for the moment their daughters will finally be admitted to residential treatment, and for ‘the magic of *Il Giardino*’ to reduce their daughters’ resistance to eating.

This prompts the psychologist Carlotta to clarify what she sees as a problematic misunderstanding on the part of parents:

It’s not the ‘magic’ of *Il Giardino* that can change the negotiations about food between you and your daughters, in the same way that it’s not the ‘magic’ of any pill that your daughters might be given. What is key is the introduction, within a dual relationship, of a third element – of something *like* *Il Giardino*. Who has the possibility of really opening a dialogue between you and your daughters in the fight about meals? It’s the famous meal plan, which contains the so-called ‘right amount of calories’ for your daughters’ daily needs. This, at the nutritional level. But at the relational level the meal plan is a deal – it is something that opens up a space for dialogue within the arm-wrestling between you and your daughters. This third relational element here, with the nutritionist and the psychologist who stand behind the meal plan, helps to prevent the negotiation from becoming a battle about demonstrating something to one another (original emphasis).

The treatment team – embodied by ‘the nutritionist and the psychologist’ mentioned by Carlotta – is here depicted as a third, neutral element that needs to be added to an already existing (and supposedly fraught) patient-parents relationship. In the previous chapters, I started setting the stage for an understanding of the treatment for eating disorders by introducing the two key parties involved – patients and professionals – and their opposing stances. However, the interaction between patients and professionals emerges here as inserting itself into a previously existing relationship of family care. Professional carers are brought in when family carers realise that their care ‘doesn’t work’. This chapter therefore introduces the patient’s family as another key actor in the network of treatment – one whose care precedes that of professionals but that, we shall see, is temporarily ‘put to one side’ by professional care, as the latter reframes and reshapes the parent-offspring relationship within this residential context.

We might note in Carlotta’s words an assumption about the need for ‘neutrality’ in medicine, and about the negative consequences that the absence of such neutrality could cause for treatment. If professional care at *Il Giardino* is defined as ‘magic’ by parents, that ‘magic’ is framed by Carlotta as the opposite of the nefarious power struggle that she

associates with the family. In an interesting parallel, in his account of witchcraft as ‘the dark side of kinship’, Geschiere (2003:46) suggests that for his interlocutors in Southeast Cameroon the most dangerous witchcraft attacks are framed as coming ‘from inside the house’, because witches are supposed to have ‘a special hold’ over their relatives. Geschiere argues that, although kinship is seen as the basis of trust and solidarity, the way people talk about and act on witchcraft highlights that ‘this very intimacy is at the same time a deadly danger’ (ibid.). For this reason, the healers who can save people subject to witchcraft cannot be from within the family (ibid.:48). Importantly for the argument of this chapter, healers are thought to be able to heal only because they are involved with witchcraft themselves: they are described as ‘super-witches’ who have been *trained* to ‘use their powers only to heal and never to kill’ (ibid). Healers are thus considered able to channel what is seen as the dangerous side of kinship and use it instead ‘in a constructive way’ (ibid.). In this chapter, we will see that something similar happens at *Il Giardino*, as the professionals are trained to channel the dangerous aspects of kinship into supportive tools towards recovery. I will suggest that they do so by ‘borrowing’ from kinship care in their therapeutic work, whilst tinkering with its constitutive practices.

Since early clinical accounts of ‘anorexia’ in the late nineteenth century, family members have been described as ‘the worst attendants’ (Gull 1874:26) – as having a ‘particularly pernicious’ influence on patients’ treatment (Charcot 1889:2010). Until the 1970s, the academic literature of both the psy-sciences and clinical practice framed ‘the family’ not only as responsible for the development of the illness, but also as a ‘toxic’ presence detrimental to recovery. Patients were therefore seen to require a ‘parentectomy’³ – i.e., exclusion of the parents from the patient’s treatment plan and work with patients were felt necessary to ‘extricate’ them from their families (Murray and Anderson 2015:279). Starting from the 1970s, however, what were subsequently considered ‘family therapists’ challenged this notion: since anorexia was seen to develop within families characterized by ‘rigidity’, ‘enmeshment’ and ‘conflict avoidance’, then rather than separating the child from their parents, treatment should be directed at the family to address those problematic aspects (see Minuchin, Rosman and Baker 1978). In Italy, the psychiatrist Mara Selvini Palazzoli launched in 1971 what came to be known as ‘the Milan family systems approach’, which called for shifting from ‘individual therapy’ to ‘family therapy’ in the treatment of anorexia

³ For a history of ‘parentectomy,’ which traces its origin in the treatment of children diagnosed with asthma in the US, see Robinson 1972.

(see Selvini Palazzoli 1978). These theories laid the foundation of ‘family based therapy’ for eating disorders – which is now the international ‘gold standard’ for treating young patients. Families then shifted from being viewed simply as the main responsible agents for the aetiology and maintenance of the illness, to being seen as the main ‘resource’ to be mobilised for a successful recovery (see Russell et al. 1987). As a result, although the specific configuration of family therapies varies across and within countries, most treatment approaches today ‘work with the family’.

Despite this fixation on the family in the history of therapeutics for eating disorders, the role of the family has been mostly overlooked in anthropological accounts of eating disorder treatment. In these accounts, the patient’s family is almost absent, except in the form of an additional obstacle to what would be ‘good care’ (e.g., Lester 2019). When kinship does appear, it thus appears either as the way clinicians make sense of patients’ distress (ibid.), or as the realm that offers a template for anorexigenic power relationships that can be observed within the treatment team and between patients and professionals (Gremillion 2003). Perhaps also because of the specificity of the Italian context – with its renowned, strong family ethos, long-term cohabitation in the parental house, and long-term economic dependence on parents (see Ghezzi 2012, Saraceno 2004, 2015) – kinship was everywhere in my field site: from national meetings organised by parents’ associations to denounce an underfunded healthcare context which often prevents patients from accessing professional care, to diagnostic processes, to the therapeutics of the lucky ones who did manage to access treatment. This chapter therefore differs from existing anthropological accounts of eating disorder treatment in that it examines a situation that places aspects of kinship care at the core.

By looking at what happens when families bring their daughters to *Il Giardino*, and at the extent and ways in which family care is incorporated into treatment, in this chapter I examine care at the intersection of professional and family care practices, and how these shape one another for the sake of what is called ‘therapeutic efficacy’. I draw on Mol, Moser and Pols’ (2010) suggestion that in care practices the knowledges, technologies, bodies, people and daily lives involved need to be ‘tinkered with’ persistently. By suggesting that professionals tinker with kinship care, I contribute a specific understanding of their notion of ‘tinkering’, as the tinkering that we will see happening here is mostly aimed at *relationships* of care. In

arguing that treatment practices involve what I call ‘technologies of kinship’⁴, this chapter both draws on and goes beyond literature that, looking at kinship in practice, has usefully highlighted the potentially harmful side of kinship (e.g. Carsten 2019, Das 1995, Pinto 2014); this includes those works that have explored how kinship can be framed as a source of mental distress and at the same time a vehicle for remedy (Buchbinder 2015; Chua 2011). Following Carsten’s (2019:146) call for concentrating on what makes kinship a powerful practical realm of action, I will suggest that in addition to all of these aspects, kinship here also becomes a therapeutic tool – albeit a difficult one to use – as professionals borrow from kinship practices in their own work with patients.

Returning for a moment to Carlotta’s words, we might also note the distinction she draws between what she calls the ‘nutritional level’ and the ‘relational level’ that the meal plan and the feeding process that follows seem to encapsulate. ‘Nutrition’ separates food here from ‘relations’ (or nurturance). Whereas in many anthropological accounts, food acts as ‘a substance of relatedness’ that creates kinship through care as nurturance (e.g., Carsten 1995), we have seen in the previous chapter how in the world of this treatment facility, scientific ‘nutrition’ is food detached from kinship-making commensality. It is problems in ‘nurturance’ through relations that are seen to be impeding ‘nutrition’. The pairing nutrition-nurturance is therefore temporarily broken in this facility: nourishing (to feed) is food necessarily detached from nurturing (to care for) ⁵.

In Chapter 3, I focused on what Carlotta called ‘the nutritional level’, and suggested how nutritionists scientise food, eradicating its associations with family commensality. We have seen how by framing food as ‘nutrition’, these professionals try to detach food from the relationality in which it is enmeshed: this detachment is a process of abstraction – of temporarily ‘eradicating the social’ (McDonald 2015:35). Since – as we have seen in Chapter 2 – the development of an eating disorder in a patient is seen, in part, to have something to do with ‘things gone awry in family relations’ (psychologist Carlotta), professionals also need to *rely* on the social: they need to re-introduce it but as part of treatment, as a reshaped ‘family’

⁴ As we will see, this is different from Goldfarb’s (2016) notion of ‘kinship technologies’, whereby material resemblance between adoptees and adoptive parents is used as a framework through which people interpret the signs that are understood as relatedness.

⁵ Professionals are adamant that this separation – which can be said to ‘take shape’ in the anonymised, packaged meals provided to patients in the residential facility – is only necessary in the residential phase of treatment. The longer-term aim for the semi-residential and outpatient phases is to re-insert the ‘socially nurturing meanings of food in the plate’ (nutritionist Viola).

turned into a therapeutic tool, because kinship relations are seen to need remodelling. This chapter therefore focuses on ‘nurturance’ – on what Carlotta called ‘the relational level’ of treatment – and suggests how the sociality of patients’ bodies is as important here as their physiology: the work of transforming the patient can only succeed if the patient’s family is transformed, too.

By examining what food affords to family and what family affords to food, we will see here how food and kinship are co-substantial. In the same way that professionals need to abstract food from the relatives and make it ‘nutrition’, they need to abstract kinship and remodel it. Kinship needs to become a scientific matter too – the social needs to be wrung out and remodelled. We will see that the aim is to end up with a co-substantiality of food and family that are then re-socialised together, in a ‘simultaneity’ (cf. Ardener 1989). This is important since simply ‘giving back food’ to patients without addressing family issues is seen as risky, especially upon discharge from the facility. After seeing in Chapter 3 the already enormous difficulty of using food as a therapeutic tool, this chapter will highlight the even greater difficulty of using family as a therapeutic tool. In their work with the family, professionals need a different kind of language from the one they use when they work with food. The complication here is that the ‘science of kinship’ is not readily available with a language that clearly guides professionals, as it is in the case of ‘the science of food’. Work with the family is thus even more about tinkering and experimenting: professionals do not have an objective model of kinship to follow in the same way that they have an objective model of food. We will see how, through the more difficult language of family, they ‘do’ (Mol 2002) a particular kind of family: family as a therapeutic tool, which is ‘caring’ because it is intended to make up for what patients ‘lacked’ in their own families.

The objects that the therapists are dealing with – food and kinship – need therefore to be momentarily ‘detached’ from their previous social context, in the sense just outlined. This is the first kind of detachment that we will observe here. The second kind of detachment that we will observe is that of the therapists themselves: they need to be ‘detached’ too, as the opening quotation from Mauro suggests. As we will see, professionals know that family care is a risky therapeutic tool, because the family is, in a way, the opposite of clinical detachment. They have to transform it into something that is therapeutic, but to do this, they need to be able to ‘stand back’ – ‘distancing themselves as part of their technology’ (cf. McDonald 2015:45). Scientising the family is much more difficult because family *is* attachment – it is hard to ‘stand back’. They only manage to do it if they are constantly on

their guard – and because they are aware that they are ‘professionals’. This clinical detachment is therefore a peculiarly difficult ‘social accomplishment’ (ibid.:50), one whereby professionals are ideally able to talk about patients as ‘cases’ and to construct case histories that are not just personal narratives. There is also, therefore, a certain scientisation of the person that has already turned persons into patients – a first step seen as necessary to help them.

In suggesting this, the chapter also contributes to anthropological approaches that explore the productive potential of ‘detachment’, revealing how the relationship between ‘detachment’ and ‘engagement’ is not simple or singular (Candea et al. 2015:1,2,16); here we will see not only how detachment always requires engagement of a particular kind (McDonald 2015), but how detachment is what *enables* the particular engagement that is seen as necessary for therapeutic work. We will see how both detachment and attachment contribute to professionals’ work ethic, but that this is not simply a case in which ‘empathetic care is not cancelled out by the intermittent need to create distance’ (cf. Crowder 2015:95).

The chapter begins by situating what happens in the residential facility through a description of the specific form of kinship care that lack of care on the part of the Italian State generates in the families of those diagnosed with an eating disorder. Against this background, I then zoom in on the cases of two patients whose families did manage to get their daughters admitted to *Il Giardino*, which might shed light on the kind of ‘family work’ that treatment for these conditions is seen to require. We will see how, in this facility, kinship is framed as a source of harm as well as of good, as it can do both ‘too little’ and ‘too much’. In the rest of the chapter, I show how professionals tinker with family care in response to those ‘excesses’ of kinship – i.e., as a remedy for the harm that ‘too much’ and ‘too little’ family care is seen to generate in patients.

When the State does not care: delegating responsibility to families

We live in Sicily, and my 15-year-old daughter was refused admission to the hospital on the grounds that she was 'not undernourished enough' – she was 32 Kilos. I had to attach my daughter to a drip of forced nutrition at home, with the help of a nurse paid by me. My daughter is doing OK now, thanks to us parents and to those who treated her privately. But who would have been responsible if something went wrong?

A patient's mother

This was one of the concluding comments of a day in November 2018 spent talking about 'the state of eating disorder treatment in Italy' – the theme chosen for the Fourth National Meeting on Eating Disorders, held in Florence every year. The meeting was organized by Consult@noi, a national non-profit association founded in 2010 by regional associations of patients' relatives, with the aim of creating a network of information and support by bringing together patients' relatives, professionals, and representatives of regional and national institutions – including Directors of local health authorities, members of the Ministry of Health and the Italian National Institute of Health. The comment of this mother was a call for responsibility, which was shared by most speakers: the lack of facilities offering services with specifically trained professionals – services that are public and accessible to all – seemed to be a problem in almost every Region.

We have seen in Chapter 1 how lack of specialised facilities for eating disorders causes a continuous migration between Regions towards the few facilities available. Parents are forced to travel for hours and spend considerable time and money to make sure their daughters receive adequate treatment. The Region where I conducted fieldwork is one of the very few that have all the four levels of treatment recommended by national and international guidelines, making *Il Giardino* one of the key destinations for these 'therapeutic migrations'. Descriptions of such migrations were a common refrain during fieldwork – patients' parents call them 'trips of hope'. Parents' stories also tended to mention a further complication: they do not 'simply' have to travel miles to obtain treatment for their daughters: first, they have to obtain an 'authorization' from their local health authority, which has to pay for the extra-regional treatment. Some local health authorities grant these authorizations more easily and for longer periods of time, but others do not – especially those in Regions where 'on paper' all levels of treatment are present. However, most of the time such facilities do not provide the services they claim to provide, and the professionals who work there are not specialised in

eating disorders. Lack of specialised training is deemed to be another consequence of the lack of attention given to eating disorders: not only many psychiatrists, psychotherapists and nutritionists do not receive adequate training on eating disorders in their standard university path, but also medical doctors – including those working in emergency departments, along with general practitioners and paediatricians, who are precisely the ones who could ‘spot the problem early’ and then refer patients to specialised professionals.

This context of the shrinking Italian welfare State, characterised by cuts to public funding and healthcare expenditures, places the burden of care entirely on the family (cf. Minelli and Redini 2015), importantly shaping the kind of family care that professionals ‘see arriving’ with patients on admission. In this scant clinical landscape, before admission to a facility there is already substantial family labour put into treatment – a labour that families need to do because the State does not. In what follows, we will see how, after admission to *Il Giardino*, much of this family work – especially the micro-care practices of feeding – must (ideally) be suspended, if only temporarily. Families that have done so much work are asked to back down and change their care.

Katia: when kin care ‘too much’

Katia was a 19-year-old girl from a large city in central Italy, who had been diagnosed with anorexia nervosa when she was 13. She was admitted to *Il Giardino* at the end of January. The Clinical Director had presented her case at the weekly staff meeting the day before, defining her as ‘a very complicated patient’ who would have to be constantly monitored because of her ‘extremely severe condition’. ‘Severity’ was defined in terms of her Body Mass Index, which on admission was 13 – a number that placed her in the category of ‘severely underweight’. Katia was emaciated, with only a little, dyed-blond hair left. On admission, it was evident that she did not want to stay. She was brought to the residential facility by her mother, a woman in her 50s whose face carried the signs of years of difficult care work and – professionals suspected – of either self-harming behaviours or scratching from Katia, in the form of uncountable little scars. Katia was seen to behave ‘abusively’ and at the same time ‘very dependently’ towards her mother. She would be alternately screaming and crying – shifting from heavily attacking her mother for being mean and betraying her, to acting as a child desperate for affection. Katia’s mother was visibly distressed and appeared

relieved when the professionals on shift asked her to leave Katia and go home, reassuring Katia that she would see her mother soon.

The following Tuesday, during the weekly staff meeting, the Clinical Director explained that Katia had been referred by a psychiatrist in Katia's city, who had been in charge of her outpatient treatment for a long time. He had informed the Director that Katia was an extremely difficult case, whom nobody else had 'managed to treat': after several failed attempts with outpatient treatment, countless hospital admissions, and three inpatient treatments in other parts of Italy, Katia's main problem was seen to have roots in a 'highly symbiotic relationship with her mother'. This 'unhealthy relationship' was reported to have developed during years of illness, but was traced back to her 'disastrous family history'. Katia and her twin sister had lost their father – who used to be violent with their mother – due to sudden death when they were 9 years old, and the children had since then been raised by their single mother and maternal grandmother. This had generated, in the view of professionals, 'pathologically dependent relationships'.

Two days after her admission, Katia had a big crisis and tried to escape – a clear sign to the Clinical Director that she could not stay without her mother. The Clinical Director agreed to the mother renting a flat close to *Il Giardino* and visiting Katia every day. Katia was therefore reserved special treatment, with the possibility of spending time with her mother. Other patients took little time to notice this different treatment, and soon started complaining that it was not fair. Most professionals agreed that this arrangement was not sustainable, and quite pointless: Katia's constant contact with her mother – they kept saying – did not help and 'made treatment more difficult'. Meals were characterised as 'a lost battle', and Katia's sessions with the psychologist and the nutritionist became 'disarming' because she was 'exclusively and unrealistically focused on not wanting to gain weight but wanting to be discharged'. At some point, Katia became so resistant to treatment that the only way the Clinical Director could convince her to stay was to allow her to stay in the residential facility from 11 am to 3 pm only, when she would go home with her mother. At 4 pm, an intern or a volunteer from the treatment centre would go to her house and stay with her until 9 pm, making sure that she ate her afternoon snack and dinner, and that she did not spend time walking around town.

I was among the 'volunteers' recruited. Katia's mother had been advised to leave the house while volunteers were there for the assisted meals, but she almost never did because Katia

would start crying. When my turn came, with difficulty I managed to send the mother away for a walk at the time of the afternoon snack. I was sitting and chatting with Katia after she had finally finished her snack, when her mobile phone rang. It was her mother telling her that she was in the square two minutes away from the house. Predictably, Katia wanted to join her mother, and there was no way of keeping her at home. I had to follow Katia, and we ended up with her mother in a small grocery shop. Katia bought her usual ‘zero-fat’ foods, that she was not supposed to buy because she should have eaten the meals sent by the residential facility. She was not even supposed to enter grocery stores in the first place. That evening for dinner – which started one hour later than planned because Katia refused to eat earlier – Katia only ate the salad sent by the facility, substituting the first course with some chickpeas, and the second course with a few slices of turkey breast. The mother ended up eating the meal of the treatment centre, and I could only make sure that Katia ate at least all the things she had chosen.

Eventually, what was characterised as the ‘counterproductive’ behaviour of Katia’s mother, and the difficulty for insufficiently trained volunteers to assist with meals in her house, led the Clinical Director to decide that Katia should be left at home with her mother every day from 5 pm, after eating the afternoon snack in the facility. I was told by professionals that this whole arrangement was unprecedented – and beyond any regulation: ‘It runs against the very principle of making parents delegate their feeding role to us. It’s clear that the mother can’t do it anymore, that the two together don’t work’. The reasons for things not working was ascribed to the fact that Katia’s mother let her do whatever she wanted: ‘she has a neurotic interlock with Katia: she is completely dedicated to her ill daughter. Once Katia recovers, she will lose her aim in life’. The implication here was that this was the reason why – ‘unconsciously’ – the mother was counteracting treatment with her presence. There was a professional awareness here that bending the rules of treatment in this new arrangement prevented the separation between food as ‘nutrition’ and food as ‘nurturance’ seen as necessary for patients treated in the facility: the mother’s nurturance, characterized as ‘excessive’, prevented Katia’s nutrition.

In Katia’s case, the patient’s mother is clearly very present in her care – ‘enmeshed’, professionals would say. The psychological term ‘enmeshment’ (*invischiamento*) is here used to denote an ‘unhealthy’ form of interdependency, suggesting that it is possible to ‘care too much’. However, equally frequent are cases in which the main obstacle to recovery is traced

back to an opposite situation. We will now turn to one of such cases, where parents are deemed ‘too absent’.

Maia: when kin care ‘too little’

Maia was a 33-year-old patient from a small town in the Region. She had been diagnosed with anorexia nervosa when she was 15, and had been in and out of the residential facility (the time ‘out’ spent mostly in hospital wards and other residential facilities across the country) for the last ten years. Maia’s parents were almost completely absent from the scene, and I managed to see them only a couple of times, in situations of emergency. There were of course important differences from Katia’s case: Katia was still considered a ‘kid’, whereas Maia was classified as a full ‘adult’; Katia’s mother was in her 50s, whereas Maia’s parents were in their 70s; Katia had been ill for a long time already – for six years – but Maia had been ill for more than half of her lifetime, reaching eighteen years of illness. These aspects made professionals somehow ‘make sense’ of Maia’s parents’ absence: they were ‘understandably exhausted’ after so many years of their daughter’s illness, and their old age now meant they did not have ‘the energy’ to be much involved in her treatment anymore.

However, many professionals did not take this as a sufficient reason for their absence, and depicted Maia’s parents’ behaviour as unacceptable: they were not only completely absent in her care, but did not even follow professionals’ recommendations when these required a little effort on their part. By December, Maia’s weight had decreased to the point that the treatment team decided to admit her to hospital. Since hospital staff are not trained or paid to monitor patients’ meals and make sure that they eat everything, the treatment team strongly advised Maia’s parents to hire a professional to take on that role. Since that would have been at the family’s own expense, Maia’s parents refused, although Maia had proposed to use money from her disability pension – which was virtually untouched since she had been living in the residential facility for the last three years. Maia’s mother eventually took the role of ‘meal controller’ for the two weeks of the hospital stay, with professionals claiming that they were sure Maia would be able to deceive her. The problem came up again when, upon discharge from the hospital, Maia’s parents were told that she would have to stay at home for a while before being readmitted to residential treatment: her condition was still precarious enough to require the intravenous feeding she had been receiving in the hospital on top of regular meals,

and that was not possible to arrange in the residential facility. The treatment team had therefore arranged some nurses (to be paid by Maia's parents) to be present at home for her.

The Coordinator of *Il Giardino* was the one who called Maia's parents to inform them of this decision. She reported to the rest of the team that the parents had reluctantly said: 'We will see what we can do. Then, it will be what the Lord wants' – and that she had felt she 'wanted to get her hands on them' when she heard them saying that. She continued: 'But *we* can't abandon her. We have to keep trying to help her, no matter what' (original emphasis). It is interesting to note that this kind of interaction could easily be imagined in many medical settings with the roles being reversed – with a patient's parents reacting to a similar statement from a doctor. Professionals were very critical of the 'delegation of parenthood' that Maia's parents were gradually pushing for, but it seemed that they themselves had already 'internalized' it in a way. Some proposed that when the moment of discharge from *Il Giardino* would eventually come, it might have been better for Maia to live in a group home such as those for people suffering from addictions, rather than returning to live with people with whom she did not 'share anything anymore'.

It is worth noticing that, in both Katia's and Maia's cases, the attempt to involve parents in treatment ended up suggesting that the only way for these patients to get better was to remove their parents' (excessive or insufficient) care from the picture – as if the move away from 'parentectomy' towards considering parents as a 'resource' in treatment for some cases hardly works. Nevertheless, it seems that there is something about kinship care that cannot be taken away: Maia's exclusion from family care resulted in the treatment team stepping in and taking that role. What happens when shifts like this occur? We will see in Chapter 6 how they can have deleterious consequences for treatment. For now, let us turn to how professionals work to tinker with kinship practices to save what they see as fundamental in kinship care – so fundamental that it has to be preserved, if in some modified form. We will see that kinship relationships are here the object and simultaneously the tools – the technologies – of the transformation that should ideally occur in treatment. But how does this transformation occur? In the two final sections, I will provide a few examples of how the treatment team reshapes kinship care by, first, teaching parents how to be 'good parents' for their children, and, second, by actually enacting appropriate kin-like relations during treatment.

Reshaping kinship care

Parents with children suffering from an eating disorder find themselves in the uncommon situation whereby their daughter is at the same time a victim to be protected from a threat and the very agent of that threat. This situation generates confusion in the otherwise natural behaviour of parents, which would make them protect their children by attacking the external threat. This confusion leads parents to oscillate between protecting and attacking, and this cannot but generate fear, anger, guilt and shame.

Clinical Director

This quotation from the Clinical Director suggests some of the reasons why parents might often respond to their daughters' needs in ways that the treatment team might see as unhelpful, as in the two cases just discussed. The eating disorder is seen as putting into question the 'natural' care response of parents towards their child, 'as if she were suddenly split in two – victim and perpetrator' (Clinical Director). During a meeting for patients' parents, the counsellor moderating the meeting intervened by saying that, for that reason, the only way to protect their children was to 'put some distance' between themselves and their daughters, and 'temporarily delegate' parts of their role as parents to the treatment team. The counsellor was here pointing to the limits of parental care: treating the eating disorder was something that 'parental love' could not do. This brings us back to the professional view of the eating disorder as an agent that 'takes over' the self of the patient, and that needs to be seen as the target of the coercive measures that treatment might require⁶. The idea is that it is very difficult for parents to understand this – hence their difficulty in managing their daughters' conditions at home, and the need to bring them to a facility where they can temporarily delegate their care to someone else.

Observing what happens on admission to *Il Giardino*, at first sight it might indeed seem that parents' responsibility for care completely shifts in the hands of the professionals. Parents are asked to 'delegate completely' their responsibility for feeding their daughters to the treatment team, which should act as 'a more skilled second family'. The team is supposed to stop patients' 'dysfunctional behaviours' by forcing them to eat 'normal meals' and by preventing them from purging and 'over-exercising', while working to understand 'the reason why they developed an eating disorder' in the first place. Parents are told that they are incapable of doing this because they are 'too emotionally involved'. On the contrary,

⁶ See Chapter 2.

professionals are supposed to be able to ‘stay detached’ from the personal dynamics underlying ‘dysfunctional behaviours’ (counsellor Carola).

A very specific form of parenthood is therefore desired from parents at *Il Giardino*: being able to entrust professionals with the ‘immediate care’ of their daughters – i.e., feeding them, monitoring their weight and health, being there in moments of crises – here becomes a fundamental part of being ‘a good parent’, and ‘a good carer’. Notwithstanding the relief that this in part brings to parents, entrusting strangers – ‘professionals, but still strangers’ – with the care of their daughters is not something that parents do easily. A designated ‘family counsellor’ has the role of updating parents, and is ready to answer their questions and worries, but parents are not told all the details of what happens in treatment – what their daughters will be fed, or how much weight they gradually gain. Parents who do not ‘trust’ professionals are characterized by the latter as ‘very demanding’ and ‘polemical’, and are seen as ‘inadequate’ and ‘counterproductive’.

In her ethnography of an eating disorder inpatient unit in the US, Gremillion (2003:101) describes how parents are excluded from participation in patients’ treatment and are not given advice about how to help their daughters at home, on the assumption that ‘a natural maternal feeling will perform invisible healing work’ (ibid:110). In *Il Giardino*, this is not the case: parents might not be given ‘unnecessary details’ regarding the calories of their daughters’ meal plans, or how much weight they gain every week, but they are very much involved in treatment, and are expected to be, so that they can ‘gather all the necessary tools’ to be able to deal with their daughters at home later. Moreover, there is no assumption of, let alone confidence in, any kind of ‘natural’ parental feeling that will be performing invisible healing work. Here, ‘proper’ healing work is the result of effort and training by professionals.

Similar to what Pinto (2014) notices for the treatment of women in a psychiatric university hospital in India, and unlike situations in which being admitted to a psychiatric institution involves loss of contact with family, being admitted to *Il Giardino* requires extensive family involvement. At the same time, unlike in Pinto’s material, the kind of family involvement required in *Il Giardino* does not consist of families having to be constantly in the facility for daily tasks of care – that would indeed be seen as counterproductive and possibly perpetuating whatever may have contributed to the illness in the first place, as we have seen in Katia’s case. In *Il Giardino*, the delegation of ‘immediate care’ comes with the expectation of other forms of care. Spotting the problem and bringing one’s daughter to treatment is only

the beginning of parents' responsibilities, as the family counsellor often pointed out during meetings for families:

We can substitute your feeding role, but there are no substitutes for parents. You entrust us with their care, but there is no way of delegating your being their parents. Your parenting role should be made even more explicit while your daughters are here. It is just a different way of parenting from the one you are used to.

After admission, parents are in fact expected to make patients feel that 'they are present' by visiting as much as possible, by 'working on themselves and their ways of parenting', and by finding 'alternative ways of doing things'. This includes different ways of managing arguments with their daughters, and – a fundamental point – learning how to manage food-related issues at home differently, 'in a way that can be supportive'. Parents are required and expected to have a very specific behaviour during mealtimes when patients are at home for weekends: the golden rule is that they should never make any kind of comment on what and how patients eat - nutrition is not their responsibility. Especially at the beginning, parents are told to cook specifically measured meals without letting patients do it. On top of this, it is preferable that during the meal other members of the family eat more or less the same things – and in any case, never less than patients, to avoid making patients feel even worse. When parents behave differently, they become the object of complaints on the part of patients and professionals alike, and are seen to be expressing either that 'they haven't understood anything', or worse, that 'they don't care'. When reporting on their 'weekend experiments' at home, patients are adamant that it is very difficult to 'stick to the rules' if their family members ignore professional advice – as they reportedly often do – and start commenting on what their daughters eat, or eat 'light' foods in front of them, and go to the gym or running for hours – all behaviours that patients are 'struggling to battle against'. Parents are supposed to learn 'how to behave' in these situations by coming to the weekly meetings for parents and to the appointments with the assigned family counsellor. They are also expected to 'work on themselves', preferably by starting their own psychotherapy. Many parents are reluctant to do this, for lack of time, money, or – in the words of the psychotherapist Michele – 'because starting to question oneself and one's family dynamics is scary'.

Meetings for parents therefore have a strong didactic function. The counsellor Sara often depicted treatment as a parallel path in which daughters and parents gradually learn to 'manage emotions'. 'Mismanaged emotions', as we have seen in Chapter 2, are here

conceptualised as the key to the ‘psychopathology’ of eating disorders – and to the ‘dysfunctional family dynamics’ that can perpetuate it:

To be a parent means to protect your daughters, in this case from your unelaborated emotions. [...] The eating disorder works as a modulator of emotions. This means that when you ask your daughters to recover, you are asking them to learn to stay in their emotions and manage them without the disorder. Therefore, you must be the first one to do it.

Sara is here asking patients’ parents to do what sociologist Arlie Hochschild (2003) calls ‘emotion work’ by ‘surface acting’ – i.e., the adjustment of one’s outward countenance to induce a desirable state in the other. However, this can only be successful if parents also engage in psychotherapeutic work, what Hochschild would call ‘deep acting’ – i.e., the effort one makes to change one’s overall ‘emotional experience’ by drawing from one’s prior experiences. When emotion work as a kind of ‘care work’ is absent, professionals often attribute the lack of progress in a patient’s treatment to the lack of involvement from the family, as in Maia’s case. This is one of the greatest causes of frustration for professionals, who often joke about the idea of setting up ‘a parallel residential facility for parents’. ‘Emotion work’ here becomes part and parcel of kinship care and care for illness, as therapy for the patient extends to therapy for the whole ‘dysfunctional’ family unit.

Unlike in other clinical contexts in which anthropologists have looked at the role of family carers (e.g., Clemente 2015; Mattingly 2010, 2014a), here recovery is seen as inherently possible. This aspect sets up the possibility of blame: if treatment seems to be failing, it is ‘people’ that are to blame, not ‘biology’ or ‘the disease’. This means that the stakes in the relations of care are even higher, as parents are placed in the position of being at the same time ‘targets of intervention’ and ‘therapeutic agents’ (cf. Buchbinder 2015:139). As we have seen in the cases of both Katia and Maia, one further complication is that this care work is supposed to last for years – Mattingly (2010:27) calls this ‘chronic homework’: for those who are lucky, two-to-five years are considered necessary for ‘complete recovery’ from an eating disorder; but for many, relapses are common and a considerable number of people end up living with the condition through the rest of their lives.

For now, we have seen how at *Il Giardino* kinship care practices are turned into an object of treatment, so that the family can be turned into a tool that helps patients’ recovery. Similar dynamics have been noted by Buchbinder (2015) in her account of the work with the family in a pain clinic for children in the US; and by Chua (2011) in her analysis of how parenting

practices in South India – especially in relation to how parents (fail to) teach children to ‘wait’ – are framed by the State, and specifically by psychiatric institutions, as responsible for and simultaneously as the vehicle of ‘therapy’ for a ‘suicide epidemic’ in children. In the next and final section of the chapter, I will suggest that something more is going on at *Il Giardino*, as kinship care is not only a ‘tool’ in the sense that patients’ families are turned into resources for recovery; here, professionals also employ kinship care as a tool in their *own* work with patients, borrowing from kinship care practices but cleaning them of the ‘dysfunctionality’ that is seen to characterise patients’ families.

Turning kinship into a therapeutic tool

In her ethnography of hospital care for children with incurable conditions in the US, Mattingly (2010:12) shows how ‘border encounters’ between families and clinicians can lead to ‘imaginative borrowing, syncretic inventiveness, the creation of common ground’. At *Il Giardino*, not only ‘imaginative borrowing’, but also a kind of ‘practical borrowing’ occurs, as the treatment team borrows attitudes and practices seen to pertain to the realm of the family, and employs them in the therapeutic work with patients. A lot of effort is put by the whole treatment team – mostly composed of women, including the Clinical Director – into recreating ‘a maternal, family-like environment’ – in a setting that is purposefully rendered as similar to a ‘home’ as possible, with professionals wearing casual clothes and supporting patients 24/7. The psychologist Carlotta explained that the treatment centre has ‘a family-like functioning’: ‘After all, we are a group of adults who, like parents, organise the times and the rules of this shared life; and a group of patients who, like children, find themselves in the position of being looked after, no matter how old they are’.

The psychologist’s explanation raises an interesting point on what is often called, in sociological studies of medicine, ‘infantilisation’ (cf. Marson and Powell 2014) – a ‘behavioural pattern’ in which a person of authority treats a grown-up person in a child-like manner. It would be easy to see ‘infantilisation’ here as a symptom of Foucauldian ‘total institutions’ and paternalistic care, but I want to take seriously the way professionals frame it: as a ‘needed step’ in the most severe phase of the illness, not only because of ‘the extreme physical and psychological vulnerability’ of patients at this stage, but also as part of a ‘re-parenting process’ that is deemed fundamental to treatment: most patients with eating disorders are deemed to have developed an eating disorder partly because, as the psychologist

Flavia explained, ‘they did not get to be children when they were children, and had to take adult responsibilities too soon’⁷:

They really need what they don’t get from their parents, they look for parental figures. That is why the key to treatment, besides the work with food, is this *maternage*⁸ that we do with patients, the emotions it generates. The relatedness itself is good. The fact that they can experiment with healthy relationships. The fact that for the first time someone dedicates to them time without judging them or attacking them, but showing them affection.

We are seeing here how clinical detachment in *Il Giardino* is self-restrained but not unemotional in the way surgical practice would be, for example, in the operating room (cf. McDonald 2015:51). The detachment these professionals need and acquire (ibid.:52) is not the same lack of emotional display, but more a neutral stance in the perceived ‘fight’ between patients and their family carers, which keeps demanding affectionate engagement of a particular kind, as the psychologist Carlotta explains:

It’s a bit as if during a football match, a player threw the ball to me - and I am the referee – asking me to start playing for his team. It is quite possible that I feel more sympathy for this player or for his team and its cause, because I am still a human being. But I know that in my role, I can’t. There is obviously the possibility that at this point the player will get nervous and angry...and this happens here. But knowing that I have this role and that therefore I cannot take the side of one person – be it the patient or a parent – allows me to bear that person’s anger and the other negative emotions that might follow my refusal – much more than I could do in a personal situation. And this holds for virtually everything here, including the assistance with meals when a patient might ask you to let her leave the table without having finished the food on her plate. It’s like telling her: ‘Look, if it were for me Carlotta, I could maybe agree with you, but as a professional I can’t’.

⁷ The way professionals talk of treatment points to a world in which a distinct category of ‘children’ is important: international law, encoded in the United Nations Convention for the Rights of the Child, defines childhood as the period between the age of 0 and 18, with childhood conceptualised as a separate space, protected from adulthood, in which children are entitled to special protection and rights (Montgomery 2008:2,6). However, anthropologists, historians and social scientists have suggested that this notion of children as weak, dependent, and vulnerable is both recent and culturally specific (e.g., Zelizer 1985, Lancy 2014, Schwartzmann 1978). Most notably, the French historian Ariès claimed that our present-day ideas about the distinct nature of childhood have come to the scene relatively late in the history of Western Europe. He stated that, before the end of the fifteenth century, people had little conception of childhood as a phase in the life-course. In medieval society, for instance, the idea of childhood did not exist – not in the sense that people lacked affection for children, but in the sense that they lacked ‘an awareness of the particular nature of childhood’ (1979[1962]:128). Ariès’ thesis relied on analyses of medieval European art, in which, he claimed, children were depicted with the posture and muscles of adults but in smaller scale. For his history of the development of current ideas about childhood, see Ariès (1979[1962]).

⁸ The treatment team often used the French term *maternage* (mothering) instead of the Italian term *accudimento* to refer to the attitude of maternal affection that they purposefully enact with patients. This was because the French term is the one commonly used in the language of psychotherapy to refer to therapeutic relationships that aim to tackle problems and traumas located in lack of parental care during infancy.

However, staying ‘neutral’ or ‘detached’ is not an easy or ‘natural’ task for professionals – even more so because the very structure of treatment asks for ‘parent-like practices’. As Marta, an educator, explains:

It’s difficult. You see us as professionals, but we get attached too. When we do the night shift, we see patients sleeping in their beds, brushing their teeth, straightening their hair... it is an intimate thing. Il Giardino is a family for us too. But we must remain distant. As professionals, we have the duty to do it.

These invocations of clinical detachment are constant refrains. When it comes to the work with the family, professionals have learnt to be affected in the way their profession demands (McDonald 2015), a way that they know will work for treatment. They know what a ‘healthy attachment’ is, and are supposed to be able to use that. Professionals strive to be caring in a way that mimics the family, but they are aware that they should not become ‘too emotionally involved’. As Marta’s words suggest, this is the ideal – what the treatment team strives for – not necessarily what always happens in practice, especially because of the residential structure of treatment, with its long shifts and prolonged contact with patients. Here, therefore, detachment is an aspiration (Anderson 2001, cited by Cook 2015:230) – and an uneasy and never complete ethical disposition that requires careful cultivation through practice and training (McDonald 2015).

An additional complication, the psychologist Carlotta explained, is that the ‘relational styles’ that patients enact when relating to professionals are seen to be those that patients supposedly constructed with their own relatives while growing up:

Sometimes there are relational styles that work in a maladaptive way – those who constantly avoid conflict for example; and we often see that both patients and their families deal with conflictual situations with us in the same way they deal with conflicts within their family. We are not interested in the result of the conflict per se, in who is right, who is guilty and the like – we are not policemen – but in how the conflict and the communication within is managed, or mismanaged.

The psychologist concluded that the treatment facility works as ‘a relational laboratory’ in which patients are given the opportunity to ‘experiment with new ways of relating that can organise their subsequent experiences in a more functional way’. This is not the same kind of ‘relational labor’ (*lavoro relazionale*) that volunteers refer to in Muehelebach’s (2011:65)

study of voluntarism in Italy – although most members of the team, be it interns, volunteers, or professionals whose salaries barely reach 1,000 euros per month, also frame their work in similar terms. Nor is it exactly like the concept of ‘moral laboratories’ that Mattingly (2014a) uses to describe the experimental nature of people’s struggle for a good life amidst deadly diagnoses for their children in the US – although Carlotta’s words also refer to the facility as a space that generates experiences of how life might be lived differently. Rather, we are closer to what Pinto (2011:384) describes in her ethnography of psychiatric treatment in North India: in this treatment centre, relations are ‘means, not just objects, of understanding’, and – this is where the specificity of what goes on in *Il Giardino* lies – of treatment, too.

One of the most telling instances of how the treatment team works as a ‘relational laboratory’ by enacting what is seen as appropriate kinship care is the way they deal with patients’ ‘crises’ during meals. I offer an example below:

Giada, a 16-year-old patient, is sitting at the table during ‘nutritional therapy’. She has just finished her portion of plain rice, and is waiting for the volunteer on shift to give her the ‘second course’. When that is placed in front of her, her eyes widen in what seems to be panic. She starts shaking her head and frantically moving her right leg. The nutritionist Irma, who is monitoring the meal while standing next to me, notices Giada’s reaction, and whispers to me that today the second course is canned tuna fish: ‘It must be the oil’, she says. She then walks to Giada, bends towards her while placing an arm on Giada’s shoulder, and – still whispering – asks her what is happening. Giada, as Irma had imagined, says that she ‘can’t do that’ as ‘there is too much oil’, and starts weeping silently. At this point, Irma asks Giada if she wants to exit the room with her for a moment, and Giada nods. They leave the dining room, while two other professionals walk around the other patients asking questions about their towns of origin and making jokes, in an effort, it seems, to draw their attention away from Giada’s crisis. I can see that Irma is talking to Giada in the hall, trying to prevent her from shaking by keeping her own hands firmly but gently on Giada’s shoulders, and looking straight into Giada’s eyes. I cannot hear what she says, but she later tells me that she was telling Giada that most of the oil she ‘saw’ was actually diluted in water, since that specific tuna has a very little amount of oil compared to what ‘normal people eat’; that her body needed that little amount of oil to function, and that she had already eaten that kind of tuna many times, so she could do it – she just needed to breathe and eat it without thinking too much. After 5 minutes or so of conversation, Giada seems to calm down a bit. Irma smiles to Giada, and gently strokes her arms and back while walking her back to her seat in the dining

room. Giada sits down, looks at the tuna awaiting her, takes a deep breath and starts eating slowly. In the meantime, Irma keeps standing next to her, telling a story of something funny that has happened to her while coming to work today, and keeping one hand on Giada's shoulder while she eats. After 10 minutes, Giada has finished the tuna, and asks for her 'side'.

This is one example of countless similar situations I witnessed, as 'crises' like Giada's – some requiring much more work and time than this one – happened every day, at every meal. Although the kind and extent of 'crises' can vary widely, the way professionals deal with them is always similar. When describing what they do, professionals say they aim to be 'maternal and firm', but 'containing patients' irrational thoughts' and, most importantly, 'not taking their difficulties with food personally and overreacting, which is exactly what their parents tend to do'. When I asked about the frequent stroking, and in some cases hugging, that I observed both during mealtime crises and in other occasions in which patients were distressed, professionals explained that most patients 'need that physical affection' because most of them 'don't get it from their families'. They remarked that through this way of relating to patients, patients experiment with the fact that 'others can accept them even if they are angry, sad and needy'. This does not mean that professionals are never 'harsh' with patients. The key is seemingly to behave as one would behave with one's own kids: 'when they need scolding, scolding; when they need cuddles, cuddles'. Here, kinship care is brought into the realm of the therapeutic, and is seen to *become* therapeutic.

In Chapter 3 we have seen how the whole treatment path – from residential, to semi-residential, to outpatient treatment – ideally consists of a gradual shift from almost complete 'dependence' on the treatment team, to more and more 'autonomy' through the different phases of treatment, and how professionals conceptualise their aim as that of 'becoming superfluous – so that patients will not need us anymore, eventually'. This path and aim are imagined as mimicking the supposedly healthy steps that should emerge from a 'healthy parental relationship'. However, professionals are adamant that this can only happen if 'there has been a healthy nurturing first, in which patients have felt bonded to their parents' (counsellor Carola).

Residential treatment is conceived as 'protecting' patients from the triggers of the external world by keeping them in the facility in a phase in which they are deemed 'extremely vulnerable', and as gradually exposing them to the difficulties that they will encounter once discharged from treatment, teaching them how to cope with those difficulties one by one, and

supporting them in the process – ‘as any parent should do while their kids grow up’ (counsellor Clara). We have seen in the previous chapter how this happens with food through the work with the nutritionists. However, this also holds for matters of ‘relatedness’. In their work with patients, psychotherapists dedicate a lot of time to discussing the difficulties of handling friendships, intimate relationships, and relationships with family members, and encourage patients to ‘experiment’ with situations they find ‘scary’. They also concretely support patients in matter such as finding hobbies they enjoy, finding a job that they like, obtaining or renovating a driving license, learning to manage one’s finances, and moving out from one’s family house.

This seems to suggest that for the treatment team, ‘health’, and the ‘autonomy’ that should go with it, do not equate to ‘complete independence’ from other human beings. The psychotherapist Mauro would often reiterate during group sessions that ‘as humans, we are all born with a deficit, and will always be deficient.’ The paradox, he said, is that patients start restricting food because ‘they want to be like God, completely self-sufficient’. And to pursue this, they end up in an illness that leads them ‘to being completely dependent on others, which is the opposite of what they wanted’. The treatment team, he insisted, tries to ‘gradually bring them back to autonomy by being present, by nourishing them with familiar things. The aim is to make patients realise that in order to be autonomous, one has to nourish oneself with healthy dependencies’. These, he explained, are those in which ‘the human needs of warmth, of being listened to, of being seen, are met. In pathological dependence, instead, you can’t live without that person or thing’. These statements suggest that ‘autonomy’ here derives not from complete independence, but from being ‘attached well’ (cf. Vogel 2018a:520).

Conclusion

In this chapter, I have suggested how attributions and delegations of responsibility to different actors in the network of care allow – or do not allow – what is seen as ‘therapeutic work’ for people with eating disorders. Patients’ parents shift from having to carry all the responsibility to make sure that their daughters survive – often beyond their possibilities – to a situation in which they are suddenly asked and expected to ‘step aside’ and let professionals do what they had to do on their own until that moment: feeding their daughters, constantly monitoring their health and dealing with their crises. At the same time, parents ‘have to be

there’ but ‘in a different way’: ‘working on themselves’ and learning how to deal with the needs of their daughters differently.

We have seen that at *Il Giardino*, kinship care is constructed as a substantial obstacle to treatment, but also as a potential solution to the problem if only it can be tinkered with and professionally channelled ‘in the right way’. Kinship here has a toxic edge, since both ‘too much’ and ‘too little’ kinship care can get in the way of recovery. The way the treatment team structures a specific form of detachment, by borrowing from kinship a kind of family care that is cleaned of its dysfunctionality, suggests how kinship care and its related ‘emotions’ can be turned into supportive tools towards recovery. This points to a form of detachment slightly different from that observed in other branches of medicine (cf. McDonald 2014,2015).

Professional detachment here is seen as what enables the affective engagement with patients that is seen as necessary for healing. Surgeons might cultivate detachment because the specific job they need to do – opening up bodies – requires them to ‘distance themselves’ at that moment, to see those bodies as ‘just bodies’ and not as ‘persons’. In that case, the process can be seen as one demanding an engagement that enables the cultivation of an attitude of ‘detachment’: a particular engagement precedes and is needed for the necessary detachment that enables the therapeutic intervention. The engagement is one that contains and holds at bay any emotional involvement or display (see McDonald 2015). In the world of *Il Giardino*, what is framed as emotional involvement is needed as *part of* treatment, but it has to be both contained AND displayed. Detachment is again seen as a necessary precondition, ‘within the self’ of the professional, to enable involvement in practice: this detachment consists of ‘keeping separate the personal from the professional part of oneself’. Detachment in this context has to be cultivated and maintained in a way that allows a ‘healthy *maternage*’ between professionals and patients – the contained affection and concern that patients seemingly need for recovery, because in their families they have experienced either complete enmeshment or complete abandonment. Detachment is the background, the ‘internal stance’ that allows the reparenting process to occur without the risks that are seen to stem from relations between kin.

Finally, this chapter has suggested how medical practice engages in kin work not only by seeking to define the appropriate mechanics of kin care (cf. Buchbinder 2015; Chua 2011; Pinto 2014) and by challenging the supposed boundaries between a ‘domestic’ or private

sphere of kinship and a ‘public’ sphere of work (McKinnon and Cannell 2013; Yanagisako 2003), but also by making kinship one of its key therapeutic tools. We have seen how in this residential facility, the ‘domestic’ of patients’ family life is purposefully made public in the clinic, so that it can become an object of treatment and problems in kinship care can be modulated by professionals. At the same time, the clinic strives to construct a domestic space, ‘but not too much’: professionals borrow from kinship care in an effort to re-parent patients – but in a way that is ‘cleaned of the dysfunctionality’ that is seen to have come with it, all the while making sure not to become ‘too involved’ in kinship technologies themselves.

What goes on in *Il Giardino* is therefore a kind of relational healing: patients are framed as being constituted by and as constituting their family relationships. This suggests that acts of bodily transformation are not confined to ‘the biologically functional’ in their effects, but necessarily result in the reconfiguration of social relations, as ‘bodies do not express, incorporate or embody the social [...] Rather, bodies are social in their materiality’ (Lambert and McDonald 2009:5,10). What happens to patients’ bodies is seen to be happening to the relations between patients and their kin – not only by analogy, but by the connections through which such relations are seen as constituting patients’ bodies (Strathern 2009:151,163). Patients are transformed through transforming the relations that constitute them.

Chapter 5

Treating patients ‘who don’t speak’: the challenge of treating children

These children are enigmatic. They have a mysterious world inside.

Clinical Director

Introduction

‘OK, I will be the housekeeper then’. The psychotherapist Michele nods from his crouching position on the floor of the group therapy room, seeming in this way to accept the role that he has just been assigned by Sofia. Sofia is 11 years old and has been living in the residential facility for the last five months. The other six patients present – all crouching in a disorderly circular shape together with Michele – giggle, apparently happy with this distribution of characters. They are all between 10 and 12 years old, and have been admitted here in the past few months following a diagnosis of severe eating disorder. All of them exhibit what is deemed to be pathological behaviour towards food and a dangerously low weight for girls of their age: Sofia only eats first courses because she is convinced that second courses, sides and fruit make people fat¹; Arianna barely eats solid food, and in extremely small quantities; Sara and Elena only eat food that is white. Susanna only eats food in liquid and semi-liquid form. Flavia and Alice refuse to eat anything but vegetables.

The other roles have been assigned: Sofia will be Arianna’s mother, Susanna will be Arianna’s father, and the others will be her paternal and maternal grandparents. Arianna will be Arianna, since the game is about her family. Next time, it will be about Sofia’s family, and so on. The game works like this: after the chosen patient has drawn the scene of a ‘family meal’, patients and therapist have to enact it following the description of the patient, who works as a director and tells each character what they would do in that circumstance. This was the first group activity of this kind in the residential facility. ‘I have never conducted a group session with preadolescents before’ – Michele had explained to me in a slightly nervous tone before the session started: ‘You will see that, unlike in my group sessions with

¹ In Italy, in ‘nutritional’ terms (see Chapter3), first courses are typically composed of ‘carbohydrates’ such as pasta and rice; second courses include ‘proteins’ such as meat, fish, eggs or cheese; sides tend to be vegetables.

adolescents and adults, there will be no chairs in a circle. We will play on the floor'. The room had quickly filled with patients' voices and giggles after a few minutes of intimidated silence, during which Michele had explained the rules of the game: patients could do anything and say anything, as long as they did not hurt one another. During our discussion in the kitchen after the end of the session, Michele further explained to me what had just happened:

As you saw, when you have patients so young – 10, 11, 12 years old – you basically play with them. Because by choosing a specific game and specific ways to play that game, children tell stories about themselves – stories that you wouldn't get in a more direct conversation. Did you notice how Sofia – who never speaks to us – was actively participating and assigning roles?!

Michele continued that although it looked like he was 'just playing' with patients, in play 'there is a deeper level in which patients communicate their most intimate parts – their emotional experiences, and how they understand those'. He noted that adolescents and especially adults are 'much more reflective and expressive of what goes on inside them', and that he had been trained and was used to dealing with *that* mode of communication. 'With preadolescents', he remarked, 'it is completely different, and therefore much more exhausting to get there'. Michele's words pointed to a model of the person in which patients are attributed internal worlds made of layers² that the therapist needs to be able to traverse, with emotions ('there') appearing to be deep down, and harder to reach in children. This increased difficulty and the need to tackle it through play required Michele to 'participate more', hence his 'exhaustion'.

Michele was not the only one who had to learn new ways of dealing with patients during that time. Every professional, intern and volunteer had to – including the anthropologist. In fact, this was the first time in the history of *Il Giardino* that nearly half of the patients admitted (seven patients out of eighteen) were what professionals defined as 'preadolescents', or more colloquially 'children' – i.e., between 10 and 12 years old. The Clinical Director would often point out that admitting such a high number of extremely young patients was unprecedented: 'We have had patients this young since we opened the centre in 2003, but we used to admit one once in a while, and it was always something exceptional; now we are admitting one every week! It is very disquieting'. This increase was a matter of concern not

² In Chapter 6 we will see the further implications of this model.

only because it found the treatment team unprepared, but because it signalled a general trend whereby the average age of onset of eating disorders was seen to becoming lower and lower. Professionals saw this as the effect of the damaging messages of mass media – to which children were increasingly exposed to by having access to mobile phones, laptops and other internet devices at an ‘inappropriately young age’ – on an even more worrying ‘deep distress and suffering’.

The whole treatment team agreed that the presence of so many children in the residential facility forced everyone to adapt to ‘a very different kind of patient’. A second weekly planner of parallel daily activities – called ‘*Planner Piccole*’ (Little ones Planner) – had to be put together by the Coordinator. This was not an easy task, because it required one of the already few professionals on each shift to take time out of other pressing tasks to organise and lead the activities dedicated to children – with the complication that most professionals had rarely worked with children before. In the past, the one occasional patient who was considered too young to participate in some group activities would be entrusted to the care of a social worker and would play some board games during those hours. But with seven patients of the same age, this was not manageable or acceptable, the Clinical Director insisted: if the treatment facility kept admitting children, it had to provide structured therapeutic activities that were tailored to their age. Interns and volunteers were all mobilized as precious resources to make this possible. As will become clear, this was far from being the greatest challenge that children posed to the treatment team.

We saw earlier how ‘infantilisation techniques’ are deliberately used by professionals to impose treatment practices that patients would otherwise refuse, but also to give back to patients the ‘proper childhood’ they seemingly lacked when they were children (Chapters 2 and 4). Professionals argue that awareness, motivation and a push towards autonomy are supposed to gradually replace this period of infantilisation (Chapter 3). Against this conceptual background, we look here at what happens in treatment when patients *are* children (10 to 12 years old), and at how professionals find themselves having to adapt treatment practices to what are seen to be the specificities of ‘preadolescent’ patients. I first situate how eating disorders in childhood are constructed by the clinical community as a worrying issue in treatment centres across Italy. I then zoom in on how those who work in the residential facility deal with this problem in practice. Focusing on two cases, I suggest that preadolescents with eating disorders are more difficult to treat than adolescents and adults because they fail to undergo the desired steps deemed essential for therapeutic

transformation, putting into question the very paradigm of care of the treatment centre. I suggested in Chapter 4 how the family and family care are constructed by professionals as a potentially fundamental resource in treatment; here I look at how the family is seen as the context and the very source of these children's conditions, while remaining the often-unchanged fundamental network of relationships into which children will inevitably have to return after treatment discharge.

Eating disorders in children?

The child doesn't eat for herself, but for her mother: that the child eats is something that tests the caring abilities of the mother.

Paediatrician, annual national conference on eating disorders, May 2019

Eating disorders have historically been mostly associated with adolescents and young adults – with what the psy disciplines define as a 'developmental age' and the profound changes and associated difficulties that this stage of life is seen to entail³. Until a couple of decades ago, children or 'preadolescents' were not in the purview of professionals researching and treating eating disorders (Bryant-Waugh and Lask 1995). It was only in the 2000s that cases of patients as young as 8 to 12 years old started to be reported in Italy and elsewhere (Ammaniti et al. 2008; Rosen 2010). Still, until a few years ago, these cases were considered rare. In 2018-2019 – while I was conducting fieldwork – 'eating disorders in childhood' had started to be considered a hot topic for researchers, and the Clinical Director was planning to publish a book about this 'emerging phenomenon'.

In May 2019, I flew to Sicily to attend the annual conference organised by a national scientific organisation that gathers researchers and clinicians specialising in eating disorders from all over the country. The common framework of most presentations was the lack of resources invested by the State to allow public facilities to treat eating disorders

³ Many cultural worlds have intermediate states between what could be classified as 'childhood' and adulthood – loosely demarcated by changes in responsibilities and rites of passage that point to the potential dangerousness of such a liminal phase (Lancy 2014). However, a medicalised notion of 'adolescence' as a demarcated and problematic life stage emerged as a peculiarly European and North American concept in the twentieth century (e.g., Mead 1928) and subsequently became a 'worldwide phenomenon' through biomedical and broader 'globalisation' (Montgomery 2008:15).

appropriately. One of the aspects felt to be particularly lacking was training for the appropriate treatment of ‘eating disorders in childhood’. In fact, one afternoon was entirely dedicated to ‘the increasing phenomenon’ of ‘preadolescents’ diagnosed with anorexia, and to the specific difficulties they posed for treatment services. Specialists working in different treatment centres across the country reported an increasing number of patients under 12 in the last three years, and shared some key observations: a) that the ‘psychological mechanisms’ underlying the eating disorder in preadolescents differ from those found in adolescents and adults; b) that preadolescents – unlike older patients – have a ‘physiological breakdown point’ whereby from a state of malnutrition they can suddenly shift to an acute situation that requires emergency life-saving treatment; c) that the most plausible cause of eating disorders in preadolescents is something gone awry in the process of ‘building a healthy attachment’ to the parents, especially the mother; d) that, also for this reason, ‘specific mechanisms of transference and counter-transference’ get activated between patients and professionals – which makes it more difficult to balance between ‘fully taking care’ of the patient and the patient subsequently having to gradually ‘detach’ from the treatment milieu; and e) that notwithstanding these complications, if treated in a timely fashion the outcomes of treatment for the youngest patients are actually reassuring, indicating that patients can ‘fully recover’. In the next section, we see how professionals who work at *Il Giardino* deal with these aspects in practice, by tracing how these facts are ‘done’ (cf. Mol 2002): we will see how working assumptions, reported as ‘facts’, effectively gain further factuality through their practice by patients, their parents and professionals in the residential facility.

The way in which both the conference attendees and staff at *Il Giardino* talked of treatment for these younger patients points to a world in which a distinct category of ‘children’ is important⁴: children are ‘a different kind of patient’ which requires ‘specific training’ on the part of professionals, and ‘tailored therapeutic approaches’. The chapter will suggest how the encounter between professionals and these younger patients also points to a series of interrelated assumptions about what characterizes childhood, and about what a ‘healthy childhood’ should look like.

In his work on the development of psychological techniques in Europe, Nikolas Rose (1990) also looks at how childhood became, starting in the 1950s, the most intensely governed of life periods. Rose claims that the introduction of children’s rights was initiated

⁴See Chapter 4, note 7.

both as a recognition of the child as a young citizen, and as a means of making children an object of government through expertise. The site for this new government was primarily the family, within which the role of the mother was to make sure that the ‘psychological well-being’ of the child was achieved. This was seen to be possible by creating a fulfilling ‘bonded relationship’, along the lines espoused by the English paediatrician and psychoanalyst Winnicott (1957,1965) and the British psychologist and psychiatrist Bowlby (1956, 1999 [1969], 1988). Rose argues that a link was thus established between the development of academic psychology and adult-child interactions in the home, with techniques of experts infiltrating the domestic sphere: the family became both responsible and autonomous, and yet always open to State intervention if its ‘products’ were deviant. Rose’s Foucauldian reading of this development will appear an obvious frame of reference for the material I present. Here again, however, I want to suggest that biopower and biopolitics are not enough to provide a full account of what is going on in the treatment of children in this facility.

‘How do you treat patients who don’t speak?’: Arianna and Sofia

Of the seven ‘preadolescents’ attending the group session in the opening of this chapter, Arianna had been the first one to be admitted to *Il Gardino*. On the day of her admission, she looked emaciated, and her gaze looked distant and scared. This was no wonder, professionals were quick to comment: she was hardly eating at the time, and yet had kept going to school and doing things as usual until the week before, when she had been admitted to the children’s ward of a nearby hospital because her weight had been declared dangerously low. Her Body Mass Index on admission was 11, a degree of ‘underweight’ that nutritionists reported as ‘unclassifiable’ on the growth curve that those working with children use as a reference point. The arrival of Arianna had therefore generated considerable anxiety in the treatment team, but also interest and affection towards what was perceived to be a particularly fragile and ‘cute’ patient.

Arianna’s official diagnosis on admission was ‘avoidant/restrictive food intake disorder’ (ARFID)⁵, but her nutritionist Monica reported ‘smelling anorexic traits’ from the beginning.

⁵ Avoidant/restrictive food intake disorder (ARFID) is a condition defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM V) as ‘avoidance’ of certain foods or types of food and/or ‘intake restriction’ in terms of overall amount eaten. ARFID is typically associated with children, and is distinguished from anorexia and bulimia nervosa in that ‘beliefs’ and ‘worries’ about weight and shape do not seem to contribute to the avoidance or restriction of food (American Psychiatric Association 2013).

It soon became clear that the treatment team would have a hard time working with her. Arianna was felt to take an ‘excruciatingly long time’ (nutritionist Monica) to finish the very little food she was given, and often refused to finish it – with professionals having to make up for the ‘lost calories’⁶ by giving her ‘nutritional supplements’ to drink. To complicate things, during both nutritional therapy and individual sessions with her nutritionist and her psychologist, Arianna barely spoke or answered questions – and when she did, she used monosyllables or movement of her head to say ‘yes’ and ‘no’.

For Fernanda, a young psychologist who had been working in the treatment centre for only one year, this was the first time she was assigned a patient this young. She would often report her worries about the fact that Arianna would not talk to her, wondering whether her inexperience was the issue: she wished she had received specific training to work with children, because she felt that it was ‘totally different’. What Fernanda found most frustrating and difficult was Arianna’s ‘lack of introspection’: ‘There is no awareness of what happens inside her...so I struggle a lot. I have to come up with alternative ways. If I ask an adolescent to tell me how the past week went, she brings to me many things that we can discuss. If I ask the same of a 10-year-old, she answers: “I don’t know”. So what?’. Fernanda eventually started reading stories, painting and drawing ‘as a way to access Arianna’s world’: ‘Now we are reading a book about emotions, with drawings that you can complete by using different colours, depending on what emotion you feel in that moment: red is for angry, purple is for scared, yellow is for happy...we start from that and then I ask her why she feels that way. But it’s difficult’.

It is worth noting the assumption here of an internal world of which the patient needs to be ‘aware’ and work on for recovery⁷. In Fernanda’s experience, working with children is much more tiring and frustrating than working with older and ‘more collaborative’ patients⁸. In fact, treatment with Arianna proceeded particularly slowly, the team felt. Her nutritionist Monica often found herself having to defend her slowed-down approach before other

⁶ For more on the measure of ‘calorie’, see Chapters 2 and 3.

⁷ See Chapter 3.

⁸ The fact that therapists have to employ different tools to ‘access children’s internal worlds’ – drawing, playing, telling stories – is not unique to the treatment of eating disorders, as the reader might guess, but also holds for other conditions seen to pertain to ‘mental health’. However, in the case of eating disorders professionals have received no specific training to work with children, and there is still very little clinical literature to which they can refer. Treatment for other children’s conditions is usually at the outpatient level, too, except for ‘acute’ episodes briefly treated in hospital wards. At *Il Giardino*, children may stay in the residential facility for months.

professionals, who thought that Arianna had to be pushed more and given more food because she was not gaining enough weight. Monica indeed said she had to increase the amount of food given to Arianna in an exceptionally slow way, by 5 grams every two weeks: 'I have never done this so slowly, but you have to consider that she started from eating 10 grams of pasta!'.

After six months in treatment, Arianna had gained five kilograms and two centimetres in height, reaching a BMI of 14. She had started going back to school in the morning and looked livelier and more playful. Arianna had also learned – Monica and Fernanda proudly reported in one of the last staff meetings before her discharge – to 'recognise that her stomach-ache, which she had always reported as the cause of being unable to eat, has to do with her emotions'. However, Arianna's weight was still considered well below a healthy weight. Nevertheless, she had become increasingly oppositional and refused any increase in her meal plan, displaying worries about 'growing up' and 'getting fat' but refusing to speak during her therapy sessions. In the meantime, professionals were growing more and more concerned about her health and 'potentially irreparably stunted growth'.

During the days of negotiations about her meal plan, Arianna was caught walking on the ledge of the building between her bedroom's window and the window of the dining room. Since she could easily have slipped and fallen from a second-floor height, the treatment team decided to discharge her: Arianna had 'crossed the line', and the team did not want to risk being held responsible if something similar happened again, resulting in Arianna hurting herself or worse. Following that incident, Arianna continued her treatment path as an outpatient.

When Arianna left, the other six young patients were saddened by the decision, as they had become a close-knit group. One patient in particular – Sofia – felt deprived of her companion. Sofia, 11 years old, had been admitted a few weeks after Arianna. At that time, she was already being treated as an outpatient by Monica, who had initially thought Sofia was a case of ARFID, but quickly changed the diagnosis to that of anorexia nervosa. Sofia's parents had in fact reported that she had started reducing her portions of food and had stopped eating her snack at school altogether. Then, at a following outpatient session, Sofia brought a question to Monica, written on a piece of paper: 'How do thighs get fat?'. This was when Monica had changed Sofia's diagnosis into that of anorexia nervosa: 'It turned out that Sofia was convinced that second courses, fruit and vegetables make you fat, so she did all she could to

avoid them'. At that point, Sofia was assigned to a psychotherapist who would see her on alternative weeks. However, with her physical condition worsening and her parents becoming increasingly worried, she was soon admitted to the residential facility. Like Arianna when she first arrived, Sofia looked emaciated, and her gaze was defined 'empty' – probably a consequence of malnutrition, the team said. Sofia stubbornly refused food, especially meat, vegetables and fruit. Even more evidently than Arianna – who after a while had started being quite talkative – Sofia refused to speak to her therapists. Her ways of communicating amounted to a gentle shake of her head to say 'no', and an almost imperceptible shrug to say 'I don't know'. This did not change with time as it had changed with Arianna; more precisely, it did not change with regards to professionals. With other patients, Sofia would talk. The rare times Sofia would speak during her individual sessions – her therapist reported – she would just talk about her fear of 'getting fat', which made Monica and Tessa feel increasingly 'helpless'. This situation of perceived impasse made the two professionals request Sofia's case be reviewed⁹ during the monthly supervision meeting that the treatment team routinely attended with an external, experienced psychotherapist. Things did not change much, and in May, after almost five months of residential treatment and with Sofia having regained some weight, Monica and Tessa eventually decided to discharge her and keep treating her as an outpatient.

During that supervision meeting, the key challenges of treating preadolescents emerged: Monica pointed out that the treatment team had to come to terms with the fact that these patients worked in different ways from those they were used to:

Preadolescent patients are not aware of their illness, and they are not motivated at all to recover from it. Telling them that if they don't eat we send them home doesn't work, because they can't wait to go home! They have been brought here by their parents totally against their will. The only thing that might work is telling them that if they don't eat, they end up in hospital.

⁹ In the world of the treatment centre, people and their stories become 'cases'. The upcoming discussion of Sofia's 'case' during the supervision meeting differed from the 'medical cases' described by Good (1993): in the distinct world of 'mental health', information and details about the patient's history, disregarded as irrelevant by a physician treating what is seen as a bodily disease, become the very object of interest for the clinical gaze.

Challenging the assumptions of treatment

‘Awareness’ of being ill and in need of help, a subsequent ‘will to abandon the eating disorder’ and ‘responsibility for ones’ own treatment’ – demonstrated by ‘active effort’ and ‘collaboration’ with professionals – are all seen as essential to treatment, as we have seen in Chapter 3. But preadolescent patients seem to lack all this. With such young patients more than with others, treatment is something that professionals ‘make them undergo’ (Clinical Director). The fact that ‘patients are still growing’ makes it also more urgent for the treatment team to act when they keep losing weight or do not gain enough weight, ‘because the damage done in this life stage in terms of bone density and loss of height can become permanent’ (endocrinologist). On the other hand, Monica often insisted that, with the youngest patients, it was fundamental to ‘proceed very gradually and without insisting too much. Otherwise, the result might be that they start refusing everything’.

Here different sciences – medical sciences on the one hand, and nutrition and psychology on the other – are vying for attention, and can send conflicting messages. Such dynamics were particularly visible during weekly staff meetings: the medical doctor would typically complain that patients were not gaining enough weight ‘to be safe’, and that their planned meals should be increased, whereas nutritionists and psychologists would make strong cases for proceeding slowly. Contrary to what one might expect given customary professional hierarchies in these sciences, it was mostly nutritionists and psychologists who eventually decided the course of treatment, on the grounds that doctors only ‘looked at numbers’ and were not the ones who spent time with patients, had sessions with them or had to make them eat every day: ‘We are the ones who know how it works in practice, in the therapy room, and it is much more difficult than the doctors make it sound’ (nutritionist Monica). As we have seen in Chapters 2 and 3, in this clinical world the numbers of calories, weight, BMI, growth curves, blood tests and so on are ‘trusted’ (Porter 1995) and construct realities that might counteract patients’ ‘distorted ones’ and redirect them towards recovery. However, here one can see how some professionals can use these numbers contextually as a frame of distrust, precisely because of what they omit.

What is the aim of treatment with these young patients – one might then wonder – besides ‘restoring a healthy weight’? Helping them to become ‘autonomous and responsible’ – which, as noted in Chapter 3, seems to be the mantra for adolescent and adult patients – does not apply well to preadolescents. When I posed this question to the psychologist Carlotta, she

told me that the aim was to reduce ‘the strong sense of omnipotence that these children have developed in response to a situation in which their primary needs have not been listened to by their parents – as if: since none of my needs is satisfied, I take control of everything’. I asked how such an aim could be achieved. Carlotta explained that ideally treatment should proceed ‘by working on their sense of frustration for their unmet needs’. ‘The aim’, she continued, ‘is to make that emotion tolerable, by giving them other instruments, different from the symptoms, to deal with it.’. Carlotta’s words seem to locate the source of the problem in children’s families – in parents’ inability to meet their children’s needs. In the following section, we will see how the particularly difficult traits of preadolescent patients tend to be ascribed to their growing up in ‘dysfunctional families’ – with the word ‘dysfunctional’ having both the literal meaning of ‘families that do not function (properly)’, and the more field-specific meaning of ‘encouraging unhealthy thoughts and behaviours regarding food, eating and body shape’ (Clinical Director).

Dysfunctional families

These are all daughters of the wind.

External psychotherapist, Supervision meeting, March 2019

In her ethnography of a children’s clinic for chronic pain in the US, Buchbinder (2015) notes that it is important to distinguish between what are seen as the causes of chronic pain and the factors that interfere with recovery. She argues that regardless of whether a biological cause could be identified, the treatment team believed that many families did things, however unwittingly, that perpetuated or exacerbated their children’s symptoms (ibid.:135).

Buchbinder suggests that whereas in ‘onstage clinical spaces’ professionals’ explanatory model attributed pain to a flaw in the patient’s ‘neurobiological wiring’ – laying the groundwork for a therapeutic approach that emphasized individual responsibility – in ‘backstage clinical spaces’ such as team meetings, another prevailing explanation circulated that targeted the family as a site of blame and intervention, and conceptualised children as ‘vessels of their families’ traumas’ (ibid:111,112.). Whereas a flaw in neurobiological mechanisms was seen by clinicians as what Buchbinder calls the ‘proximal cause’ of chronic pain, problematic families were seen as the ‘distal cause’ (ibid.).

This complex network of explanations challenges the notion of a singular, autonomous patient that has long been prevalent in North American and European biomedical settings, and illustrates how treatment is aimed not only at managing chronic pain, but also at defining what constitutes ‘good parenting’ and a ‘good family’ (ibid.:112). Buchbinder ultimately argues that paediatric pain treatment is a matter of ‘making patients’, but also ‘making parents’, following specific cultural views of adolescent development, family roles, and desirable parenting. Throughout this process, kin relationships and caregiving patterns become targets of clinical judgment and change (ibid.:113). In her ethnography of psychiatric care for women in India, Pinto (2014) has also illustrated that clinical ethics are tied to kin ethics, with clinical rationality deployed to crafting more ideal families. As we have seen in Chapter 4, at *Il Giardino* parental behaviour also becomes implicated in patient’s treatment, as part of a larger project of ‘treating the family’. ‘On stage’ – during individual and group meetings for parents – families are never explicitly blamed but effectively constructed as a fundamental resource in treatment to secure their collaboration. ‘Backstage’, however – during weekly staff meetings, monthly supervision meetings, and daily chats in the protected space of the kitchen – professionals explicitly put the blame for patients’ conditions on their ‘messed up families’.

Buchbinder (2015:38) also reports that, at the pain clinic, the parents of younger children were depicted by clinicians as overprotective, whereas with older adolescents, parents’ inattentiveness and precocious ‘adultification’ was more commonly the case. Instead, at *Il Giardino*, whereas one could find both situations in adolescent and adult patients (see Chapter 4), most younger children appeared to live in families in which lack of care was seen to be the defining feature. If we return to the cases of Arianna and Sofia, we will see how their eating disorder and the ‘special’ character traits that make their treatment particularly difficult are put down to these children’s families being ‘dysfunctional’ in several ways, and mostly to their parents failing to meet the expected parenting role.

Arianna’s family was the object of many weekly staff meetings and discussions during mealtime breaks in the kitchen. Through regular sessions and phone conversations with Arianna’s parents, her nutritionist Monica, her psychologist Fernanda, and her assigned family counsellor Sara had put together a rather worrying picture of Arianna’s home environment, completing Arianna’s fragmentary descriptions. The first thing that had struck Arianna’s therapists was that she never referred to ‘my home’ or ‘our home’, but always to ‘grandma’s home’, ‘mum’s home’, and so on. She had also drawn her house with wheels,

which was read as a clear sign of a perceived ‘instability’. When Arianna was asked to make a drawing of a typical family meal and describe it, it came out that she would usually eat ‘some stuff’ – not further specified – at her grandmother’s house, either sitting alone at the kitchen table, or in front of the TV. Her grandmother and occasionally her mother would eat in the house too, but often at different times and standing in the kitchen. Her father, instead, would mostly eat out in restaurants. Upon further investigation with Arianna’s parents, her therapists reported that the whole family had ‘dysfunctional behaviours’ towards food and eating: Arianna’s mother ‘would never cook’ and seemed not to know how to cook, so when she had to provide food for Arianna she would buy a take away in a trusted rotisserie in the neighbourhood; Arianna’s father would never eat pasta, and would weigh himself every morning to make sure his weight was always in the same 300gr range. Even Arianna’s grandfather seemed to be ‘exceptionally worried’ about food, and prevented himself and all his family members in his presence from eating any kind of ice cream other than ice lollies, which he considered healthier because they were just ‘water and sugar’. All these ‘weird behaviours towards food’ – Arianna’s therapists held – made it difficult for Arianna to have a clear idea of what ‘normal eating’ meant, since she lacked appropriate reference points; they were also seen as dangerous predictors for the development of ‘a full-blown anorexia’ later in her adolescence. Therapists felt that Arianna’s current obsession with the quantity of her ‘portions’ was therefore also a way to ask for reference points that her own parents had failed to give her. Arianna’s nutritionist and psychotherapist kept insisting with Arianna’s parents that it was important for Arianna to have meals in their home during weekends, just the three of them sitting at a table and eating something that Arianna’s mother would cook specifically for the occasion – suggesting quite strongly their normative reference point for an ideal family¹⁰.

The lack of attention to Arianna’s eating patterns on the part of her parents – and to her in general, professionals held – were so stark that nobody at home had noticed her substantial weight loss. It was Arianna’s grandmother who eventually noticed and brought it to the attention of the parents. The treatment team found this ‘astonishing’, even more so because

¹⁰ The reader might note that there seems to be much consensus within the treatment team on what a ‘healthy family’ should look like. This might partly have to do with the similar social background of professionals working at *Il Giardino*. Most of them are from the same Region in central Italy, whose inhabitants are renowned for their ‘traditional views’.

both Arianna's parents were medical professionals. Similarly, reconstructing Arianna's eating patterns since infancy had proved 'absurdly impossible'.

Another aspect of Arianna that worried her therapists was her 'relational difficulty', especially in establishing friendships with children of her own age: 'She hardly has any relationship with other children, other than a female cousin. Which is pretty much the same for her parents: they don't seem to have friends' (nutritionist Monica). The treatment team had soon recommended Arianna's parents to undergo psychotherapy themselves, but they proved very resistant:

They would really need that, because they are completely unable to draw boundaries for Arianna. Her mother reports that she never says 'no' to Arianna because Arianna doesn't listen to her, but it seems to me that it is more because she gets scared at Arianna's tantrums. Her father equally says that if they fight, Arianna always wins. The result is that Arianna has no coordinates whatsoever: she doesn't know what is right, what is wrong, how much is too much, how much is too little...she is so confused!

Monica kept explaining that she had to take Arianna around the city one afternoon to ask random people on the street roughly how many grams of pasta they ate for their meals, because Arianna was convinced that eating 20 grams was 'normal': 'You should have seen her face when someone told her 150!'. Professionals had come to the conclusion that the situation of Arianna's family was 'dysfunctional both in relational terms and as regards attitudes towards food' – and that until her parents realised that and did some work on themselves to change, it would be very difficult for Arianna to really get better.

On the other hand, Sofia's family was not only at the centre of weekly staff meetings and informal discussions over lunch breaks in the kitchen, but also became the topic of the monthly supervision meeting. Each month, a 'particularly difficult case' was chosen among the admitted patients. An experienced psychotherapist who would otherwise work somewhere else would listen to the 'presentation of the case' by the treatment team, and help them 'see what they could not see' due to their daily involvement with the patient in question – confirming that the clinical detachment deemed to be fundamental in the clinic was not always easy to maintain.

Sofia's case had been chosen because her therapists 'did not know what to do with her', and were growing increasingly frustrated at the fact that Sofia seemed to have nothing to tell them, or if she did, she would not tell them:

I feel powerless...because when you try to go in depth with her, it feels like you are standing in front of a black painting. She is completely empty and alone in her fears, she doesn't have an identity. She doesn't interact with anything. Even the other patients she seems to have bonded with, you realise she actually cares very little about them (psychotherapist Tessa).

When the external psychotherapist asked about the history of the child, and about what might have precipitated her anorexia, Sofia's nutritionist, Monica, reported what she had been told by Sofia's mother: Sofia – second child of four – had been breastfed 'for only twenty-four days' because her mother suddenly had to receive surgery for appendicitis. Sofia's weaning had proceeded 'normally' although she had always refused fruit and vegetables¹¹. When she was very young, she had developed a severe allergic reaction after eating some hazelnuts, with her throat swelling and preventing her from breathing. She had also suffered from asthma and tonsillitis. These were all seen as potential risk factors. Starting from 2017, she had become increasingly selective with food. In the same year, her paternal uncle, to whom Sofia was very attached, had died of cancer. This sudden and early death was considered a highly possible 'precipitating factor'. Another likely precipitating factor was located in the beginning of marital problems between Sofia's parents, around the same time. Moreover, during one of the meetings with the family counsellor, Sofia's mother had revealed that she had never told anyone that she herself had suffered from anorexia when she was 16, but that 'nobody had noticed' and the problem 'had gone away naturally' once she moved to university – something that the treatment team struggled to believe. Even more interestingly for professionals, Sofia's mother had reported that during the time she was ill, she had also virtually stopped talking – what professionals saw as a striking similarity with Sofia's symptoms: 'It's as if Sofia's mother is unconsciously using her daughter to express the unsaid parts of herself' (psychotherapist Tessa).

What the treatment team found particularly worrying in Sofia – besides her refusal to eat and talk to them – was her 'absolute incapacity to choose' and 'do anything on her own': 'She gets paralysed when she has to choose something: for example, the kitten she was given for Christmas, it still doesn't have a name because she can't choose one. And it's the same with her favourite colour, places she likes, where she wants to go...she always imitates others.' Professionals related this 'problematic trait' to growing up with 'highly problematic

¹¹ Psychotherapists would often remark on the importance of looking at what happened during the weaning process of the child, and of exploring whether something had happened during that phase that might have affected the patient's current eating disordered behaviour.

and immature parents’ – notwithstanding the fact that they had both graduated from university and were economically well off. Sofia’s father was portrayed by the family counsellor as being ‘very individualistic and not very present in the family’, and as incapable of facing problems; at one point, his worries and anxiety about Sofia reportedly caused him to be admitted to hospital for heart issues. This, coupled with the fact that Sofia’s mother had revealed that she had herself suffered from anorexia only one year after Sofia had been in treatment, made professionals suggest that Sofia’s parents had an issue with ‘facing reality’ and talking about it: ‘We always end up knowing these important things late, and through indirect ways. Which is the same dynamic that Sofia has with us’ (psychotherapist Tessa). More than this, when Sofia was admitted, neither of her parents brought along the life-saving adrenaline doses that professionals soon found out (by reading her clinical record) that Sofia always needed to have ready, in case she mistakenly ingested hazelnuts. Sofia’s parents – who had been living in her mother’s parents’ house for a long time – were ultimately characterised as ‘living their life as kids rather than parents’. Sofia’s parents were deemed by the external psychotherapist as ‘unable to self-determine as parents: they seem more like older brothers, judging from how they behave with their children’.

Patients’ families were, in summary, seen by professionals as examples of a more widespread fracturing of families in contemporary Italy, as remarked by the external psychotherapist:

To me it seems like we are trying to draw the contemporary family here, and the figures don’t add up. What are the prerequisites to create a family? The eating disorder is the symptom of a fragile family – you have to make the family understand how they have conceived and understood the creation of their family. To me it feels like these little girls are not daughters who have been desired and imagined; they are more like bio-objects – bodies that simply need to function. And the problem is not that their parents are distracted by other things and don’t want to care for their children; the problem is that these parents have fallen into a black hole themselves. It’s not by chance that these little girls are trying to recreate a second family here. What you are doing here is quite heroic – but the problem is where you send them back to.

Parents are therefore not simply seen as guilty: they are seen as victims as well, and thus incapable of acting differently unless they themselves decide to undergo some psychotherapeutic work. The external psychotherapist was adamant that to really understand ‘what is happening to these children’, it was necessary to go back to their great grandparents’ generation and investigate the stories of the relationships between the generations. Complicating taken-for-granted notions of mother-child ‘attachment’ and ‘bonding’, she seemed to be saying that parents cannot be nurturing if they have not been nurtured

themselves. These might not be the ‘conditions of extreme scarcity’ that Scheper Hughes (1987:149) refers to when she questions the usefulness of decontextualized terms such as ‘bonding’ in field sites like Brazilian shantytowns, but the psychotherapist here seems to classify the conditions of these families as conditions of extreme ‘psychological’ and ‘emotional’, if not material, scarcity:

We are born inasmuch as we are conceived in the head of those who want us. Our internal world is born from the internal world of our parents. Therefore, it’s important to understand what these pregnancies generated in Sofia’s mother. What are they the result of, the desire of?

In the world of this treatment facility, people have ‘internal worlds’ that are inevitably interconnected with those of their kin, and that are directly affected by those of their ancestors: Sofia did not know that her mother had suffered from anorexia and had stopped talking when she was 16 – and yet, the external psychotherapist argued, her ‘internal world’ knew, because ‘psychological life is passed on through generations’.

A failure of kinship?

The psychotherapist’s argument above strongly resonates with a point made by Janet Carsten (2019:146), who sees kinship as providing ‘an imaginative realm for thinking, partly in ethical terms, but also more speculatively, about who we are, and how we might be in the future; about our connections in the present as well as to past generations, and to the unborn’. Here what the psychotherapist calls ‘psychological life’ – the internal word that people supposedly have within themselves – becomes the ‘substance’ that makes the temporality of kinship ‘more immediate and thinkable’ (ibid.). Professionals’ discussion of Sofia’s ‘empty internal world’ as the consequence of the absence of proper kinship ties – and of what kinship ties should ideally pass on – is exemplary of Carsten’s argument that ‘when time is erased and memory occluded, many people find themselves in danger of losing not only their connections to the past, but also their sense of who they are in the present, and the possibility of creating kinship in the future’ (Carsten 2019:148). It is in this sense that kinship is conceived by Carsten as allowing relatedness to be imagined as ‘a special mode of travel, a way to engineer secure social landscapes and reliable histories’ (Shryock 2013:78, cited in Carsten 2019:143). When kinship fails – the external psychotherapist seems to be saying –

what should have been secure social landscapes and reliable histories fall apart, generating illness.

On a similar note, in her ethnography of child welfare institutions in Japan, Goldfarb (2019) suggests how children's bodies – their smaller body size, their inability to chew, improper chopstick use, left-handedness – are seen by social workers as carrying the signs of the absence of kinship care. She thus argues for a model of 'embodied relationality' that calls attention to the ways in which relatedness itself turns into biological materiality (ibid.:155). The ways children in Japanese State care engage with their bodies – particularly at mealtimes – tells caregivers about a child's former caregivers (ibid.:159). The staff view food practices as central to the institution's goal to produce a kin-like network for children, and to re-socialize the children as 'normal' members of Japanese society (ibid.:161). Here, the child's body is very much an 'embedded body' – 'heavily impregnated by its own past and by the social and material environment within which it dwells' (Niewöhner 2011:290). In the world of those I have been studying, such interpersonal histories are similarly seen to produce visible effects in patients' bodies, but through an additional intermediate step which is seen to be located in 'the mind': here there is a 'mind' distinct from and at the same time clearly entangled with 'the body'. If we take the 'embedded body' seriously as a language of analysis, then this mind-body is the body that patients have *acquired* in their relational worlds (see McDonald 2014, 2018). The relationality that professionals privilege are relations of kinship, especially of the close kin that are 'the family', for which they have examples of apparent dysfunction in their young patients.

In both Arianna's and Sofia's cases, their emaciated bodies – the corporeal aspect here of their ill minds – are seen as the result of the lack of proper family care, of what we might call relatedness. In summary, we can say that we acquire particular bodies in relational worlds, an important aspect of which here is acquiring particular forms of relatedness. It is also through relatedness that successful autonomy is seen to be acquired. It is worth noting how the body becomes privileged in this model of the person and family that professionals are working with. Here we have relational persons with bodies and minds: the mind is internal and is deep down and finds expression through the corporeal body. It is also worth noting how a specific notion of the autonomous individual holds in this treatment centre, perhaps surprisingly to some since we are in Italy, which is commonly seen as the bearer of an exceptionally strong family ethos (cf. Ghezzi 2012; Saraceno 2004,2015). In this centre, instead, professionals can talk of relational issues and uphold an ideal of autonomous individual at the same time. As

we have seen in the previous chapter, ‘healthy’ relatedness brings about autonomy, that is the ideal here. Moreover, it seems that there are different models of autonomy based on different classes of patients depending on age. Arianna’s and Sofia’s cases seem to suggest that a form of ‘internal autonomy’ is supposed to develop in children before ‘practical autonomy’ can be achieved.

Complicating clinical detachment

It is boundaries that nurture the child.

Philosophical counsellor, seminar for parents, December 2018

As we have seen for older patients in the previous chapter, professionals seem to agree that the children admitted for treatment need urgent ‘reparenting’ – to make up for the lacks and absences they experienced at home. We have seen that, as in Goldfarb’s (2019) ethnography, teaching them how to eat is central to this reparenting process. However, with these young patients there is more going on: ‘reparenting patients’ does not seem to be simply a temporary phase of treatment in these cases, as we have seen happening with older patients; preadolescent patients will still be the children of their ‘absent families’ once discharged¹². In her work on Amazonian kinship, Vilaça (2002) argues that ‘kinning’ is a process whereby parents turn their babies into ‘humans out of others’, i.e., out of a less specified spiritual and especially animal world. Parents have to create boundaries between their babies and the animal world. At il *Giardino*, professionals try to ‘de-kin’ and then ‘re-kin’ patients by similarly constructing the supposedly necessary ‘boundaries’ between these children and others – which in this case are not animals, but their own kin. However, the other side of the

¹² It is important to note here that the kind of ‘lack of care’ seen as negatively impacting these children’s life is rarely enough to take the children away from their families and put them in foster care. Professionals do sometimes conclude that the children would be better off if removed from their families, but they seldom have the ‘right kind of evidence’ needed for that. In most cases, the ‘bad parenting’ that is seen as causing the children’s problems consists of aspects that are felt to be quite widespread in families, and not prosecuted by law (e.g., ‘unhealthy’ attitudes towards food; family dynamics that only reward control and discipline, or inversely total lack of rules; marital problems; not enough time to spend with their children because of work). The case of Arianna (whereby her parents did not notice her weight loss until it reached a critical stage) was quite extreme, and the fact that her parents were ‘respectable medical professionals’ in the Region made it impossible for the treatment team to even think about removal action. The only instances in which professionals would contact social services to question the suitability of patients’ parents and act so that patients could be removed from their families were cases in which there was suspect or proven physical and/or sexual abuse in the family.

problem is that a ‘substance’ that should ideally flow between parents and children’s boundaries – that is, kinship care and the ‘internal world’ of the family that comes with it through generations – fails to flow and to be passed on, generating illness and suggesting how such relatedness is seen as fundamental to health. In this situation of absence of kinship care – whether in the absence of boundaries, or of relatedness flowing through those boundaries – professionals have to make up for it.

These children’s perceived ‘weaker boundaries’ seem to make it more difficult for the treatment team to maintain clinical detachment. The boundaries that the professionals have to create and maintain serve in part as a re-kinning process, with them acting as proxies for patients’ family members. Most professionals – especially those who have individual sessions with children – report that they easily feel ‘overinvolved’ with these young patients: that it is hard to stop thinking and worrying about them after their shifts. Preadolescent patients seem to generate an inevitable ‘maternal instinct’ here that makes it more painful and frustrating to treat them, especially when they keep refusing food and talk. The psychologist Mara was among those who spoke of ‘the maternal function that kicks in’ with preadolescent patients, especially for women professionals, which makes it more difficult to ‘keep the boundaries’. This ‘excessive’ sense of protection is often related to the notion of being ‘activated’ by a patient, which the psychologist Fernanda explained as having to do with the notion of ‘countertransference’: with the parts of the professional’s self that the patient touches. When professionals say that a patient ‘activates them’ – something that seems to happen more commonly with children – they refer to a state of hyperarousal, of ‘physiological activation’, that can be ‘healthy because it makes you do things’; but also ‘dysfunctional because it doesn’t help you see things from an external perspective, from above’.

Here we see in a nutshell one key problem of the treatment apparatus as it stands: since one of the main causes contributing to the development of eating disorders is seen to lie in dysfunctional or absent kinship relationships, a therapeutic relationship between therapist and patient is seen as key to recovery. It is believed to be the tool through which patients can learn and experiment with what they could not learn in their family environments – i.e., how to deal with interpersonal relationships effectively once discharged. The problem is seen to lie in the fact that, as Myers (2015) has noted in her ethnography of a mental health clinic in the US, this complicates the dominant mantra of maintaining strict boundaries between patients and professionals. Certainly, this issue is relevant to therapeutic work with any patient in the treatment centre – as we will see in the next chapter. However, I would argue

that it is specifically so with children because the element of ‘fiction’ that professionals can resort to with older patients – i.e., that the reparenting dynamics of treatment are temporary and will gradually lead patients to find their own autonomy, as it is expected for their age – is absent when treating preadolescents.

Conclusion

We have seen in Chapter 3 how treatment practices in the residential and semi-residential facility are based on the assumption that the patient who is being treated has a psychological, internal world that she is aware of, capable of discovering and communicating about with her therapists. It is an internal world that has been relationally constructed – and can be deconstructed through talk. It is also assumed that the aim of treatment – besides weight restoration – is to help patients regain some sort of ‘autonomy’. This aim is based on the idea that part of the reason why patients developed an eating disorder in the first place has to do with their parents being ‘overinvolved’ or ‘enmeshed’, with their offspring thus lacking clear ‘identity boundaries’. Explicitly ‘psychological’ treatment mostly addresses these issues.

In this chapter I have suggested that treating preadolescents with eating disorders puts into question the very paradigm of treatment and its underlying equation between health and autonomy, because children fail to undergo the desired steps deemed essential for therapeutic transformation. These young patients are deemed incapable of expressing their thoughts and feelings with the depth considered necessary for successful therapeutic work. The highly sought-after collaboration between health professionals and patients seems hard to reach when children are seen as lacking a supposedly coherent internal world to be disclosed to professionals during psychological therapy. Similarly, helping patients to regain their autonomy is difficult with children, who by virtue of their age cannot disentangle themselves from their families. This treatment logic thus comes to an impasse with preadolescents, forcing professionals (and anthropologists) to question its basis and look for ‘other ways’ of treating them.

‘Dysfunctional’ family dynamics – most notably characterized as ‘lack of boundaries’ – come to be seen as the main roots of patient’s illness. Well-entrenched family traits and relations are put under scrutiny, ‘dissected’ and analysed as doctors might do with damaged body tissues in a patient with a physical ailment. This process has a further effect on the therapeutic relationship, as professionals find themselves having to ‘reparent’ patients in a

way that is not as clearly temporary as with the older ones. 'Maternal instinct' and 'counter-transferential activation' get in the way of the supposedly necessary clinical detachment. Whereas professional detachment seems to be possible with adolescent and adult patients, with preadolescents clinical boundaries seem to be harder to maintain.

Chapter 6

When ‘things don’t work’: chronicity, comorbidity and the limits of care

*Here there’s a tendency towards death, not life – through a whole set of self-destroying behaviours.
You can feel the spectre of death always looming in the background.*

Psychotherapist Mauro

Introduction

It is a Friday morning in January 2019. I am in a town one hour’s drive away from *Il Giardino*, and I have just managed to reach the hospital wing where, on the sixth floor, I have been told I would find Maia’s ward. She was admitted here a week ago. I am debating whether to take the stairs or the visibly old and shaky lift, when its metallic doors open to reveal Maia and another woman, her mother. ‘Ohhh Giulietta, you found me!’, Maia greets me with her characteristic enthusiasm, while her mother proceeds to introduce herself. Although I have known Maia for more than six months through my research and volunteer activities at the residential facility – where Maia had been staying until she was admitted to hospital – this was the first time I had seen her mother. Maia tells me that they are going ‘to have the mid-morning snack’ at the hospital café, and that I should join them. While we are sitting in the café chatting over a cappuccino, I cannot help but notice the dissonance between the liveliness of that moment and the fact that we are in a hospital because of Maia’s continuous weight loss over the previous weeks, which had put her in a situation deemed to be at ‘immediate risk for life’. The drip for intravenous nutrition that Maia’s arm is attached to, connected to a plastic bag containing some white nutritious substance, is a visible reminder of that. What professionals at *Il Giardino* call ‘the spectre of death’, usually looming in the background, today is patently visible.

Patients diagnosed with anorexia or bulimia are reported to frequently experience severe health complications (Katzman 2005; Mehler, Crews and Weiner 2004). Longitudinal studies have suggested that they have the highest mortality rate of all mental illnesses¹, with a crude mortality rate between 4% and 5% – seen as the result of the physical consequences of malnutrition and of suicide (Crow et al. 2009; Smink, van Hoeken and Hoek 2012). One of the reasons behind this figure, the literature suggests, is that rates of relapse after treatment

¹ See Berkman, Lohr and Bulik 2007; Crisp 2006; Franko and Keel 2006; Herzog and Greenwood 2000.

are very high, and between 10% and 23% of cases develop into ‘chronic conditions’ (Berkman, Lohr and Bulik 2007; Signorini et al. 2007). Given this mortality risk, professionals who work with eating disorders experience patient death during their careers. A multinational study of therapists’ ‘burnout’ (Warren et al. 2013) suggests that high relapse rates and worry about patient survival are amongst the key factors that make these patients ‘challenging’ and ‘emotionally exhausting’ to treat.

Luckily, none of the patients whom I met during fieldwork died during admission (nor afterwards, as far as I know). However, news about the death of ex-patients and of prospective patients did reach the treatment team during my fieldwork. One case concerned a patient who had been in treatment at *Il Giardino* a few years earlier. The Clinical Director happened to receive an email from the patient’s mother during one of the weekly staff meetings. The mother was replying to an invitation to a seminar for parents that would take place before Christmas. In the reply, she had written that her daughter had died of anorexia the previous morning. A glacial silence had filled the room, with most staff visibly distressed, and those who had known the girl almost in tears. On two more occasions, the Clinical Director told the treatment team that a patient who was on the waiting list to be admitted – and was ‘kept on hold’ because of bureaucratic problems with her authorisation – had ‘died while waiting’. She condemned a system that ‘did not work well enough’ and kept ‘failing patients’.

We have seen in previous chapters how treatment aims at deconstructing ‘the eating-disordered part of the patient’s self’, so that it can ‘leave’ the patient. Here I ask: when this is seen to ‘fail’, what are the reasons posited for the failure?² One reason immediately obvious to any observer will be what can be framed as ‘lack of resources’. As mentioned in Chapter 4, the State is seen as the main actor responsible for the numerous patients’ deaths. Long

² In his account of treatment failure for a man’s illness in a village in Papua New Guinea, anthropologist Gilbert Lewis (2000) poses the question of what it means when we say that treatment has failed: what is it that fails, exactly? The answer, he suggests, depends on the different and multiple ways in which the aim of treatment is locally imagined. In his case, the complex healing ritual put together by the whole village can be said to have failed to save the man’s life, but did not fail to make the whole process of being ill and dying meaningful, and thus more bearable, to his kin and the whole village. Lewis points out how the temporality of the illness in question profoundly shapes the way treatment is imagined, organised and enacted: an acute illness may require a sudden and unreflective response, which is not the same as a long-lasting condition. Anxiety about, hope for and belief in treatment test social ties in different ways (ibid.). In an interesting parallel with eating disorder treatment, in Lewis’s field site the man’s illness is framed as an issue of possession by a spirit that is seen as needing to leave the person for recovery to occur – and its persistence, eventually leading to death, as the result of the spirit failing to depart.

waiting lists lead to residential treatment that, most of the time, is felt to be too short and disconnected from the wider network of semi-residential and outpatient care. Professionals working at *Il Giardino* would often complain and worry about the ‘ridiculously short time’ (an average of 12 weeks) they had to treat what were seen as extremely complex conditions, which should – in an ideal world – be addressed with months of continuous treatment and support. These limited time frames are imposed by the ‘authorisation’ that the patient’s Region of residence would grant for treatment in another Region. Since it is the patient’s Region of residence which pays for the treatment, professionals have to routinely plead for at least 12 weeks of treatment, and the necessary extensions (cf. Lester 2009). When discharged from the residential or semi-residential facility, most patients thus go back to their Regions – where outpatient services are often disorganised and lack the specially trained staff. Unless patients have the means to pay for private outpatient treatment, they would probably meet a therapist once a week, or in many cases once every two weeks: this, professionals agree, ‘blows up all the work done here’, often causing what is known in psychiatry as the phenomenon of the ‘revolving door’ – of patients being re-admitted in a cyclical pattern as a consequence of severe relapses. All these problems are in turn ascribed to lack of proper funding for what should be essential healthcare services accessible to anyone regardless of income.

These systemic issues play an important role in what comes to constitute ‘treatment failure’, and have recently been at the forefront of discussions in the national and international press³. Focusing on these factors would be in line with the anthropological scholarship⁴ in which systems of care are characterized as deeply flawed – such that people are structurally unable to care in good ways for each other (Cook and Trundle 2020:179). For eating disorder treatment specifically, anthropological works (Gremillion 2003, Warin 2005, Lester 2019) have examined how these structural problems, coupled with the unintended iatrogenic effects of many treatment settings and with an ascription to patients of some inherent ‘treatment resistance’ by many professionals, all contribute to what is framed as ‘treatment failure’. These works have shown how looking beyond the patient-professional

³ See, for example, Palazzo 2020, Stevens 2020 and Marsh 2021.

⁴ For instance, Han (2012) and Stevenson (2014) have criticized the employment of neoliberal ideologies of autonomy in care contexts; Biehl (2005) and Glenn (2010) have highlighted how care is often entangled with State violence; and Street (2014) and Ticktin (2011) how unequal practices of care are sometimes sustained through political and economic infrastructures.

encounter is helpful to understand why ‘things do not work’. In these accounts, what appears to be required is more resources that would enable the expansion of better-attuned care.

As noted by Cook and Trundle (2020:179), however, this approach risks limiting the possibility to think creatively about care. Similarly, in this chapter I will suggest that something important can be missed when we lose focus on the patient-professional interaction, especially in the cases of patients who, like Maia, receive residential treatment *within* their Region of residence, and therefore are not subject to the same time limits that the healthcare system imposes on others⁵. We will see here how care practices transform over time in unpredictable, complicated, and conflicted ways – how different enactments of care can both nurture and harm over time, unsettle and yet ‘work to ensure the vitality of relational life’ (ibid.:181,182).

This chapter continues along the lines of Chapter 5, as it questions the treatment paradigm but by looking at treatment ‘failure’ in the form of ‘chronicity’⁶. We will see how it is not only ‘preadolescent’ patients who seem to put in question the basics of treatment. Instead, the time of treatment and the time of illness intersect in important ways with the kind of care that is seen as fundamental to patients’ recovery. The temporal dimension of care here becomes salient – care emerges as an action on time which carries with it the hazards of relationality. We will see how, in cases of ‘chronicity’, the desired therapeutic transformation does not happen, and the different constructions of the eating disorder – of patients on the one hand, and of professionals on the other – keep clashing. Once again, relationships of kinship care appear as key to treatment, but also as carrying the risk of producing disastrous effects. By focusing on two cases of so-called ‘chronic’ patients, we will see how time acts on ‘the substances’ that constitute kinship (Carsten 2019). I will explore the different ways in which the treatment team understands and deals with chronicity, and with ‘the spectre of death’ looming behind it. We will see how caring for patients becomes part of professionals’ own self-cultivation, and how this is affected by the fact that patients might never stop

⁵ Or in managed care contexts like the US (cf. Lester 2019).

⁶ ‘Chronicity’ indicates that something, such as pain or an illness, continues for a long time. In medicine, the ‘long time’ is often assumed to be the duration of the patient’s life, which means that the condition in question is seen as ‘incurable’ and only ‘manageable’ to some degree (Smith-Morris 2010). The notion of ‘chronicity’ is thus inevitably bound up with negative connotations, although this is slightly different for conditions such as Diabetes and AIDS, which have shifted from being ‘acute’ and leading to early death, to being ‘chronically’ manageable where there is access to biomedical technologies and pharmacological treatment (see Feudtner 2015; Kendal and Hill 2010).

experiencing such caring work as going against their own self-care practices. Professionals, we will see, have to deal with the limits of their own care.

As noted by anthropologists Carrol and colleagues (2017:6), what is usually concealed when things work smoothly is made visible when things ‘fail’. At *Il Giardino*, the reasons professionals posit for ‘failure’ do not simply relate to wider structural impossibilities of doing good (as in Lester 2019), but also put into question two of the pillars that constitute the very logic of their treatment model: family-based care and framing the eating disorder as a part of the patient’s self that can be dispensed with. Carrol and colleagues (2017:2) also point out the temporal and moral aspect of failure, framing it as ‘a moment of breakage between the reality of the present and the anticipated future’ which carries moral gravity because what should be the case has not happened (ibid). Following them, I do not talk of ‘failure’ here as if accusing professionals of failure, but focus instead on failure as a lived reality (ibid:4). Although treatment failure materialises in patients’ bodies, which fail to gain weight or to maintain what is seen as a ‘healthy’ weight gain, we will see that it is mostly non-material things that are seen to be failing when ‘treatment fails’: relationships, and especially relationships of kinship care. But we will also see that failure here is not the direct opposite of success; instead, it works as a productive space for the development of novel forms of care.

Let us now go back to Maia for a moment, and to the hospital visit in the opening of the chapter. Once back in her room on the ward, I asked Maia how she was doing. She told me that things were ‘going well’ – that she was regaining weight and was managing to avoid ‘hyperactivity’ (the technical term used in the world of eating disorder treatment to refer to patients’ tendency to constantly move with the aim of ‘consuming calories’ and therefore ‘losing weight’⁷). The hardest part, Maia remarked, was ‘staying away from *Il Giardino*’ and from the treatment team. She could not wait for the moment she would be allowed to return. Yet, at the same time, she said she was worried that once returned she might go back to her ‘dysfunctional habits’. This comment was striking in that it strongly resonated with the way most other patients I had met talked of their stay in the residential facility: the hardest part of residential treatment, many had been telling me, was being away from home and their families; they could not wait to go back home, and yet were worried that once they found themselves back in their familiar spaces, they might easily slip back into old ‘unhealthy habits’. In Maia’s words, instead, there was no desire to return ‘home’. She wanted to go

⁷ See Chapters 1 and 2.

back to the residential facility and its treatment team. How could this make sense? By looking back at Maia's long history with her condition – now deemed 'chronic' by professionals – it becomes clear how the residential facility had become 'home' for Maia.

When the clinic becomes 'home': the perils of family-based care through time

It isn't natural for anybody to stay in a treatment facility. One comes here when life outside is impossible. But keeping someone in a treatment facility for too long can cause dependence on the facility itself.

Educator Flavia

'Oh, you met Maia then, our little scab', I was told by the psychotherapist Michele at the end of my first day of fieldwork at the residential facility. We were in the kitchen, and I was helping him to load the tray trolley for the patients' dinner. I had just come back from a 'guided tour' of the facility, arranged for me by the Clinical Director. I had soon realised that my 'guide' was not a professional nor an intern, but a patient. Her blonde thin hair, puffed up in a way that made it the most voluminous part of her body, seemed to be leaving a trace of pale light behind while she walked – like a flame stubbornly burning on its fragile candlestick when someone moves it around. 'Maia will tell you everything – she knows more of this place than we do!', the Clinical Director had commented when Maia was called to give me the tour. This comment, I would later learn, related to the fact that Maia had been an inpatient at *Il Giardino* for almost four successive years.

Several anthropologists (e.g., Biehl 2005; Myers 2015; Pinto 2014) have suggested how inpatient facilities elsewhere can contribute to the chronicisation of conditions that are biomedically classified as pertaining to 'mental health': people receiving care find themselves trapped in situations in which the criteria for being declared 'healthy' and capable of living a so-called 'normal life' seem impossible to obtain. This scholarship depicts inpatient treatment as riddled with ambiguous, if not outrightly harmful 'care'. This is also the case for the treatment of eating disorders, which are known to easily become chronic if not treated at the onset of symptoms. As I noted in Chapter 3, in her work on eating disorder treatment in Canada, the UK and Australia, Warin (2005) for instance suggests how hospital inpatient programmes unwittingly reproduce the very configurations of space that support eating disordered practices, and calls for research on residential programmes that position

themselves in contrast to hospital-based treatment. My own fieldwork might give insights here. The treatment model of *Il Giardino*, we have seen, explicitly aims to reproduce a temporary ‘second home’ for patients. In this section I explore how the residential facility can acquire a particular significance vis-a-vis a chronic patient’s own home, in ways that are different from those of ‘non-chronic’ patients. I will suggest that Maia’s specific needs, symptoms and disrupted kinship configurations and aspirations for a ‘life outside’ made the residential facility – and on occasion even a temporary stay in the hospital – a paradoxically ‘vital’ place in the midst of suffering and the looming spectre of death. Yet, as we will see, this very vitality, nurtured by the relationships with professionals, also engendered the risk of its end.

When we met Maia in Chapter 4, I suggested that the lack of her family’s involvement in treatment was framed by the professionals as a major cause of her ‘chronic state’. The reader will remember that Maia was a 33-year-old patient from a city nearby, who had been in and out of *Il Giardino* for the last ten years – the time ‘out’ spent mostly in hospital wards and other inpatient facilities. This is also why the treatment team referred to her as ‘our little scab’ – because she had been sticking to the facility for such a long time, ‘like a mussel that keeps sticking to its rock’ (psychotherapist Michele). From the beginning of my fieldwork, it became evident that Maia was a ‘special’ patient. The first notable aspect was that Maia always had a personal assistant during meals. The staff explained that Maia had herself requested to have a professional sitting next to her for the duration of the meal, so that she could be watched ‘second by second’ and could not ‘do tricks that she knows she would otherwise do’. The second noticeable difference was her absence from shared spaces. Patients were supposed to spend as little time as possible alone in their rooms, and were often called if they failed to show up in the living room during the ‘relaxation time’ between meals and group activities. Maia, however, seemed to be exempted. Similarly, she seemed to be exempted from participating in the otherwise compulsory group activities that would not normally start until every single patient was in the therapy room. Why? Some (mostly the youngest professionals) told me this was just ‘the way it is’ – that it was impossible to keep running after her with all the other things to do, and pointless to do so because she would always find a way ‘to sneak away’. Others (usually those who had been working in the facility for longer) would answer in a way that expressed anxiety and apprehension, and a sense of guilt: ‘That is our biggest problem here, we don’t know what to do with her anymore. We are failing her’.

What did ‘failure’ mean here? Gradually, I came to realise that the ‘failure’ professionals referred to was equated with ‘giving up’ on the fact that Maia would ever recover and have ‘a life outside’ – they felt they were now concerned with ‘just keeping her alive’. A few months into my fieldwork, however, even ‘keeping her alive’ seemed to have become difficult. Maia – who had been ‘stable’ at a very low weight for a long time – started losing more and more weight. Professionals reported finding ‘traces’ of some of the ways in which she was perhaps managing to do that: notwithstanding the personal assistant during meals, Maia somehow managed to spread bread crumbs on the floor and tomato sauce on the edge of her chair, unnoticed at the time. Some said they thought Maia was hiding food in her clothes and keeping some food in her mouth without swallowing it, so that she could spit it into the toilet after the meal. The treatment team therefore decided to make her undergo ‘searches’ right outside the dining room before she could go anywhere else: one professional would ask her to open her mouth to check that food had been swallowed, and to empty the pockets in her clothes and pull up her T-shirt so that one could see if there was any food hidden *between* the clothes, including her bra and underwear. Maia did not seem to oppose those invasive searches. Sometimes food was found during searches, but it was agreed that this could not possibly be enough for her to lose so much weight, considering the high calorie meal plan that she had. The main problem was instead located in her ‘hyperactivity’ – in the fact that whenever she was not watched, she would ‘constantly move’, consciously ‘burning calories’. Volunteers reported seeing her walking up and down the stairs that were located in the bedroom area while the other patients were forced to stay in the living room or to participate in group activities. Those on night shifts suspected that she spent most of the night walking in her bedroom. Frustratingly for those treating her, Maia did not deny any of this. She recognised that she was unable to control her ‘urge to move’, and even asked the treatment team to place a small gate at the entrance to the bedroom area to prevent her from sneaking out and spending hours moving up and down the stairs. Some suggested putting Maia in a wheelchair to reduce her movement, but others quickly reminded the team that they had already tried with a wheelchair in the past, and it had not worked: ‘We would have to tie her to the wheelchair to prevent her from moving!’.

Besides the supposedly obvious risks to Maia’s physical health, her behaviours were a source of professional concern because they seemed to be shrinking Maia’s world, cutting her out of shared spaces and relationships. During a staff meeting, the Coordinator of the facility noticed how Maia’s world was ‘reduced to those little stairs behind the bedrooms, where she

walks up and down and keeps her nail polishes. It is very sad. How do we shake her out of that?’ One therapist pointed out that Maia needed someone with her all the time, all day, ‘because she cheats everyone, with the excuse that she has to go to the toilet, or has to brush her teeth...she is extremely manipulative. Everything has the aim of losing weight’. The Clinical Director therefore stipulated that, from that moment onwards, group activities would not start unless Maia was present. She reasoned that Maia would then feel a responsibility to participate, ‘because if she doesn’t, she prevents the others from receiving treatment’. A daily rota of shifts was also put together such that Maia would never be left alone: one intern or volunteer, with her all the time, would make sure she did not retreat into her ‘hyperactivity world’.

The result, in practice, was mostly heated arguments between Maia and the unlucky intern or volunteer looking after her, and Maia often falling asleep during group activities; a further proof – it was held – of the fact that she was so tired from constantly moving that as soon as someone forced her to stop, she could not help but fall asleep. The new arrangements were then soon abandoned. Many professionals reported frustration at the fact that Maia kept asking for help, demanding that someone constantly control her, but would then become very aggressive with those same persons: ‘Rationally, she knows she needs help, but then she can’t stay with it. She wears you out’ (psychotherapist Michele). The treatment team eventually came up with what was seen by some colleagues as ‘a crazy idea’: ‘promoting Maia’ to the role of staff assistant. The move was meant to ‘shake her up’, but many professionals were perplexed. This seemed a rather risky move to the anthropologist, too, but an interesting reasoning behind it soon emerged.

What came to be known as ‘the crazy proposal’ was discussed during a supervision meeting with the external psychotherapist. Maia’s case had been chosen because the whole treatment team felt ‘stuck’. This was a common reason for a case to be selected for supervision, but this time something in the way the case presented to the external psychotherapist seemed exceptional: the object of this supervision would not really be Maia, but *the relationship* that the treatment team had with her. This particular request came from a gradual realisation on the part of the team that they were ‘unconsciously treating her differently from the other patients’ (Clinical Director) and that it was important to understand how that was affecting her treatment. The Clinical Director was adamant that notwithstanding the role that Maia’s family dynamics had played in the development and persistence of her condition, the

influence of Maia's family on her state was now 'virtually inexistent'. After all, she saw her parents 'barely 30 minutes per week':

What we should reflect on, instead, is the dynamic that she has with *us*, and how we interact with her after all the time she has spent here. It is as if we have lost hope with her. The resignation that we see in her parents, she probably sees it in us. She can probably perceive that we are keeping her here just to keep her alive. It is hard to think something like this. She, but also *we*, see this treatment as an end point, not as a transition towards something else. These behaviours lately with food are a challenge that she is throwing at us.

Maia's 'case' was presented to the external psychotherapist as one of 'pure anorexia'⁸, 'extremely severe and incurable', with the patient having been 'really close to death' twice. The last time this had happened, Maia's BMI had reached 9, she had almost turned blind and was saved from a cardiac arrest. The main problem now, the treatment team felt, was that after more than three years in a row in the residential facility, Maia had recently started presenting again some 'old dysfunctional behaviours'. These behaviours – spreading bread crumbs and tomato sauce around her seat, refusing to leave the bedroom area – were framed as possibly a way for her to tell the team that they were 'forgetting her'. Some professionals agreed that perhaps that was exactly what was happening: 'Rules don't exist for her anymore. We are so exasperated with her that we have stopped trying'.

Even more interestingly, some of the team read Maia's 'regressing behaviours' as symptomatic instead of a fear of being potentially discharged: 'She sees us as her family now, we are her only meaningful relationships. She doesn't have anything nor anyone waiting for her outside'. This was what prompted the 'crazy idea' of proposing an 'assistant role'. The plan was to ask her to assist the Coordinator in carrying out administrative tasks for the centre, rather than participating in the patients' group activities. Maia would then feel reassured that she would not be 'abandoned' outside if her conditions improved, but would always have a place in the facility. Many, however, thought that it was absurd to even imagine Maia doing any kind of work, considering her physical state: 'We have tried to give her jobs in the past, when her condition was much better than now. She always tends to get worse physically once she starts working, and what do you do then? She literally burned whatever idea we came up with'. The endocrinologist noted how Maia, whose current BMI was 12, was at a point of immediate risk to her life: 'A cold or a flu could be enough for her to die'. Eventually, the Clinical Director decided that although it was obvious to everyone

⁸ We will see in the next section what this means, through comparison with its opposite.

that Maia was very ill, assigning those tasks to her amounted to ‘a paradoxical intervention’ to see if she turned toward ‘the direction of health’. Arguing against this decision, Maia’s nutritionist observed that Maia lacked ‘the minimum of motivation necessary for treatment’, and that other patients with similar behaviours had been discharged because that kind of treatment was not seen as appropriate: ‘Why haven’t we discharged her? She is putting us at the limits of our capacities, and there is so much frustration amongst us. Is it possible that there is no alternative to keeping her here?’. When the external psychotherapist asked why this case was different from the many others that the treatment team had had to deal with, the Clinical Director replied that it was because Maia was ‘from here’ (i.e. from the same Region): whereas other patients at some point had to be discharged because their authorization had an expiry date, with her this was not the case, and it was difficult to send her to other residential facilities in different Regions. That had been done a few times in the past, but without long-lasting improvements.

Just as anthropologist Davis (2012:221) pointed out in her analysis of psychiatric treatment in Greece, the therapeutic contract here seems to have little binding power. The dilemmas generated by patients’ breaches of the rules of treatment provide instead occasions for professionals to work out their responsibilities toward patients, and to face the fact that part of their work might be to end therapy when necessary (ibid.:223):

That these occasions took the form of tedious, repetitive, inconclusive debates that actually amplified and congealed their responsibilities toward patients, rather than resolving them, did not mitigate the high stakes of the debates, which implicated the health and survival of patients, as well as therapists’ capacity to help. When therapeutic contracts did not produce treatment outcomes that would redeem and thus dissolve them, they produced dependencies that were nearly impossible to dismantle (ibid.:221).

The difficulty of dismantling ‘dependencies’ in Maia’s case seems to have to do with professional care being entangled with kinship care. In her account of psychiatric institutions in India, Pinto (2014) argues that the clinics are not so much a zone of social abandonment in which the normal is reasserted by keeping the unhuman confined there (as in Biehl 2005), but a place where people with very human difficulties inherently tied to kinship end up when kinship ties fall to pieces. In the eating disorder facility, and especially in the case of Maia’s ‘abandonment’, perhaps what is defined and reasserted is the ideal nature of those kinship ties that are seen to have broken. When this reconfiguration fails, the patient is bound to stay in the clinic. However, unlike Pinto’s interlocutors, Maia does not want to get out – there is not

‘an out’ with other relationships for her anymore. In fact, she is scared of being discharged, of being abandoned once again – this time by her ‘second family’.

The ‘crazy plan’ was implemented for a few weeks, but Maia kept losing weight. As the reader knows from the opening of the chapter, she was eventually admitted to hospital for intravenous nutrition. However, that was not a solution to the problem that the treatment team had posed to the external supervisor. The hospital admission would last for a few weeks – after which Maia was supposed to return to a residential facility. Many team members at *Il Giardino* felt that Maia should be sent to a different facility upon discharge from hospital, because they were ‘too emotionally involved’ and therefore ‘unable to help her anymore’ (Coordinator). Others found the mere idea unthinkable for the same reason: ‘We can’t abandon her in such a difficult situation. We are the only meaningful relationships she has, her only family left’ (educator Flavia). The Clinical Director herself – although she agreed that treatment in the facility was ‘not working’ – was very resistant to the idea of moving Maia somewhere else. At one point, she proposed to send Maia to a different residential facility that had opened a few years earlier as a ‘spin off’ of *Il Giardino* in a Region nearby. Other professionals saw that as a clear sign that the Director wanted to do something for Maia but could not stand the idea of ‘entrusting strangers with her care’. The team of the facility that she had in mind was in fact mostly composed of professionals who had previously worked or had done their internships at *Il Giardino*: ‘But this is exactly why it wouldn’t work. Most of them know Maia and have already been involved in her treatment here. There would be dysfunctional dynamics all the same’, a team member pointed out. What Maia needed, most professionals held, was to be admitted to a residential facility ‘where nobody knows her’. Only this way, it was felt, could she be treated ‘as strictly as any other patient’ and have some chance of getting better. After weeks of prolonged discussions, Maia was eventually sent to a different residential facility in Northern Italy. The Clinical Director of *Il Giardino* knew the treatment team there well, as the two facilities had been in a partnership for a while. But the other team – with a couple of exceptions – had not met Maia before, and that was seen to be enough.

Here we see an interesting dynamic at work: the reparenting model of treatment – which is supposed to be a key ingredient for recovery – becomes problematic when the time the patient spends in the residential facility goes beyond the standard few months. In Maia’s case this lasted for years, with the result that the treatment team literally substituted for Maia’s family in her care. We have seen in Chapter 4 how Maia’s exclusion from kinship care was

understood, if not justified, by constructing her as inherently incapable – as so many years of illness appeared to have shown – of making that care ‘fruitful’. However, this was not enough for professionals to constitute her as ‘unworthy’ of that care. In fact, professionals ‘made up for it’ while she was in treatment. In Maia’s case, the boundaries between professional care and family care had thus become blurred, and professional care had suddenly found itself immersed in the same issues that are typically ascribed by the treatment team to family care – i.e., excessive ‘emotional involvement’ and a subsequent inability to impose the rules necessary to tackle the symptoms of eating disorders. In summary, it was a matter of failing to be ‘clinically detached’ due to ‘too much care’. Once the treatment team realised this, they had to do what patients’ families have to do when they bring their daughters to *Il Giardino*: delegate their daughter’s care and entrust professional strangers with it. As we have seen, the process is difficult and painful for those who have to ‘delegate’ care. Once Maia left, her absence was made constantly present by professionals, who reported that they were ‘so used to having her around’ that they felt ‘as if a key piece of the facility’ was missing.

One month after Maia was sent to the new residential facility, part of the treatment team – the Clinical Director, the Coordinator, the President of the Association and a couple of educators who were ‘most attached’ to her – organised a day trip by car and drove for more than six hours each way to go and visit Maia for an hour and a half. The President of the Association, when telling me about the trip, was quick to notice that although Maia was ‘full of joy’ and ‘thought she was dreaming’ when she saw them appearing in her room, the trip was mostly something they had done for themselves, something that had made them ‘feel better’. The fact that Maia’s family had not gone to visit her yet added to the feeling of the treatment team that they were ‘more of a family to Maia than her parents’.

Maia’s case highlights that the temporal dimension of care can have unsettling effects on care practices that might otherwise work in a ‘snapshot’. Long term care in the treatment facility complicates what otherwise allows clinical detachment: the treatment team ends up literally taking the place of the patient’s family, with professional care and family care mixing ‘too much’ with one another. This was framed as the main cause of treatment failure for Maia. But an extended duration of treatment is not the only factor that puts into crisis the basics of the centre’s approach. In what follows, we will see that another kind of patient shakes the foundations of what it means, for professionals, to effect treatment.

When ‘you can’t take it all away’: questioning the dispensability of the eating disorder

Sometimes, the eating disorder protects the patient from another disorder that is underneath. In those cases, you can’t take the eating disorder away. When there is only the eating disorder, one should thank God...

Franca, President of the Association for patients’ relatives

One morning in May 2019, during the weekly staff meeting, the treatment team seemed to have become stuck while discussing the case of Giada, a 16-year-old girl from a nearby Region who had been admitted to the residential facility one month earlier – for the second time, after a three-month admission the previous summer. Giada had been admitted with a ‘double diagnosis’ of severe anorexia nervosa and obsessive-compulsive disorder (OCD)⁹. Tessa, Giada’s psychotherapist, was trying to convey to the rest of the team that they were at an impasse with her:

It’s becoming increasingly clear that Giada is at risk of psychosis, from which the eating disorder protects her. Her nutritionist and I have therefore agreed that it is best to leave the eating disorder there. We will provide Giada with just the necessary balance that would keep her away from the risk of death and allow her to have a decent quality of life when she goes home.

‘Leaving the eating disorder there’ sounded to the anthropologist like the opposite of what, until that moment, had appeared to be a key aim of treatment. But Tessa seemed to be saying that treating the eating disorder in this case would harm the patient, so the aim of treatment needed to be reframed. However, even this reframed plan was proving increasingly difficult. Giada had been losing weight since she had been admitted, so her nutritionist had to slightly increase her meals – in practice, one more rusk for breakfast, and one teaspoon of sugar in the tea for snack. This had generated ‘a total crisis’ in Giada, who had started scratching herself and crushing her head against a wall:

She calmed down only after one hour of one-to-one discussion with the nutritionist. We feel completely stuck. I mean, you should have seen that crisis...remember that she is that kind of patient who jumps from the stairs landing on her knees, and that she had jumped from a window when she was 13...We feel we can’t add anything to her meal plan, but she keeps

⁹ Obsessive compulsive disorder (OCD) is defined in the DSM V as being characterized by the presence of ‘obsessions and/or compulsions’. Obsessions are described as ‘recurrent and persistent thoughts, urges, or impulses that are experienced as intrusive and unwanted, and that in most individuals cause marked anxiety or distress’; compulsions are described as ‘repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly’ (American Psychiatric Association 2013).

losing weight. We are basically facing an impossible choice: do we risk broken knees or extreme underweight? How can one decide? (psychotherapist Tessa)

Irma, the nutritionist who had been supervising dinner the previous day, agreed that Giada was ‘at serious risk of a self-harming act’. She had had a very bad crisis during dinner because she had received tuna like the previous day¹⁰, and whatever alternative the nutritionist would offer her, it seemed not to be OK: ‘She seemed to be in a state of total despair, she kept biting her hands...so I would urge everyone not to insist with her during meals, for God’s sake’. The team agreed that the only way to go forward with Giada was by doing ‘extremely small and gradual changes’ to her meal plan, but that one should not even try to ‘take away’ the eating disorder, because Giada was ‘too fragile’. During subsequent team meetings, her therapists kept reporting that they were barely managing to keep Giada in a state of ‘precarious psychological compensation’: ‘She told us clearly that she feels if she stops adhering to her schemes, she would fall into pieces like a glass bottle’ (psychotherapist Tessa).

Giada was not the first and only case of ‘double diagnosis’ at *Il Giardino*: several other patients were presented as displaying an eating disorder ‘on top’ of other – supposedly more severe – psychiatric conditions, ranging from OCD, to borderline personality disorder, depression and dissociative disorders. In most of these cases of so-called ‘comorbidity’ – literally meaning ‘with (another) illness’ – the second, more severe and ‘deeper’ psychiatric condition was reported to be ‘emerging’ while the ‘eating disorder symptomatology’ (food restriction, food rituals, hyperactivity etc.) started subsiding. In these cases, the consensus among professionals was that the eating disorder could not be treated ‘completely’ – that ‘some of it’ had to be left there for the sake of the patient’s wellbeing, because treating it completely would mean ‘making the more severe disorder explode’.

In addition to the notion that the eating disorder is a psychopathology that assumes the form of a ‘second self’ that tries to take over the patient’s ‘very self’ (see Chapter 2), we find here the view that in some cases the eating disorder is only the ‘first layer’ of psychopathology within a patient. These two conceptions of the self – external vs. internal and an internal self made of ‘layers’ – exist side by side and are related. The eating disorder is externalised for the purpose of treatment – it is framed to patients and families as something ‘external’ to the self that became ‘internal’; by virtue of this, the process can be reversed because the eating

¹⁰ We have already encountered Giada dealing with tuna in Chapter 4, and on that occasion the nutritionist had managed to deal with her crisis and make Giada eat her food.

disorder is theoretically separable from the patient's self. We have seen, however, that some professionals also talk of the eating disorder as the embodiment of the 'untold parts of the patient', therefore as something that is *already within* a patient – that does not come 'from outside':

When people say things like: 'It isn't you, it's the disorder that makes you do or think this..' well...it is like saying: 'Not only are you dissociated, but you are double, and when you are that other part, you don't even recognise it – it is a part that acts without you noticing it, so there is a severe dissociation (psychotherapist Mauro).

Mauro's critical view of the externalisation rhetoric seems to suggest that mental disorders should be framed, instead, as if emerging from the inside, and going back inside during remission – as if they were all already there, inside the 'body-self'.

In patients with a 'comorbidity', the eating disorder thus becomes something that the patient's self has developed as a protection from a deeper, more severe psychopathology. These cases are therefore seen as 'particularly difficult', with the right balance between 'physical' and 'mental' health harder to establish. Sometimes, as in Giada's case, a second disorder – typically OCD – is framed as not only lying 'just underneath' the eating disorder, but as itself covering a third, even deeper layer of what is usually characterised as 'psychosis'. In such cases, it is not infrequent to hear professionals (usually psychiatrists or psychotherapists) warn colleagues 'not to touch' (i.e., not even to attempt to treat) a patient's OCD, because by doing so they might run the risk of making patients 'turn toward a schizoid disorder'. Nevertheless, in many of these cases, 'peeling off' the most debilitating symptoms of the eating disorder and 'leaving the second disorder there' seems to be possible at least. Giada's case was different in that the 'room for manoeuvre' on the eating disorder seemed to be much smaller – her eating disorder seemed impossible to touch without consequences 'on the deeper layer': 'She is one of those who *need* the eating disorder' the nutritionist explained. 'We can't take it away. For us nutritionists it's very difficult because we feel the urgency of the low weight, and yet we have to restrain ourselves'. The nutritionist felt she had to go against what her job 'would tell her to do', after seeing the effects that increasing the meal plan had on Giada's 'mental stability'.

Giada's case was also brought to the monthly supervision with the external psychotherapist. Giada was presented as a patient with a 'very low tolerance to stress', and an 'absolute inability to modulate emotions: fear and anger are either not felt or felt uncontrollably'. As it

was reconstructed by her psychotherapist and nutritionist, Giada's issues with food had started when she was 12, when her weight had quickly dropped from 34 to 25 Kg, and she was admitted to the children's ward of the local hospital. From that moment, she alternated periods during which she was doing slightly better but would mostly do home schooling, and periods of severe 'relapses' followed by other admissions to hospital and feeding through a nasogastric tube. In July 2018, the day I started fieldwork, she had just been discharged from the children's hospital in her Region and admitted to *Il Giardino* for the first time. 'Hyperactivity' was reported as her only compensatory behaviour alongside 'food restriction': she would walk outside, and at home, with a pedometer, and calculate the calories of everything she ate. She had seemed to be a 'typical case of anorexia, nothing more'.

Things had started appearing 'suspicious' – her psychotherapist reported – when Giada seemed to be accepting all the food she was given after only ten days in the residential facility, without apparent crises. She had in fact gradually regained weight, and her only moments of crisis were related to anxiety for her return to school and fear of falling behind. In fact, she was discharged after three months, and during the following weeks as an outpatient her BMI reached the 'normal threshold' of 18,4 for the first time. She had started going out with friends and had gone back to gymnastics. However, during the Christmas vacation, Giada had reported she started having 'bad thoughts' about not being able to keep up with school, so she stopped going to the gym and out with friends altogether. She had started restricting food again and walking a lot, and had gradually lost 7 Kg. Eventually, Giada had to stop going to school, and at that point the local services contacted *Il Giardino* to urge them to admit her again.

During this second admission, it became clear to the treatment team that although, at that time, Giada had only received a formal second diagnosis of OCD, she might be 'developing a psychotic disorder underneath' which would more clearly emerge with age, but could explode 'at any moment':

I have the feeling she is really on the edge of developing a psychotic disorder, because from what she tells me, she doesn't seem to have any internal containment; she seems to have a desert without any kind of boundaries. What I perceive is that she needs to control, not only her body, but everything that happens inside her. She found in the eating disorder the way of controlling this chaotic void that she feels inside herself. She really needs a context that can compact her. I am trying to provide her with some of those boundaries here, and the protective context here is working. But it is very difficult to transfer this to her family, to make them understand (psychotherapist Tessa).

Here we see once again how the patients' family is perceived and constructed by the treatment team as an obstacle to patients' recovery. When the external psychotherapist asked Giada's therapists to describe her parents, everyone agreed that they seemed like the perfect parents: well dressed, always calm, never arguing nor getting angry and with caring and supportive manners between one another and with Giada; but that 'underneath, in practice' they were 'angry with the world' for what had happened to their family through Giada's illness, and were constantly opposing and 'boycotting' the treatment team's suggestions regarding what Giada needed to recover. They were characterised as apparently incapable of understanding the severity of their daughter's condition, and the risks that she was facing for her physical and mental health.

Professionals were particularly startled by the way Giada's parents had reportedly reacted when Giada had jumped out of a window on the second floor of their house, when she was 13. She was at home on her own that afternoon, while her parents and sister were attending a family counselling session which was part of Giada's outpatient treatment path. After jumping and apparently landing without too much damage, Giada had gone back into the house and had called her parents to tell them what had happened. When they came back, after assessing that she only had 'a few scratches', nothing else followed: 'They didn't even bring her to a hospital, nothing! They said that because Giada is a gymnast, she knows how to land from high jumps without hurting herself...'. The same approach was reported by Giada's parents on another occasion when Giada acted in a way that was considered 'self-harming' by professionals: she had repeatedly jumped from the top of a staircase and landed on her knees after a food-related argument during a meal at home. When Tessa had asked them how they felt about these behaviours, Giada's parents had claimed they were now 'used to it'. Moreover, Giada's parents seemed to be very resistant to the professionals' suggestion that Giada would have benefited from changing school – moving from her current, competitive school to a private, 'easier' school with special support. The reason behind this opposition was located by the treatment team in the fact that both Giada's parents' families had managed to reach a better economic situation and quality of life than the one they were born into thanks to studying in good schools. In the reconstruction of professionals, Giada's parents were worried that without a good school they would undermine Giada's future, and that Giada would later blame them for letting that happen. They also seemed really concerned that

Giada risked failing to become ‘autonomous enough’ and capable of fending for herself, because in the future she would not have all the support network she currently had.

Professionals reported frustration at the fact that notwithstanding the understandable reasoning behind their position, Giada’s parents could not see that Giada was ‘really on the edge of exploding into a full-blown psychotic disorder’, and there was no way this could be prevented without such a strong network of ‘support and containment’. Giada’s psychotherapist could not believe that her parents were still unmovable regarding the school matter, after she had explicitly told them that Giada, even with a heavy daily pharmacological treatment consisting of an antidepressant, an antipsychotic and lithium, risked a severe psychotic break: ‘They are in complete denial, and I don’t know what to do with them anymore. If they don’t support our treatment plan, we can’t do much’. Here we see how giving and receiving care can be informed by fantasies of the future, and how care is located within broader relationships and values (cf. Cook and Trundle 2020:178). The school arrangements that Giada’s parents wanted for her could be said to sit along a transgenerational continuum of kinship care: Giada’s parents offered care in their own terms, even if the school they wanted for her was experienced by Giada, and seen by professionals, as harmful (cf. Mody 2020:196-198).

The external psychotherapist, after hearing further stories about Giada’s family, concluded that Giada’s condition was ‘the result of the costs that her family paid to reach the socio-economic position they reached, of all the impulses that they had to suppress along the way, which ended up canalised into Giada – lives paid dearly at the level of the body’. Giada’s parents, in the psychotherapist’s reconstruction of their life, had to rigidly control reality by suppressing ‘impulses’ and ‘excesses’ to obtain a good social position. These ‘missed impulses’ were now ‘inside Giada’, who herself kept controlling them and suppressing them ‘in her body’, but sometimes exploded. Here again we see that patients’ parents are not so much blamed for being the cause of their daughters’ conditions; rather, as we have seen in previous chapters, they are also constructed as victims themselves, as unwittingly and unknowingly contributing to the development of the patients’ conditions. What they are blamed for is the refusal to question themselves, and for failing to support the treatment team’s suggestions.

Eventually, Giada was discharged in September 2019 and sent back to the local services in her Region. This decision was taken on the grounds that her parents had proved too devaluing

of the work the treatment team had done with Giada. The team felt it was impossible to keep working on Giada without her parents backing up their strategies, as every individual session was now monopolised by anxiety about the return to school. Giada's psychotherapist agreed that with the family constantly boycotting their ideas, nothing could be done. As a result, although reluctantly, Giada's therapist decided they could not do anything but discharge her: 'She could only be saved if taken away from her family. I have explained the situation to the local services that will keep treating her...they are terrified'.

Here we see the treatment team unwittingly 'giving up', and failure emerging as always relational (cf. Carrol et al. 2017:14). The real failure perceived by the treatment team was not so much located in the 'not doing' that Giada's 'comorbidity' required with regards to her eating disorder. Although dealing with that was very difficult for professionals, and made them question the aim of their work, the impossibility of treating Giada's eating disorder had pushed the team to look for novel forms of care – to focus their attention on Giada's family and school, while addressing her eating disordered symptoms as little as possible to keep her 'in balance'. We see here how 'not doing' and 'not intervening', rather than being always forms of clinical neglect and, therefore, of biomedical failure, can become a creative, deliberative, complementary and valuable aspect of treatment (cf. Borgstrom, Cohn and Driessen 2020). Moreover, doing 'nothing' is here reframed as 'something', because doing nothing is very hard to do for professionals – it requires effort. Doing and not doing never happen independently. Here 'not doing' is necessary in favouring a 'good life with the illness' – in a situation in which not only 'good life without the illness' is unattainable, as in situations of end-of-life care (cf. *ibid.*), but in which life without the eating disorder would be even worse. 'Not doing' is therefore a specific act of treatment that occurs alongside other forms of doing, shaped by a specific patient configuration in which the object of 'doing' needs to be shifted from the eating disorder to 'what is around it' – family, school, and so on.

However, we have seen how novel forms of care can themselves fail sometimes. What professionals mostly perceived as 'failure' was the impossibility of enacting those alternative forms of care: Giada's family and decisions about Giada's school ended up being 'untouchable' – unchangeable – like her eating disorder.

In her account of eating disorder treatment in the US, Lester (2009:284) argues that the 'double diagnosis' of 'borderline' allows clinicians to make sense of their impossibility to treat those patients, and to feel OK discharging them. That, crucially, also has to do with the

fact that in the context of managed care, patients' lack of weight gain during treatment is – paradoxically, Lester suggests – a key reason to withdraw treatment coverage. Clinicians in Lester's context could never do what the treatment team of *Il Giardino* had decided to do with Giada. Nevertheless, what is interesting in Giada's case is that a focus on her double (or triple) diagnosis does not result in professionals reconciling with the limits of their care. On the contrary, it makes them experience their limits in a way that is difficult to bear. Even the alternative forms of care they come up with do not point to any reconciliation with those limits.

Conclusion

The ethnographic material in this chapter suggests that 'failure' and 'success' are not simple binary opposites (Carrol et al. 2017:7); nor are 'doing' and 'not doing' (Borgstrom, Cohn and Driessen 2020): failure can function socially by being part of a continuum between illness and recovery, and by existing within ambivalent outcomes. The social function of failure emerges in that even if what is seen as failure is inherent to the system of care, it is made to appear as if it lies outside, in order to bring a sense of coherence within (cf. Carrol et al. 2017:16): In Giada's case the failure in treating the eating disorder is framed as inevitable by professionals because of an additional, posited third 'agent' that is part of the patient's self (the more severe psychiatric disorder but also, on closer inspection, her uncollaborative family). In Maia's case the reason for failure becomes, in a sense, a category error (ibid.): family care becomes mixed with professional care, suggesting that when things go wrong, their wrongness rests in the border-crossing, in practice and matter 'out of place' (a la Douglas 1966, for example). Still, in both cases, failure becomes productive because it motivates professionals to try different ways (cf. Carrol et al. 2017:17).

We have seen how 'failure' in these cases puts into question two of the very pillars at the basis of treatment: Maia's story questions the model of family-based care for those 'chronic patients' who require more time in residential treatment than the standard few months. In those cases, kinship care might stop being only a temporary 'therapeutic tool' and end up assuming the features of 'real' family care – including the 'dysfunctional ones' that are seen to prevent treatment from working by impairing the professionals' clinical detachment.

Giada's case instead sheds light on the limits of the centre's construction of the eating disorder as a part of the patient's self that can be dispensed with. Here the removal of the

eating disorder is seen as potentially harmful because it would let ‘deeper and more serious disorders’ come to the surface and ‘completely dismantle the patient’s self’. The eating disorder thus emerges as having a protective function. In a way, professionals here recognise the patient’s eating disorder as a ‘self-care practice’: they do not agree with it, but they feel that the patient would be worse without it¹¹.

Ethnographically, the treatment team here experiences failure as a disjuncture between what they want or expect to occur as the result of their care practices and what actually happens (cf. Carrol et al. 2017:14): professionals act with a desire to materialize a potentiality in the patient’s body, but are thwarted in this. Two temporal scales and two kinds of bodies are at play here: on the one hand, there is the biomedical body and its temporalities of looming death; on the other hand, there is the body-self acquired through transgenerational family histories which can render it unresponsive to acts of care that normally do not fail. The disjuncture between the two creates a space of failure, but this failure is ultimately generative of further relational work and of novel forms of care (Buchli 2017:201,206).

In Maia’s case, signs of ‘failure’ prompted professionals to question their work with the patient and to realise that the relationship of care between her and the treatment team had changed over time, reaching a point that made it unhelpful to the patient. This, in turn, called for coming up with new treatment strategies ‘out of the box’ – the ‘crazy proposal’, like the other ideas that had preceded it, was definitely not part of standard treatment in the facility, but a matter of continuously tinkering with the resources that were available (cf. Mol, Moser and Pols 2010). When it became clear to the treatment team that none of the tinkering *within* the facility would work, a new care took shape in the delegation of Maia’s treatment to a different team. It is important to note that this was not a case of ‘careless abandonment’ driven by exhaustion – although the professionals were exhausted. On the contrary, it was a difficult and long-resisted decision that required effort and ‘keeping emotions at bay’ (Clinical Director). Similarly, Giada’s relapse after the first admission generated more attentive care and experimenting with a different kind of work: limiting the physical damage of the eating disorder without ‘taking it away’ and shifting any intervening practice to what was *around* the disorder.

¹¹ It is worth noting how the patient’s eating disorder as a self-care project is ‘legitimised’ when it is seen to protect the patient from another diagnosed mental disorder, but not when it is seen to do the same for experiences that cannot be categorised in medical terms, like dealing with painful family dynamics, for example.

In both cases, the generative work of failure highlights what is seen to really need more care – problems with kinship care emerge as the reason for the need to delegate care to someone else: in Giada’s case because her family care does not match and does not support professional care; in Maia’s case because professional care becomes ‘too much’ like family care and unwittingly incorporates its ‘dysfunctions’ – its inability to stay ‘clinically detached’ and impose the necessary rules for treatment.

Conclusion

In 2013, a documentary filmed in an outpatient eating disorder treatment centre in Rome came out: it had the title *Ciò che mi nutre mi distrugge* ('What nourishes me destroys me')¹. The 'what' stands for 'food' in this documentary, and the title points to the complicated relationship that people diagnosed with an eating disorder have with food in their daily lives. This thesis has shown, however, that when one talks about 'eating disorders', the 'what' stands for a lot more than food: we have seen that it includes other elements, notably kinship care, and that it extends into treatment practices. Indeed, we have seen that not only what 'nourishes' can 'destroy', but also the ambivalent factors that are seen to generate harm can be tinkered with through treatment practices, so that their mortiferous effects can be avoided.

I first heard about 'refeeding syndrome' a few weeks into my fieldwork, during a weekly staff meeting. Roberta, aged 17, had just been admitted earlier in the morning, and the endocrinologist was briefing the rest of the team after her medical examination: 'This patient is extremely malnourished. She has been basically surviving on water, apple juice and fat free yogurt for the last six months. We need to be really careful about refeeding syndrome with her – and keep watching out for any symptom'. Noticing the bewilderment in the eyes of the anthropologist and of the two newly arrived psychology interns, the endocrinologist paused to address our lost gazes: 'refeeding syndrome' – she explained – is the medical term for a condition that can occur when 'nutrition' is initiated in a severely malnourished patient. During prolonged fasting, she continued, the patient's body undergoes 'hormonal and metabolic changes' as a way to prevent 'protein and muscle breakdown' – a kind of 'automatic survival mechanism'. When the patient starts being 'refed' – whether through food by mouth, by 'enteral nutrition' (through a nasogastric tube), or by 'parenteral nutrition' (through an intravenous tube that brings the nutrients directly into the bloodstream) – the patient's newly adjusted 'metabolic balance' is disrupted, and the consequences can be severe. Using the language of biochemistry, the endocrinologist went on to say that the hallmark feature of refeeding syndrome consists of 'electrolyte imbalances', including 'hypophosphatemia' (low phosphorous in the blood), 'hypomagnesium' (low magnesium), and 'hypokalemia' (low potassium). The clinical features of refeeding syndrome are seen to occur as a result of the 'functional deficits' of these electrolytes and of the rapid change in

¹ See Brunetti and De Laurentis 2013.

‘metabolic rate’ that occurs as a consequence of sudden refeeding. Other ‘warning signs’ are ‘blood sugar fluctuations’, ‘vitamin deficiencies’, and ‘irregular heartbeat’. If these symptoms occur, the endocrinologist stressed, they need to be addressed immediately, as they can lead to neurological and respiratory issues as well as death from cardiac failure. It is therefore fundamental, she concluded, that refeeding occurs ‘slowly and gradually’, and with the support of phosphorous, magnesium and potassium supplements.

Here we see how ‘nutrition’ – the food that patients are given during treatment to keep them alive – can turn out to be potentially deadly if it is not given gradually and in small doses at the right time. Throughout the thesis, we have seen that something similar holds for the specific form of kinship care that patients are seen to need, and which they have to be ‘refed’ by professionals. It is important to stress that for the professionals this parallel is not just a metaphor: during that same staff meeting, the psychiatrist who had ‘evaluated’ Roberta pointed out how Roberta’s eating disorder was not surprising given the context she had been living in. The girl, the psychiatrist explained, had grown up in a ‘symbiotic relationship’ with her mother, which was generated by a situation of ‘abandonment’ due to her mother being a single parent with a job that kept her away from home all day:

Her mother works as a cook and is away from early morning to late at night during the week, so Roberta has always been alone during mealtimes. In the weekend, when her mother is at home, she is so tired that she never cooks. Before the onset of the disorder, they would spend the weekend by staying mostly in bed together, including while eating!

This has been a common theme running through the thesis: things that nurture – food and family – can also kill.

I started this thesis with the words of a young patient who had just been admitted to *il Giardino* because a medical examination had declared her weight to be dangerously low, and her life to be at risk without a professional intervention that would treat her ‘eating disorder’². The words she used to describe her life before admission, however, pointed to a set of practices, of things she would *do* every day to feel *better*. What professionals call ‘eating disorder’ was not a dis-order in her framing: it was a way to cope with and move through life. The implications of this framing have carried with them through these pages a recurring conundrum: how do professionals care for people who frame their practices as self-care practices – and who therefore do not necessarily perceive themselves to be in need of

² See Introduction, p.1

professional care? In what follows, I sum up what my ethnographic material suggests on this and related questions, and then take a final focus on how the arguments that my thesis advances enable us to think more about the complexity of bodies and diseases, and of food and kinship.

A journey through the grey areas of eating disorder treatment

Drawing on anthropological accounts of eating disorders as ‘technologies of the self’ (e.g., Lester 1997; Gooldin 2008; Eli 2018) and ‘technologies of presence’ (Lester 2019), and on the few existing ethnographic works on the failures of eating disorder treatment in North America (Gremillion 2003; Lester 2019), the UK, Israel and Australia (Eli and Lavis 2021; Warin 2005), this thesis has made a case for a study of eating disorder treatment that goes beyond a binary conception of success or failure. By focusing on the professionals and examining the difficult care work that they do within the less-than-ideal context of a public treatment centre in Italy, I explored the kind of care that the encounters between patients, the treatment team and family carers generate. This approach allowed me to highlight the grey areas between ‘failure’ and ‘success’, and how, when things seem to be failing, novel forms of care emerge as professionals try other ways to make their interventions work.

I started in Chapter 1 by introducing the field site, its history, and the kind of patients, professionals and volunteers inhabiting it. I located the centre’s treatment approach within a history of how ‘eating disorders’ became a problem in medicine and gradually in psychiatry in Italy, and how treatment developed accordingly. In doing this, I paid attention to how the ‘eating disorders’ that are currently described in *The Diagnostic and Statistical Manual of Mental Disorders* could claim a long history, with the first framing of ‘restricted eating’ and ‘excessive thinness’ of a woman in medical terms dating to at least the thirteenth century. I traced some of the changes since then, suggesting that what is now called ‘eating disorder’ – initially bounded to ‘anorexia nervosa’ – shifted from pre-psychiatric conceptualisations of sixteenth century physicians – who explained the condition as a consequence of impaired digestion – to psychological conceptualisations in the eighteenth century that categorized ‘it’ as a matter of *voluntary* starvation, all the way to ‘modern psychiatric’ framings in the nineteenth century – when, for the first time, it was stressed that the matter was not ‘lack of appetite’: on the contrary, women affected did feel hungry, and yet actively refused food. This, crucially, made their restricted eating not a symptom of another medical disorder, but

the central feature of an ‘independent disorder’ due to a ‘psychological dysfunction’ that affected their ‘will’ to eat. In the twentieth century, the ‘psychiatrization’ of ‘eating disorder’ reached its peak with studies that differentiated ‘anorexia’ from neurological diseases that also resulted in extreme thinness: anorexia was now seen as sharing some features with schizophrenia – such as ‘flat mood’ and ‘lack of reality testing’ – but with these features being restricted to ‘body size’ and ‘eating’, as if it were a ‘monosymptomatic psychosis’ (Accornero 1941). Studying the ‘psychological problems’ of the patient thus became key. Finally, towards the end of the twentieth century, the eating disorder started being framed as a disorder of the whole family (Selvini-Palazzoli 1978), and interventions were aimed at revealing the ‘pathogenic links’ between the eating behaviour of the patient and the behaviour of her relatives.

An ‘eating disorder’ was thus moved away from the category of ‘organic disease’ and closer to that of ‘mental illness’. As a consequence, ‘psychotherapy’ became essential to its treatment. Yet, the unescapable fact that this mental illness had severe consequences ‘on the body’ made inpatient treatment in general medical wards fundamental for people with a life-threatening condition. This also generated the need to develop a treatment approach whereby intervention ‘in the mind’ somehow could be transferred ‘to the body’ through a change in the patient’s behaviour. In the 1980s and 1990s, specialised ‘multidisciplinary’ inpatient units thus started appearing: cognitive-behavioural therapy (CBT) became the preferred psychotherapeutic approach in these units in Italy, drawing on parallel developments in other countries such as the UK and Canada. Starting as a strictly behavioural programme, CBT as practised in Italy was adjusted to allow for ‘more flexibility’, by adding ‘psychoeducation’ and ‘nutritional restoration’ organised by a nutritionist ‘trusted’ by the patient who would provide reassurance about ‘weight phobia’ and present food as ‘a medicine’.

This approach was the one that the treatment team of *Il Giardino* was ‘trained into’. However, as we have seen through the thesis, in practice realities are more complicated than that. The care practices involved in treatment must deal with the fact that professionals encounter two kinds of actors who, in different ways, make the process difficult: patients and their family carers. These actors do not passively and willingly ‘receive’ the treatment that professionals are trained to offer. On the contrary, they usually resist that. How do professionals deal with this situation?

In Chapter 2, I examined the different ways in which patients and professionals at *Il Giardino* construct the causes, manifestations and effects of the eating disorder. Drawing on previous ethnographic literature concerning patients' experiences, I suggested that patients frame their eating disorder as a self-care project, but that their self-shaping practices point strongly to *relational* aspects. I then examined how, through the patient's assessment preceding admission, what might be experienced by patients as self-care practices are framed by professionals as pathology, diagnosed and then treated through a careful tracking of the patient's 'body' and 'mind', performed by biomedicine and the psychological sciences respectively. We saw that patients' and professionals' diverging constructions have something in common: eating disorders, both parties seem to be saying, *appear* to be about food, but are not 'really' about food; instead, food, 'the body' and weight are framed as the vehicles of a distress that has something to do with relatedness.

I suggested that in this context of care, symptoms are ascribed to an entity that is at the same time external to and within 'the person' of the patient; in this way, professionals construct a partible 'eating disordered self' that helps them to make sense not only of the failures of treatment (as in Lester 2007, 2019), but also of the everyday practices of enforcement that are seemingly necessary for treatment 'to work'. By framing their somewhat coercive measure as directed 'to the eating disorder, not to the person', professionals resolve the tension between care and coercion.

Chapter 3 then explored how patients who are brought to treatment by force, and who are seen to be in need of constant surveillance, get to the point of assuming responsibility for doing and avoiding the very things that professionals have forced them to do and avoid at the beginning of treatment. On admission, a therapeutic contract sets a framework whereby patients are assigned responsibility for their treatment, even if professionals see this responsibility as something that patients will only gain *during* treatment. We saw that the structure of treatment in its ordering of time, space and therapeutic activities forces patients to gradually deal with that responsibility by cultivating their 'awareness' – that is, a shift from 'seeing' the condition they find themselves in as a self-care project, to seeing it as a form of enslavement to an external force that 'took over their minds' and literally 'blurred their vision' – neurologically 'distorting' the way they see their own bodies. This apparent distortion is reconfigured by teaching patients to see their bodies as composed of parts that are all important, with food necessary for their functioning.

Food is thus put at the centre of treatment practices because of the urgency that ‘malnourishment’ is seen to generate in the materiality of patients’ bodies: food here becomes scientised and re-emerges as the ‘nutrition’ needed to stay alive. Unlike instances in which food acts as a ‘substance of relatedness’ that creates kinship through care (e.g., Carsten 1995), in the world of this treatment centre what is conceived as the nutritional aspect of food (nutrition) needs to be momentarily separated from its kinship-making aspect (nurturance through relations), because problems in the latter are seen to be impeding the former. I suggested that treatment means gradually substituting patients’ ways of being well with a definition of health that is jointly constituted by the treatment team through the use of scientific knowledge and its apparently impartial numbers and statistics. Only once this shift has occurred are patients deemed able to acquire the tools for a self-transformation that will enhance their health, a point when they will themselves want to ‘abandon the eating disorder’.

Chapters 4 and 5 showed that the work of transformation is felt to succeed only if the patient’s family is transformed too. Here, the sociality of patients’ bodies is seen to be as important as their physiology. Chapter 4 suggested that the treatment team tinkers with kinship care by purposefully functioning as a ‘relational laboratory’, as the professionals channel what they see as the dangerous aspects of kinship into therapeutic tools. We have seen how they do so by ‘borrowing’ from kinship care in their therapeutic work, whilst tinkering with its constitutive practices, cleaning it of its perceived dysfunctionality. Here kinship not only has an ambivalent and potentially harmful side – whereby the patient’s family can be framed as a source of distress; kinship can also become a therapeutic tool, in the double sense that 1) professionals work to reshape kinship care in patients’ families by turning them into resources for recovery, and 2) that professionals simultaneously borrow from kinship practices in their *own* therapeutic work of ‘reparenting’ patients. The kinship care enacted by professionals requires attention to boundaries, so that they can stay ‘detached’. Here, we have seen, detachment is a vehicle, an ‘internal stance’ that allows what is seen as the necessary affective engagement with patients, without the dangerous effects that would follow in kinship relations.

Chapter 5 explored one of the instances in which the transformation sought in patients and their families hardly happens, and in which this specific clinical detachment seems to be harder to maintain: cases of ‘pre-adolescent’ patients. After seeing that eating disorder treatment practices are based on the assumption that the patient who is being treated has an

internal world that she is aware of, capable of discovering and communicating about with her therapists – and that the aim of treatment, besides weight restoration, is to help patients regain some sort of ‘autonomy’, in this chapter I suggested that treating preadolescents with eating disorders puts into question the very paradigm of treatment: children do not become ‘aware’ of being in need of help, and do not reach the point when they want to abandon the eating disorder – failing to assume responsibility for their own treatment. The reasons for this failure, we have seen, is located by the treatment team in patients’ ‘dysfunctional families’ – in their failure to care for their daughters in a way that provides them with ‘boundaries’. These families seem to be so dysfunctional that they cannot even be tinkered with – generating in professionals more difficulties in staying clinically detached, because what should be a temporary reparenting role then lacks a foreseeable end.

The last chapter covered another category of cases in which the transformation sought in patients and their families does not happen in the way professionals would expect, and the two opposing constructions of the eating disorder (that of patients and that of professionals) keep clashing: ‘chronic’ patients show that the time of treatment and the time of illness intersect in important ways with the kind of care that is seen as fundamental to patients’ recovery – ways seen by professionals as generating ‘treatment failure’. ‘Failed cases’ put into question two of the pillars that constitute the very logic of their treatment model: family-based care and framing the eating disorder as a part of the patient’s self that can be dispensed with. By focusing on how treatment failure is experienced as a lived reality, I suggested that although failure materialises in patients’ bodies – which ‘fail’ to gain weight or to maintain what is seen as a healthy weight gain – it is mostly relationships of kinship care that are seen to be failing.

After seeing in Chapter 4 how medical practice turns kinship care into medicine – by ‘dosing’ kinship care and framing the treatment team as a temporary, ideal ‘second family’ – Chapter 6 looked at how the reparenting model of treatment becomes problematic when the time the patient spends in the residential facility goes beyond the standard three-to-five months. Long-term care in the facility seems sometimes to result in the treatment team literally substituting for patients’ families, thus complicating what otherwise allows professional detachment: professional care and family care mix with one another, and this is seen to generate failure. This perceived failure, however, makes the treatment team question their care practices and eventually delegate the patient’s care to another team.

Finally, in cases of so-called ‘comorbidity’, treating the eating disorder can be seen as potentially harmful because it could let what are posited as ‘deeper and more serious disorders come to the surface’. ‘Leaving the eating disorder there’ is not necessarily seen as failure by the treatment team therefore, but can be seen as an act of good and experienced care – while professionals shift the object of treatment to what is ‘around the disorder’: school, family, and so on. All in all, failure and success are not necessarily binary opposites therefore: what is perceived as ‘failure’ becomes productive because it motivates professionals to try and improve the patient’s condition in a different way, generating more attuned attempts of care – which at times seem to work, and at others seem to fail, too.

At the end of this journey through the rough land of eating disorder treatment in Italy, I now pause to consider how the arguments that this study advances – sitting at the intersection between anthropologies of science and biomedicine, and anthropologies of ethics, care and kinship – contribute to some anthropological conversations on bodies and diseases, and on food and kinship.

Beyond the body multiple: the multiplicity of good care

My study of eating disorder treatment in Italy contributes to the literature on ‘the body’ and ‘disease’ by expanding on what Annemarie Mol (2002) calls ‘the body multiple’. Drawing on her work on atherosclerosis in the Netherlands – which examined how bodies and diseases are ‘done’ differently in different places outside and within medical practice, and how their different ontologies are coordinated into one for the purpose of treatment – I followed her call for adding an exploration of how the work of coordination is or can be done ‘well’ – which is, the question of ‘the good’ (Mol 2002: 165,166).

Patients and professionals – and within this latter category, different kinds of professionals – each do ‘the body’ and ‘the eating disorder’ differently. For those who become patients, the eating disorder is a way to better cope with life by re-shaping their body according to their will and control. For professionals, the eating disorder is a pathology that has to be treated within the realm of medicine – a deviation from how ‘normal’, ‘healthy’ bodies and minds should ‘function’. But within this second reality, there is more multiplicity. Like ‘atherosclerosis’ in the outpatient clinic in Mol’s study, the ‘eating disorder’ of the treatment centre is not a natural unity. It might form a unity in contrast to the eating disorder of a patient, but if one looks at the practicalities of treatment, the treatment centre appears to be

full of contrasts (cf. Mol 2002:50,51): for endocrinologists and nutritionists, the eating disorder is a pathology of the body whose symptoms are mostly caused by malnutrition – and which therefore can only be solved by re-feeding, without which psychotherapy is pointless. For psychiatrists and psychologists, it is a pathology of the mind – malnutrition and its physical effects are the ‘symptom of something else’, the external form that ‘inner mental distress’ takes; it is a ‘paradoxical act of self-care’ chosen by patients to deal with problems that they feel they cannot manage. For philosophical counsellors, it is a ‘disorder of identity’ whereby the eating disorder gives a person who does not know who she is an illusory answer, ‘becoming an indivisible part of the patient’s self’.

In practice, therefore, the ‘eating disorder’ and ‘the body’ of the patient could be said to be more than one, but these different bodies and eating disorders are not fragmented. They are all deeply intertwined, and brought together in the practical meetings and discussions, and the professional publications, of treatment. Although the ‘roots’ of the eating disorder are framed as residing in the mind, the practicality of malnourishment in the body is seen in turn to play a key role in the worsening and ‘crystallization’ of the disorder in the mind, as in a feedback loop. Even if there are tensions within these various bodies and disorders, they therefore depend on one another (cf. Mol 2002:5).

Co-ordination is not always smooth, however. Mol argues that in the case she observed, the ‘technicity of intervening’ is more important than the ‘consistency of facts’ (Mol 2002:88), and that the work of treatment may go on as long as the different parties are ‘separated between sites in some sort of distribution’ (ibid.), and as long as each of the variants of the condition takes the other into account (ibid.:116). She argues that ‘a single patient tends to be supplied, if not with a single disease, then at least with a single treatment decision’ (ibid.:88). My thesis is an example that this is not always the case: At *Il Giardino*, the psy sciences and the nutri sciences do act on different fronts and take each other’s ‘eating disorder’ into account, but sometimes their ontologies and the practices that follow end up clashing. In Chapter 6 we have seen how in some cases the treatment for ‘malnutrition’ – gradual increase in the meal plan – endangers the ‘psychological integrity’ of the patient. Here the condition that the endocrinologist and the nutritionist would treat does not match the condition that the psychotherapist and the psychiatrist would treat, resulting in an impasse.

It is not only the singularity of the disease that is an accomplishment of the work of coordination, therefore, but also the singularity of treatment. Which brings us to the issue of

what Mol (2002:124) calls ‘switching registers’: professionals are asked to turn their work from intervening in a malnourished body, to intervening in a person’s life and that of her family. As Mol remarked, this is not a matter of ‘zooming out’, but a matter of ‘moving the camera sideward and focus it on another object’ (ibid.): whereas in the endocrinologist’s and nutritionist’s scene the focus is on the patient’s body, sometimes they are asked to move to a scene in which the patient’s ‘psychological stability’ and ‘capacity to stay related to the world’ is centre stage. In this act of switching, the modes of reasoning and the necessary skills also switch. All the professionals – no matter their specialisation – are expected to be able to do this work of switching as they are asked to enact multiple roles during their shifts: during lunch, a psychotherapist might find herself in the role of ‘meal controller’; during a night shift, a nutritionist might find herself in the role of ‘confidant’ and ‘psychological supporter’, and so on.

As noted by Mol (2002:176,177), however, the different ontologies come with different ways of doing ‘the good’: we have seen in Chapter 6 how when a patient is seen to be severely malnourished and at the same time on the verge of ‘psychotic fragmentation’, professionals find themselves stuck, facing an impossible choice: ‘do we risk broken knees or extreme underweight? How can one decide?’. In each case, the ‘dis’ of dis-ease is different – malnutrition, obsessive and intrusive thoughts, lack of care – and therefore the ideals that orientate treatment practices are different, too, and can clash. We have seen how defining what is ‘good’, ‘worse’ and ‘better’ does not precede practice, but forms part of it – perhaps the most difficult part. Professionals can only try through ‘small steps’ to increase a patient’s meal plan in a way that does not generate a psychotic crisis, but this requires getting as close to the limit as possible. It is a process that generates ambivalences, disagreements, insecurities and conflicts, even more so because the stakes are high. This means that ‘good and bad’ are never settled, and professionals have to continuously deal with new twists and complications (cf. Mol 2008:75,76).

Mol indeed had pointed out that her study provokes the question of how the body multiple and its diseases ‘might be done well’, but that her purpose was not to answer that question (ibid.:7). My thesis was an attempt to offer one answer to Mol’s question by exploring how the multiple dis-eases and bodies that circulate within and outside the eating disorder treatment centre are coordinated with the aim of providing ‘good care’. I have explored the ‘goods’ that are sought after, the ‘bads’ that are fought, and how ‘goodnesses’ are framed as being good (Mol 2002;176,177). I have also explored how professionals cope with the limits

of the good they can do, and I have provided ethnographic evidence of what Mol has anticipated theoretically: that ‘like ontology, the good is inevitably multiple: there is more than one of it [...] Doing good does not follow on finding out about it, but is a matter of, indeed, doing. Of trying, tinkering, struggling, failing, and trying again’ (ibid.).

Food as a substance of relatedness, relatedness as a substance of feeding

We have seen that the ‘eating disorder’ is multiple. The multiplicity of ‘eating disorder’ requires coordinating not only different ‘bodies’ and ‘diseases’, but also different ‘goods’ and ‘bads’ in treatment. This complex coordination, I have suggested, requires tinkering with food and family: it requires temporarily eradicating food from the social – cleansing it from the messiness of commensality by scientising it and turning it into ‘nutrition’. In the meantime, the family needs to be cleansed of its harmful aspects too, so that after discharge from the facility, when commensality will be put back into food, it will not harm the patient. Doing that requires not only turning the patient’s whole family into a patient – into an object of treatment. It also requires professionals to practice kinship care with patients: to ‘reparent patients’ in a ‘healthier way’, so that that they can unlearn ‘dysfunctional’ dynamics of relatedness and learn more ‘functional’ ones. What are the implications of this argument for our understanding of the relationship between food and kinship?

After what was seen as a ‘crisis of kinship’ in the 1970-80s, a new generation of anthropologists suggested that in many socio-cultural settings ties of what was now called ‘relatedness’ were constituted by giving, receiving, and sharing food (e.g., Carsten 1995, 1997; Janowski & Kerlogue 2007). Carsten (1995:223), for example, has shown how among the Malays on the island of Langkawi feeding (in the sense of both receiving and giving food) is a vital element in the process of becoming a person and participating fully in social relations as kin. In her context, the core substance of kinship is seen to be blood, and the major contribution to blood is seen to be food. Food therefore creates both persons in a physical sense, and the substance through which they are related to one another (ibid.:224). This suggested a processual view of kinship that challenged anthropological definitions that had assumed a universal division between the ‘biological’ and the ‘social’, or ‘nature’ and ‘culture’. Similarly, Amazonian ethnographers have suggested how commensality is a central means through which indigenous people engage in processes of ‘familiarization’ (Fausto and

Costa 2013): by eating together and sharing food, people turn into kin (Vilaça 2002) and create intimate relationships.

These authors did not, however, consider much how parental feeding practices intersect with local ideas of what might be called ‘good parenting’ and ‘healthy development’. In her Langkawi work on food as a substance of relatedness, Carsten (1995:234) mentions that the mother’s milk is the source both of shared substance and of ‘the strong emotional bond between mother and child’, acting as ‘the enabling substance of kinship’. She also shows how eating meals in other houses implies a dispersal of ‘intimate substance’ and is therefore discouraged (ibid.). In her more recent work on blood in clinical labs in Malaysia, Carsten (2019b) suggests how the way food is consumed together by lab technicians during their lunch breaks often works to initiate friendships between colleagues, to signal thickening and thinning of relations, and, over time, even to generate kinship relations (Carsten 2019b:175). She argues that food acts as a ‘barometer of the warmth and strength of connections’, and therefore as a ‘kind of moral barometer of social relations’ (ibid.:171). This work parallels her recent call for focusing on what kinship does, rather than on what kinship is (Carsten 2019:133) – which means also focusing on the *effects* of kinship, especially on the effects of kinship through time.

Answering Carsten’s call in a way that contributes to examining the implications of ‘feeding’ for theories of relationship formation, the ethnographic material in this thesis is an example of a world in which feeding is indeed deemed to be not only fundamental to the development of ‘healthy bonding’ and ‘healthy development’, but also as a something that *stands for* this healthiness: irregularities in feeding are conceived as a symptom of something gone awry in the bonding process, with certain parenting practices being considered detrimental to the creation of ‘healthy affective bonds’ and therefore of ‘healthy eating’.

The few anthropologists who have been exploring how parental feeding practices intersect with local ideas of development and good parenting tend to frame caring through food and materiality as a hitherto neglected *alternative* to ‘psychological’ warmth and ‘attention to emotions’³ Mezzenzana (2021), for example, shows how the Runa of the Ecuadorian Amazon do not tend to verbally speculate about others’ ‘inner feelings’ or ‘thoughts’, nor to talk about ‘emotions’ with their children. She argues that care and love are, instead, entirely conceived as being manifested through feeding. She offers her case as an example to contrast with

³ see Mezzenzana 2021 and Funk 2021.

normative European and North American practices of fostering emotional attachment which focus on imagination and emotion talk. In my context, on the contrary, the two domains of ‘feeding’ and ‘psychological warmth’ are intimately linked. My ethnography has shown that food is not only a ‘substance of relatedness’ that generates kinship (cf. Carsten 1995), but the reverse is also true: food can function as a vehicle to unmake kinship (by refusing it), and, in turn, kinship itself becomes a substance that shapes whether and how food is incorporated into persons. It is not only that food makes people into kin – kinship also makes and unmakes people through food. The fact that food is a substance of relatedness, but also the other way around, is precisely what allows professionals to tinker with food and family in the treatment centre – by turning food into ‘nutrition’ first and then, later, putting relatedness back into food but in a modified form. In this treatment centre, patients’ bodies are transformed through transforming the relations that constitute them, suggesting how bodies are ‘material in their sociality’, but also ‘social in their materiality’ (Lambert and McDonald 2009:10).

Whereas classical psychological analyses of eating disorders have framed (the refusal of) food as a way to rebel against kinship care, to negate kinship care, or to ask for more kinship care – with food always framed as a vehicle whose ‘end’ is kinship – here we see that an ethnographic lens can illuminate how what has been framed as an end can become a vehicle itself – Carsten (2019) would call it ‘vector’ – and, in turn, what has been framed as a vehicle, can become an end. ‘Vehicles’ and ‘ends’ are not static, and the various elements of care can be both, depending on which ‘eating disorder’ one is looking at – that of patients, that of endocrinologists and nutritionists, that of psychotherapists and psychiatrists, and so on.

Where to go from here?

I conclude with this question, so that further research may add to what I have offered in these pages. I hope that by challenging the dichotomy of ‘failure’ vs. ‘success’ in studies of eating disorder treatment, and by highlighting the grey areas in between those two ends of the spectrum, I have done justice to the immensely complex and difficult work of both living with an ‘eating disorder’ and treating ‘eating disorders’ – as much as it is possible for a temporary visitor to do so. I hope to have opened lines of inquiry that could bring themes dear to anthropologists and to those treating these conditions – the relationship between bodies, illness, kinship, food, detachment and boundaries – under further scrutiny, and,

perhaps, generate more collaborative endeavours; and I hope that my study will be relevant to those studying similar contexts elsewhere, offering a point of comparison. More than anything, I hope that this thesis might generate questions that will serve as a springboard for further unravelling of what remains to be unravelled about care for people living with eating disorders. I see three particularly important avenues for further ethnographic research: 1) an exploration of how eating disorder treatment is being adapted, in Italy and elsewhere, to the increasing number of ‘preadolescent’ patients – and what this could reveal about taken-for-granted notions of ‘dependence’ and ‘autonomy’; 2) a comparative analysis of family care ‘at home’ before and after treatment, with a particular focus on whether and how the kinship work that occurs during treatment ‘travels back’ to patients’ homes, with what kind of short- or long-term effects; and 3) attention to the forms that care can take, within and outside clinics, for the many ‘chronic’ patients who end up living with the condition for the rest of their lives, and for whom clinics sometimes become homes. Finally, I hope that the tenacity that we have seen to characterize both the people living with an eating disorder and those who care for them will inspire tenacity in those who set out to disentangle the messiness that is care. Living with, caring for, and writing about ‘eating disorders’ all call for tenacity – or for, as Mol (2008:79) has put it, ‘a sticky combination of adaptability and perseverance’.

References

- Accornero, F. 1941a. 'L'Anoressia Mentale, una Priorità Italiana e l'Osservazione di 4 Casi'. *Rivista sperimentale di Freniatria* **67**, 447.
- Accornero, F. 1941b. 'L'Anoressia Mentale'. *Rivista Sperimentale di Freniatria* **66**, 3.
- American Psychiatric Association. 1952. *Diagnostic and Statistical Manual of Mental Disorders: DSM-I. First Edition*. Washington: American Psychiatric Publishing.
- American Psychiatric Association. 1968. *Diagnostic and Statistical Manual of Mental Disorders: DSM-II. Second Edition*. Washington: American Psychiatric Publishing.
- American Psychiatric Association. 1980. *Diagnostic and Statistical Manual of Mental Disorders: DSM-III. Third Edition*. Washington: American Psychiatric Publishing.
- American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV. Fourth Edition*. Washington: American Psychiatric Publishing.
- American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR. Fourth Edition, Text Revision*. Washington: American Psychiatric Publishing.
- American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5. Fifth Edition*. Washington: American Psychiatric Publishing.
- Ammaniti, M., Lucarelli, L., Cimino, S. & D'Olimpio, F. 2008. 'Psicopatologia dello Sviluppo e Anoressia Infantile: Continuità Omotipica ed Eterotipica'. *Noos* **3**, 197-216.
- Anderson, A. 2001. *The Power of Distance: Cosmopolitanism and the Cultivation of Detachment*. Princeton: Princeton University Press.
- Antze, P. 2010. 'On the Pragmatics of Empathy in the Neurodiversity Movement'. In *Ordinary Ethics: Anthropology, Language, and Action* (ed.) M. Lambek, 310-27. New York: Fordham University Press.
- Arcelus, J., Mitchell, A.J., Wales, J., & Nielsen, S. 2011. 'Mortality Rates in Patients with Anorexia Nervosa and Other Eating Disorders. A Meta-analysis of 36 Studies' *Archives of General Psychiatry* **68**(7), 724-31.

- Ardener, E. 1989. *The Voice of Prophecy and other essays*, ed. M. Chapman. Oxford: Blackwell.
- Aries, P. 1962. *Centuries of Childhood*. New York: Vintage Books.
- Arteaga, I. 2018. 'Life must go on: Everyday experiences of colorectal cancer treatments in London'. PhD Thesis, University College London.
- Banks, C. G. 1992. "'Culture" in Culture-Bound Syndromes: The Case of Anorexia Nervosa'. *Social Science & Medicine* **34**(8), 867–84.
- Baraldi, M. 1952. 'Contributo allo Studio dell' Anoressia Mentale'. *Rivista Sperimentale di Freniatria e Medicina Legale delle Alienazioni Mentali* **76**, 381.
- Barbagli, M., and Kertzer, D. 1990. 'An Introduction to the History of Italian Family Life'. *Journal of Family History* **15**(4), 369-83.
- Barret, R.J. 1996. *The Psychiatric Team and the Social Definition of Schizophrenia: An Anthropological Study of Person and Illness*. Cambridge: Cambridge University Press.
- Basaglia, F. 1959. 'L'Anoressia Mentale è una Nevrosi o una Psicopatia?'. *Medicina Psicosomatica*, **4**, 263.
- Beccari, J.B. 1745. *De Bononiensi Scientiarum et Artium Instituto atque Academia Commentarii. Tomi Secundi, Pars Prima: Commentarii de Longa Cibi Potusque Omnis Abstinencia*. Bologna: ex typographia Laelii a Vulpe.
- Becker, A.E. 1995. *Body, Self, and Society: The View from Fiji*. Philadelphia: University of Pennsylvania Press.
- Becker, A.E. 2004a (ed.). 'New Global Perspectives on Eating Disorders' [Special Issue]. *Culture, Medicine and Psychiatry* **28**(4).
- Becker, A.E. 2004b. 'Television, Disordered Eating, and Young Women in Fiji: Negotiating Body Image and Identity During Rapid Social Change'. *Culture, Medicine and Psychiatry* **28**(4), 533-59.
- Bell, K. 2019. 'The "Problem" of Undesigned Relationality: Ethnographic Fieldwork, Dual Roles and Research Ethics'. *Ethnography* **20**(1), 8–26.
- Bell, R. M. 1985. *Holy anorexia*. Chicago: University of Chicago Press.

- Benedetti, A. 1533. *Collectionum Medicinalium Libellum, Liber XI, cap. X*. Venezia: La Giunta.
- Benson, S. 1997. 'The Body, Health and Eating Disorders'. In *Identity and Difference* (ed.) K. Woodward, 121-66. London: Sage.
- Berkman, N. D., Lohr, K. N., & Bulik, C. M. 2007. 'Outcomes of Eating Disorders: A Systematic Review of the Literature'. *International Journal of Eating Disorders* **40**, 293–309.
- Berliner, D., et al. 2016. 'Anthropology and the Study of Contradictions'. *Hau: Journal of Ethnographic Theory* **6(1)**, 1–27.
- Bernini, S., 2004. 'Natural Mothers: Teaching Morals and Parent-craft in Italy, 1945–60' *Modern Italy* **9**, 21–33.
- Biehl, J., 2005. *Vita: Life in a Zone of Social Abandonment*. Berkeley: University of California Press.
- Bordo, S. 1993. *Unbearable Weight: Feminism, Western Culture, and the Body*. Berkeley: University of California Press.
- Borgstrom, E., Cohn, S., & Driessen, A. 2020. 'We Come in as "the Nothing": Researching Non-intervention in Palliative Care'. *Medicine Anthropology Theory* **7(2)**, 202-13.
- Bowlby, J., 1956. 'The Growth of Independence in the Young Child'. *Royal Society of Health Journal* **76**, 587–91.
- Bowlby, J. 1988. *A Secure Base: Parent-Child Attachment and Healthy Human Development*. New York: Basic Books.
- Bowlby, J. 1999 [1969]. *Attachment: Attachment and Loss*. New York: Basic Books.
- Bradley, B., & Ecks, S. 2018. 'Disentangling Family Life and Hair Pulling: Trichotillomania and Relatedness'. *Medical Anthropology* **37(7)**, 568-81.
- Brodwin, P. 2008. 'The Coproduction of Moral Discourse in U.S. Community Psychiatry'. *Medical Anthropology Quarterly* **22(2)**, 127-47.
- Brodwin, P. 2011. 'Futility in the Practice of Community Psychiatry'. *Medical Anthropology Quarterly* **25(2)**, 189-208.

- Brodwin, P. 2013. *Everyday Ethics: Voices from the Frontline of Community Psychiatry*. Berkeley: University of California Press.
- Bruch, H. 1962. 'Perceptual and Conceptual Disturbances in Anorexia Nervosa'. *Psychosomatic Medicine* **24**(2), 187–94.
- Bruch, H. 1978. *The Golden Cage: The Enigma of Anorexia Nervosa*. Cambridge, MA: Harvard University Press.
- Brugnoli, G. 1875. 'Sull'Anoressia'. *Memoria dell'Accademia delle Scienze dell'istituto di Bologna* **3**, 351.
- Brumberg, J.J. 1988. *Fasting Girls: The Emergence of Anorexia Nervosa as a Modern Disease*. Cambridge, MA: Harvard University Press.
- Brunetti, R. & De Laurentis, L. 2013. 'What Nourishes Me Destroys Me'. Produced by B&BFILM, co-produced with RAI3. Available in English at: <http://www.ciocheminutremidistrugge.com/en/>
- Bryant-Waugh, R. & Lask, B. 1995. 'Annotation: Eating Disorders in Children'. *Journal of Child Psychology and Psychiatry* **36**(2), 191-202.
- Buchbinder, M. 2015. *All in Your Head: Making Sense of Pediatric Pain*. Berkley: University of California Press.
- Buchli, V. 2017. 'Afterword: Failure'. In *The Material Culture of Failure: When Things Do Wrong* (eds.) T. Carroll, D. Jeevendrampillai, A. Parkhurst & J. Shackelford, 197-207. London: Bloomsbury Academic.
- Burns, M. 2004. 'Eating Like an Ox: Femininity and Dualist Constructions of Bulimia and Anorexia'. *Feminism and Psychology* **14**(2), 269-95.
- Button, E. 1986. 'Body-size Perception and Response to Outpatient Treatment in Anorexia Nervosa'. *International Journal of Eating Disorders* **5**, 617-29.
- Bynum, C.W. 1987. *Holy Feast and Holy Fast: The Religious Significance of Food to Medieval Women*. Berkeley: University of California Press.

- Candea, M. 2007. 'Arbitrary Locations: In Defence of the Bounded Field-Site'. *The Journal of the Royal Anthropological Institute* **13**(1), 167-84.
- Candea, M. 2018. 'No Actor, No Network, No Theory: Bruno Latour's Anthropology'. In *Schools and Styles of Anthropological Theory* (ed.) M. Candea, 209-23. London: Routledge.
- Candea, M., Cook, J., Trundle, C., & Yarrow, T., (2015). 'Introduction: Reconsidering Detachment', In *Detachment: Essays on the Limits of Relational Thinking* (eds.) T. Yarrow, M. Candea, C. Trundle, & J. Cook, 1-31. Manchester: Manchester University Press.
- Caplan, P. 2003. 'Introduction: Anthropology and Ethics'. In P *The Ethics of Anthropology: Debates and Dilemmas* (ed.) P. Caplan, 1-33. New York: Routledge.
- Carroll, T., Jeevendrampillai, D., and Parkhurst, A., 2017. 'Introduction: Towards a General Theory of Failure'. In *The Material Culture of Failure: When Things Do Wrong* (eds.) T. Carroll, D. Jeevendrampillai, A. Parkhurst & J. Shackelford, 1-20. London: Bloomsbury Academic.
- Carsten, J., 1995. 'The Substance of Kinship and the Heat of the Hearth: Feeding, Personhood, and Relatedness among Malays in Pulau Langkawi'. *American Ethnologist* **22**(2), 223-41.
- Carsten, J., 1997. *The Heat of the Hearth: The Process of Kinship in a Malay Fishing Community*. Oxford: Oxford University Press.
- Carsten, J., 2019a. 'The Stuff of Kinship'. In *The Cambridge Handbook of Kinship* (ed.) S. Bamford, 133-50. Cambridge: Cambridge University Press.
- Carsten, J. 2019b. *Bloodwork: Life and Laboratories in Penang*. Durham, NC: Duke University Press.
- Castel, R. 1981. *La Gestion des Risques: De l'Anti-psychiatrie à l'Après-psychanalyse*. Paris Éditions de Minuit.
- Charcot, J.-M. 1883. 'Clinique de l'Hydrothérapie Scientifique [Clinical Applications of Scientific Water Cure]: Lecture reported by C. Féré. *Journal de la santé publique: Annales de l'hydrothérapie scientifique*, July 15, 3-5.
- Charcot, J.-M. 1889. *Clinical Lectures on Diseases of the Nervous System*. London: New Sydenham Society.

- Cheney, A. M. 2013. 'Altering the Social: An Ethnography of Disordered Eating among Southern Italian Women'. *Food and Foodways* 21, **87**–107.
- Cheney, A.M., Sullivan, S., & Grubbs, K. 2018. 'The Morality of Disordered Eating and Recovery in Southern Italy'. *Medical Anthropology Quarterly* **32**(3), 443–57.
- Chua, J.L. 2011. 'Making Time for the Children: Self-temporalisation and the Cultivation of the Anti-suicidal Subject in South India'. *Cultural Anthropology* **26**(1), 112–37.
- Clemente, I. 2015. *Uncertain futures: Communication and Culture in Pediatric Cancer Treatment*. Chichester: Wiley Blackwell.
- Cook, J. 2015. 'Detachment and Engagement in Mindfulness-based Cognitive Therapy'. In *Detachment: Essays on the Limits of Relational Thinking* (eds.) T. Yarrow, M. Candea, C. Trundle, & J. Cook, 1-31. Manchester: Manchester University Press.
- Cook, J. 2020. 'Unsettling Care: Intersubjective Embodiment in MBCT'. *Anthropology and Humanism* **45**(2), 184-93.
- Cook, J., & Trundle, C. 2020. 'Unsettled Care: Temporality, Subjectivity, and the Uneasy Ethics of Care'. *Anthropology and Humanism*, **45**(2), 178-183.
- Cooper, P.J., Taylor M.J., Cooper Z., & Fairburn, C.G. 1986. 'The Development and Validation of the Body Shape Questionnaire'. *International Journal of Eating Disorders* **6**, 485-86.
- Crisp, A. H. 1980. *Anorexia Nervosa: Let Me Be*. London: Academic Press.
- Crisp, A. H., et al. 2006. 'Death, Survival and Recovery in Anorexia Nervosa: A Thirty-five-year Study'. *European Eating Disorders Review* **14**, 168–75.
- Crow, S.J., et al., 2009. 'Increased Mortality in Bulimia Nervosa and Other Eating Disorders'. *The American Journal of Psychiatry* **166**(12), 1342-6.
- Crowder, K. 2015. 'Artisanal Affection: Detachment in Human-Animal Relations within Intensive Pig Production in Britain'. In *Detachment: Essays on the Limits of Relational Thinking* (eds.) T. Yarrow, M. Candea, C. Trundle, & J. Cook, 1-31. Manchester: Manchester University Press.

- Cubelli, R., & Nichelli, P. 1990. 'Giovanni Brugnoli and the Origin of Neuropsychology in Italy'. *The Italian Journal of Neurological Sciences* **11**, 501-5.
- Cuj, M., Grabinsky, L., & Yates-Doerr, E. 2021. 'Cultures of Nutrition: Classification, Food Policy, and Health'. *Medical Anthropology* **40**(1), 79-97.
- Cullather, N. 2007. 'The foreign policy of the calorie'. *The American Historical Review* **112**(2), 337–64.
- Cuzzolaro, M., Vetrone, G., Marano, G., & Battacchi M., 2000. 'Body Uneasiness Test, BUT'. In *Repertorio delle scale di valutazione in psichiatria* (ed.) L. Conti, 1759-61. Firenze: SEE.
- Dalla Ragione, L., & Giombini, L. 2014. *Solitudini Imperfette: Le Buone Pratiche di Cura nei Disturbi del Comportamento Alimentare*. Italy: Ministero della Salute.
- Dalle Grave, R. 1996. *Anoressia Nervosa: I Fatti*. Verona: Positive Press.
- Dalle Grave, R., Bartocci, C., Todisco, P., Pantano M. & Bosello O. (1993). 'Inpatient Treatment for Anorexia Nervosa: A Lenient Approach'. *European Eating Disorders Review* **1**, 34-44.
- Das, V. 1995. 'National Honour and Practical Kinship: Unwanted Women and Children'. In *Conceiving the New World Order: The Global Politics of Reproduction* (eds.) F. D. Ginsburg and R. Rapp, 212–33. Berkeley: University of California Press.
- Davis, E. A., 2012. *Bad Souls: Madness and Responsibility in Modern Greece*. Durham, CA: Duke University Press.
- Deiana, F. 2012. 'Seeing with New Eyes: Field Research and Self-analysis in a Clinic for Treatment of Eating Disorders'. *Medische Anthropologie* **24**(1). 57-71.
- Delinsky, S.S. & Wilson, G.T. 2005. 'Mirror Exposure for the Treatment of Body Image Disturbance'. *International Journal of Eating Disorders* **39**(2), 108-16.
- Di Abano, P. (Petri de Abano). 1958. *Conciliator Controversiarium quae inter Philosophos et Medicos Versantur*. Venezia: Giunta.
- Di Angelantonio E. et al. 2016. 'Body-mass Index and All-cause Mortality: Individual-participant-data Meta-analysis of 239 Prospective Studies in Four Continents'. *Lancet*, **388**(10046), 776–86.

- Di Nicola, V.F. 1990. 'Anorexia Multiforme: Self-starvation in Historical and Cultural Context; Part II, Anorexia Nervosa as a Culture-reactive Syndrome'. *Transcultural Psychiatric Research Review* **27**(4), 245–86.
- Dogliotti, G.C. 1936. 'Sulla Magrezza Ipofisaria Giovanile'. *Rivista Critica di Clinica Medica* **37**, 303.
- Dotti, F. 1950. 'Il Problema Diagnostico e Terapeutico dell' Anoressia Nervosa e della Malattia di Simmonds'. *Giornale di clinica medica* **31**, 1431.
- Douglas, M. 1966. *Purity and Danger: An Analysis of Concepts of Pollution and Taboo*. London: Routledge.
- Dragojlovic, A., & Broom, A. 2018. *Bodies and Suffering: Emotions and Relations of Care*. New York: Routledge.
- Eknoyan, G. 2008. 'Adolphe Quetelet (1796-1874) – the Average Man and Indices of Obesity'. *Nephrol Dial Transplant* **23**(1), 47-51.
- Eli, K. 2012. "'4st 7lbs': Eating Disorders, Between Horror and Survival'. *UBVO Opinion Paper Series* No. 03. Available from: <http://www.oxfordobesity.org/opinionpapers/OpinionPaper03.pdf> (Accessed: 20 December 2020).
- Eli, K. 2014. 'Between Difference and Belonging: Configuring Self and Others in Inpatient Treatment for Eating Disorders'. *PLoS ONE* **9**(9), 105452.
- Eli, K. 2016. "'The Body remembers': Narrating Embodied Reconciliations of Eating Disorder and Recovery'. *Anthropology & Medicine* **23**(1), 71-85.
- Eli, K. 2018. 'Striving for Liminality: Eating Disorders and Social Suffering'. *Transcultural Psychiatry* **55**(4), 475–94.
- Eli, K. & Lavis, A. 2021. 'Material Environments and the Shaping of Anorexic Embodiment: Towards A Materialist Account of Eating Disorders'. *Culture, Medicine & Psychiatry* <https://doi.org/10.1007/s11013-021-09715-8>.

- Eli, K. & Ulijaszek, S. 2013. 'Anorexia Nervosa', *Oxford Bibliographies*, 26 August. Available at: <http://www.oxfordbibliographies.com/view/document/obo-9780199766567/obo-9780199766567-0116.xml> (Accessed: 20 December 2020).
- Eli, K. & Warin, M. 2018 (eds.). 'Anthropological Perspectives on Eating Disorders: Deciphering Cultural Logics' [Special Issue]. *Transcultural Psychiatry*, **55**(4).
- Fainzang, S. 2002. 'Lying, Secrecy and Power within the Doctor-patient Relationship'. *Anthropology & Medicine* **9**(2), 117-33.
- Fairburn, C. 1981. 'A Cognitive Behavioural Approach to the Treatment of Bulimia'. *Psychological Medicine* **11**, 707-11.
- Fairburn, C.G., Cooper, Z., & Shafran, R. 2003. 'Cognitive Behaviour Therapy for Eating Disorders: A "Transdiagnostic" Theory and Treatment'. *Behaviour Research and Therapy* **41**(5), 509–28.
- Fassino, S., Piero, A., Tomba, E., & Abbate-Daga, G. 2009. 'Factors Associated with Dropout from Treatment for Eating Disorders: A Comprehensive Literature Review'. *BMC Psychiatry* **9**, 67.
- Fausto, C. & Costa, L. 2013. 'Feeding (and Eating): Reflections on Strathern's 'Eating (and Feeding)'. *The Cambridge Journal of Anthropology* **31**(1), 156-62.
- Féré, C. & Levillain, F. 1883. 'Apepsie Hystérique (Gull), Anorexie Hystérique (Lasègue), Anorexie Nerveuse (Gull, Charcot)'. *Le progress médical* **11**, 127-28.
- Feudtner, C. 2015. *Bittersweet: Diabetes, Insulin, and the Transformation of Illness*. Chapel Hill, NC: University of North Carolina Press.
- Foot, J., 2015. *The Man Who Closed the Asylums: Franco Basaglia and the Revolution in Mental Health Care*. London: Verso.
- Foucault, M. 1986 [1984]. *The Use of Pleasure: The History of Sexuality, Volume 2*. London: Viking.
- Foucault, M. 1991[1975]. *Discipline and Punish: The Birth of the Prison*. Penguin Books.

- Franko, D. L. & Keel, P. K. 2006. 'Suicidality in Eating Disorders: Occurrence, Correlates, and Clinical Implications'. *Clinical Psychology Review* **26**, 769–82.
- Freeman, R.J., Beach, B., Davis, R., & Solyom, L. 1985. 'The Prediction of Relapse in Bulimia Nervosa'. *Journal of Psychiatric Research* **19**, 349-53.
- Freud, S. & Breuer, S. 2004 [1895]. *Studies in Hysteria*. Translated by Nicola Luckhurst. London: Penguin Books.
- Funk, L. 2021. 'Feeding as an Attachment System among the Tao (Taiwan)'. Paper presented at ENPA 2021: Mind Embedded and Embodied – Futures of Psychological Anthropology. University of Helsinki, June.
- Galdi, F., Cassano, C., Monasterio, G., & Lami, G. 1936. *Adiposità e Magrezze Patologiche: Relazione al Quarantaduesimo Congresso della Società Italiana di Medicina Interna*. Roma: Pozzi.
- Gard, M.C.E. & Freeman, C.P. 1996. 'The Dismantling of a Myth: A Review of Eating Disorders and Socioeconomic Status'. *International Journal of eating Disorders* **20**(1), 1-12.
- Garfinkel, P.E. & Garner, D.M. 1984. 'Perceptions of the Body in Anorexia Nervosa'. In *The psychobiology of anorexia nervosa* (eds.) K.M. Pirke, & D. Ploog. Berlin: SpringerVerlag.
- Garghentini, P.G. et al. 2003. 'Historical Perspective'. In *Eating Disorders in the Mediterranean Area: An Exploration in Transcultural Psychology* (ed.) G.M. Ruggiero, 165-75. New York: Nova Science Publishers.
- Garner, D.M. & Bemis, K.M. 1982. 'A Cognitive-Behavioural Approach to Anorexia Nervosa'. *Cognitive Therapy and Research* **6**(2), 123-50.
- Geschiere, P. 2003. 'Witchcraft as the Dark Side of Kinship: Dilemmas of Social Security in New Contexts'. *Etnofoor* **16**(1), 43-61.
- Ghezzi, S. 2012. 'Parenthood and the Structuring of Time among Urban Households in Northern Italy'. *Ethnologie française* **42**(1), 37-44.
- Gibson, D., Workman, C. & Mehler P.S. 2019. 'Medical Complications of Anorexia Nervosa and Bulimia Nervosa'. *Psychiatric Clinics of North America* **42**, 263–74.

- Giordano, C. 2011. 'Translating Fanon in the Italian Context: Rethinking the Ethics of Treatment in Psychiatry'. *Transcultural Psychiatry* **48**(3), 228-56.
- Giordano, S. 2005. *Understanding Eating Disorders: Conceptual and Ethical Issues in the Treatment of Anorexia and Bulimia Nervosa*. Oxford: Clarendon Press.
- Glenn, E.N. 2010. *Forced to Care: Coercion and Caregiving in America*. Cambridge, MA: Harvard University Press.
- Goldfarb, K. 2016. 'Coming to Look Alike Materializing Affinity in Japanese Foster and Adoptive Care'. *Social Analysis* **60** (2), 47–64.
- Goldfarb, K.E. 2019. 'Embodied Relationality Beyond "Nature" vs "Nurture": Materializing Absent Kinships in Japanese Child Welfare'. In *The Cambridge Handbook of Kinship* (ed.) S. Bamford, 153-78. Cambridge: Cambridge University Press.
- Good, B.J. 1994. *Medicine, Rationality and Experience: An Anthropological Perspective*. Cambridge: Cambridge University Press.
- Gooldin, S. 2008. 'Being Anorexic: Hunger, Subjectivity, and Embodied Morality'. *Medical Anthropology Quarterly, New Series* **22**(3), 274-96.
- Gordon, R.A. 2004. 'Commentary: Towards a Clinical Ethnography'. *Culture, Medicine and Psychiatry* **28**, 603-06.
- Gremillion, H. 2003. *Feeding Anorexia: Gender and Power at a Treatment Center*. USA: Duke University Press.
- Guidano V.F., & Liotti, G. 1983. *Cognitive Process and Emotional Disorders: a Structural Approach to Psychotherapy*. NewYork: Guilford Press.
- Guisinger, S. 2003. 'Adapted to Flee Famine: Adding an Evolutionary Perspective on Anorexia Nervosa'. *Psychological Review* **110**(4), 745–76.
- Gull, W.W. 1997[1874]. 'Anorexia Nervosa (Apepsia Hysterica, Anorexia Hysterica)'. *Transactions of the Clinical Society of London* **7**, 22–8, republished in *Obesity Research* **5**(5), 498-502.
- Hacking, I. 2006. 'Making Up People'. *London Review of Books* **28**(16), 1-9.

- Han, C. 2012. *Life in Debt: Times of Care and Violence in Neoliberal Chile*. Berkeley: University of California Press.
- Harari, D., Furst, M., Kiryati N., Caspi A. & Davidson M. 2001. 'A computer-based method for the assessment of body-image distortions in anorexia nervosa patients'. *Information Technology in Biomedicine* **5**(4), 311-319.
- Hargrove, J.L., 2007. 'Does the history of food energy units suggest a solution to "Calorie confusion"?'. *Nutritional Journal* **6**, 44.
- Hastrup, K. 1993. 'Hunger and the Hardness of Facts'. *Man, New Series* **28**(4), 727-739.
- Hendricks, J. 2003. *Slim to None: A Journey Through the Wasteland of Anorexia Treatment*. Columbus, OH: McGraw-Hill.
- Herzog, D. B. & Greenwood, D. N. 2000. 'Mortality in eating disorders: A descriptive study'. *International Journal of Eating Disorders* **28**, 20–26.
- Hirschkind, C., 2001. 'The Ethics of Listening: Cassette-Sermon Audition in Contemporary Egypt'. *American Ethnologist* **28**(3), 623–49.
- Hochschild, A. 2003[1983]. *The Managed Heart*. Berkeley: University California Press.
- Ingold, T. 2000. *The Perception of the Environment: Essays on Livelihood, Dwelling and Skill*. London: Routledge.
- Istituto Superiore di Sanità (ISS). 2012. 'Conferenza di consenso sui Disturbi del Comportamento Alimentare (DCA) negli adolescenti e nei giovani adulti'. *Rapporti ISTISAN* **13/6**.
- Janet, P. 1907. *The Major Symptoms of Hysteria*. London: Macmillan.
- Janowski, M., & Kerlogue, F. 2007. *Kinship and Food in South East Asia*. NIAS Press.
- Katzman, D. K. 2005. 'Medical complications in adolescents with anorexia nervosa: A review of the literature'. *International Journal of Eating Disorders* **37**, 52-9.
- Keel, P. K., & Brown, T. A. 2010. 'Update on course and outcome in eating disorders'. *International Journal of Eating Disorders* **43**(3), 195–204.

- Kendall, C. & Hill, Z. 2010. 'Chronicity and AIDS in Three South African Communities'. In *Chronic Conditions, Fluid States: Chronicity and the Anthropology of Illness* (eds.) L. Manderson & C. Smith-Morris, 175-94. New Brunswick: Rutgers University Press.
- Kendall, S. 2011. 'Ethics and Involuntary Treatment for Anorexia Nervosa in Context: A Social Work Approach'. PhD Thesis, UNSW.
- Key, A., George, C.L., Beattie, D., Stammers, K., Lacey, H. & Waller, G. 2002. 'Body image treatment within an inpatient program for anorexia nervosa: The role of mirror exposure in the desensitization process'. *International Journal of Eating Disorders* **31**(2),185-190.
- Keys, A., Brožek, J., Henschel, A., Mickelsen, O. & Taylor, H. L. 1950. *The Biology of Human Starvation*. (2 Vols.). Minneapolis: University of Minnesota Press.
- Keys, A., Fidanza, F., Karvonen, M.J., Kimura, N. And Taylor, H.L. 1972. 'Indices of Relative Weight and Obesity'. *Journal of Chronic Diseases* **25**, 329-43.
- Khalsa, S.S., Portnoff, L., C., McCurdy-McKinnon, D. & Feusner, J.D. 2017. 'What Happens After Treatment? A Systematic Review of Relapse, Remission, and Recovery in Anorexia Nervosa'. *Journal of Eating Disorders* **14**(5), 20.
- Kleinman, A. 1988. 'Neurasthenia: Weakness and Exhaustion in the United States and China'. In *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.
- Kleinman, A. 2010. 'Caregiving: The Divided Meaning of Being Human and the Divided Self of the Caregiver'. In *Rethinking the Human* (eds.) J. M. Molina and D. K. Swearer, 17-29. Cambridge, MA: Harvard University Press.
- Kleinman, A. & Good, B. (eds). 1985. *Culture and Depression: Anthropology and Cross-Cultural Psychiatry of Affect and Disorder*. Berkeley: University of California Press.
- Koopman, C. 2019. *How We Became Our Data: A Genealogy of the Informational Person*. Chicago: The University of Chicago Press.
- Laidlaw, J. 2010. 'Agency and Responsibility: Perhaps You Can Have Too Much of a Good Thing'. In *Ordinary Ethics: Anthropology, Language, and Action* (ed.) M. Lambek, 143-64. New York: Fordham University Press.

- Laidlaw, J. 2013. *The Subject of Virtue: An Anthropology of Ethics and Freedom*. Cambridge: Cambridge University Press.
- LaMarre, A. & Rice, C. 2021. 'Recovering Uncertainty: Exploring Eating Disorder Recovery in Context'. *Culture, Medicine, Psychiatry* <https://doi.org/10.1007/s11013-020-09700-7>.
- Lambek, M. 2010. 'Introduction'. In *Ordinary Ethics: Anthropology, Language, and Action* (ed.) M. Lambek, 1-36. New York: Fordham University Press.
- Lambek, M. 2011. 'Kinship as gift and theft: Acts of succession in Mayotte and Israel'. *American Ethnologist* **38**(1), 2-16.
- Lambert, H. & McDonald, M. 2009. 'Introduction'. In *Social Bodies* (eds.) H. Lambert and M. McDonald, 1-15. New York and Oxford: Berghahn Books.
- Lancy, D. 2014. *The Anthropology of Childhood: Cherubs, Chattel, Changelings*. Second Edition. Cambridge University Press.
- Landecker, H. 2011. 'Food as Exposure: Nutritional Epigenetics and the New Metabolism'. *BioSocieties* **6**(2), 167-94.
- Landecker, H. 2013. 'Postindustrial Metabolism: Fat Knowledge'. *Public Culture* **25**(3 71), 495-522.
- Landecker, H. 2017. 'Metabolism, Autonomy, and Individuality'. In *Biological Individuality: Integrating Scientific, Philosophical, and Historical Perspectives* (eds.) Lidgard, S. & L.K. Nyhart, 225-248. Chicago: The University of Chicago Press.
- Laségue, C. 1997[1873]. 'On hysterical anorexia'. *Medical Times and Gazette*, Sept. 6, 265-6; Sept. 27, 367-9, republished in *Obesity Research* **5**(5), 492-7.
- Latour, B. 2004. 'How to Talk About the Body? The Normative Dimension of Science Studies'. *Body & Society* **10**, 205-29.
- Lavis, A., Abbots, E-J. & Attala, L. 2015. 'Introduction: Reflecting on the embodied intersections of eating and caring'. In *Careful Eating: Bodies, Food and Care* (eds.) E.J. Abbots, A. Lavis & L. Attala, 1-22. London: Routledge.

- Lavis, A. 2015. 'Careful starving: exploring (not) eating, care and anorexia'. In *Careful Eating: Bodies, Food and Care* (eds.) E.J. Abbots, A. Lavis & L. Attala. London: Routledge.
- Lavis, A. 2016. 'A Desire for Anorexia: Living through Distress'. *Medicine Anthropology Theory* **3**(1), 68-76.
- Lavis, A. 2018. 'Not Eating or Tasting Other Ways to Live: A Qualitative Analysis of "Living Through" and Desiring to Maintain Anorexia'. *Transcultural Psychiatry* **55**(4), 454-74.
- Lederman R. 2013. 'Ethics: Practices, principles, and comparative perspectives'. In *The Handbook of Sociocultural Anthropology* (eds.) J.G. Carrier & D.B. Gewertz, 588-611. London: Bloomsbury.
- Lederman, R. 2017. 'Deception and objectivity in the social and behavioral sciences', Paper prepared for the 'Fakery, Insincerity, and the Anthropology of Humbuggery' workshop, convened by Giovanni Da Col and Theodoros Kyriakides. Capri, Italy, September 2017.
- Lee, S. 1996. 'Reconsidering the status of anorexia nervosa as a Western culture-bound syndrome'. *Social Science & Medicine* **42**(1), 21-34.
- Lee, S., Ho, T. P., & Hsu, L. K. G. 1993. 'Fat phobic and non-fat phobic anorexia nervosa: A comparative study of 70 Chinese patients in Hong Kong'. *Psychological Medicine*, **23**(4), 999-1017.
- Leira, A. & Saraceno, C. 2006. 'Care: actors, relationships, contexts', *SOSIOLOGI I DAG* **36**(3), 7-34.
- Lelwica, M.M. 1999. *Starving for Salvation: the spiritual dimensions of eating problems*. Oxford: Oxford University Press.
- Lester, R.J. 1997. 'The (dis)embodied self in anorexia nervosa'. *Social Science & Medicine* **44**(4), 479-89.
- Lester, R.J. 2007. 'Critical Therapeutics: Cultural Politics and Clinical Reality in Two Eating Disorder Treatment Centers'. *Medical Anthropology Quarterly* **21**(4), 369-87.
- Lester, R.J. 2009. 'Brokering Authenticity: Borderline Personality Disorder and the Ethics of Care in an American Eating Disorder Clinic'. *Current Anthropology* **50**(3), 281-302.

- Lester, R.J. 2011. 'How Do I Code for Black Fingernail Polish? Finding the Missing Adolescent in Managed Mental Health Care'. *Ethos* **39**(4), 481-96.
- Lester, R.J. 2014. 'Health as moral failing: medication restriction among women with eating disorders'. *Anthropology & Medicine* **21**(2), 241-250.
- Lester, R.J. 2017. 'Self-governance, psychotherapy, and the subject of managed care: Internal Family Systems therapy and the multiple self in a US eating-disorders treatment center'. *American Ethnologist* **44**(1), 23-35.
- Lester, R.J. 2018. 'Ground zero: Ontology, recognition, and the elusiveness of care in American eating disorders treatment'. *Transcultural Psychiatry*, **55**(4)516-33.
- Lester, R.J. 2019. *Famished: Eating Disorders and Failed Care in America*. Berkeley: University of California Press.
- Lewis, G. 2000. *A Failure of Treatment*. Oxford: Oxford University Press.
- Littlewood, R. 1995. 'Psychopathology and personal agency: Modernity, culture change and eating disorders in South Asian societies'. *British Journal of Medical Psychology* **68**(1), 45–63.
- Lock, J. & Le Grange, D. 2005. 'Family-based treatment of eating disorders'. *International Journal of Eating Disorders* **37**, 64–7.
- Lock, M. 1993. 'Cultivating the Body: Anthropology and Epistemologies of Bodily Practice and Knowledge'. *Annual Review of Anthropology* **22**, 133-55.
- Lock, M., and Nguyen, V. 2010. *An Anthropology of Biomedicine*. Oxford: Wiley.
- Lupton, D. 2016. *The Quantified Self: A Sociology of Self-Tracking*. Cambridge: Polity.
- MacSween, M. 1993. *Anorexic Bodies: A Feminist and Sociological Perspective on Anorexia Nervosa*. London: Routledge.
- Mahmood, S. 2005. *Politics of Piety: The Islamic Revival and the Feminist Subject*. Princeton: Princeton University Press.
- Malson, H. 2008. 'Deconstructing Un/healthy Body-weight and Weight Management'. In *Critical bodies: Representations, identities and practices of weight and body management* (eds.) S. Riley, M. Burns, H. Frith, S. Wiggins, & P. Markula, 27–42. London: Palgrave/McMillan.

- Malson, H., Finn, M., Treasure, J., Clarke, S. & Anderson, G. 2004. 'Constructing 'The Eating Disordered Patient: A Discourse Analysis of Accounts of Treatment Experiences'. *Journal of Community & Applied Social Psychology* **14**, 473–89.
- Marks, A. 2019. 'The evolution of our understanding and treatment of eating disorders over the past 50 years'. *Journal of Clinical Psychology* **75**, 1380–91.
- Marsh, S. 2021, April 22. 'Eating disorders: families tube-feeding patients at home amid NHS bed shortage', *The Guardian*. Available at: <https://www.theguardian.com/society/2021/apr/22/eating-disorders-families-tube-feeding-patients-at-home-amid-nhs-bed-shortage>
- Marson, S.M. & Powell, R. M. 2014. 'Goffman and the Infantilization of Elderly Persons: A Theory in Development'. *The Journal of Sociology & Social Welfare* **41**(4), 143-58.
- Martin, E. 2007. *Bipolar Expeditions: Mania and Depression in American Culture*. Princeton: Princeton University Press.
- Martinotti, G. 1953. 'Un metodo di cura dell' anoressia psichica'. *Lavoro Neuropsichiatrico* **13**, 121.
- Mattingly, C. 2010. *The Paradox of Hope: Journeys through a Clinical Borderland*. Berkeley: University of California Press.
- Mattingly, C. 2014a. *Moral Laboratories: Family Peril and the Struggle for a Good Life*. Oakland: University of California Press.
- Mattingly, C. 2014b. 'Moral Deliberation and the Agentic Self in Laidlaw', *Hau: Journal of Ethnographic Theory*, Vol.4(1): pp.473–486.
- McDonald, M. 2014. 'Bodies and Cadavers'. In *The Routledge Companion to Objects and Materials* (eds.) P. Harvey et al. Abingdon and New York: Routledge.
- McDonald, M. 2015. 'Some Merits and Difficulties of Detachment'. In *Detachment. Essays on the limits of relational thinking* (eds.) T. Yarrow, M. Candea, C. Trundle, and J. Cook, 35-57. Manchester: Manchester University Press.
- McDonald, M., 2017. 'The Ontological Turn Meets the Certainty of Death'. *Anthropology and Medicine* **24**(2), 205-220.

- McDonald, M. 2018. 'From "the Body" to "Embodiment", with Help from Phenomenology'. In *Schools and Styles of Anthropological Theory* (ed.) M. Candea, 185-194. Oxford: Routledge.
- McKearney, P. 2017. 'L' Arche, Learning Disability, and Domestic Citizenship: Dependent Political Belonging in a Contemporary British City'. *City & Society* **29**(2), 260-80.
- McKearney, P. 2018, 'The Weight of Living: Autonomy, Care, and Responsibility for the Self'. *Journal of Disability & Religion* **22**(3), 266-82.
- McKearney, P. 2021. 'What Escapes Persuasion: Why Intellectual Disability Troubles 'Dependence' in Liberal Societies'. *Medical Anthropology* **40**(2), 155-68.
- McKinnon S. & Cannell, F. 2013 (eds.). *Vital Relations: Modernity and the Persistent Life of Kinship*. SAR Press.
- Mead, M. 2001[1928]. *Coming of Age in Samoa*. New York: Harper Collins.
- Mehler, P. S., Crews, C. & Weiner, K. 2004. 'Bulimia: Medical Complications', *Journal of Women's Health* **13**, 668–75.
- Mezzenzana, F. 2019. 'Between Will and Thought: Individualism and Social Responsiveness in Amazonian Child Rearing'. *American Anthropologist*, 540-53.
- Mezzenzana, F. 2021. 'Feeding and Being Fed: Child Care and Food Consumption among the Runa of the Ecuadorian Amazon'. Paper presented at ENPA 2021: Mind Embedded and Embodied – Futures of Psychological Anthropology. University of Helsinki, June.
- Minelli, R & Redini, V. 2015. 'Il "Caso", la Vita e le Sue Condizioni. Per una Antropologia Politica del Welfare State in Italia'. *Anuac* **4**(1), 145-69.
- Ministero della Sanità 1998. 'Commissione di Studio per l'Assistenza ai Pazienti Affetti da Anoressia e Bulimia Nervosa'. *Annali della Sanità Pubblica* **III**, 9-20.
- Minuchin, S., Rosman, B. L. & Baker, L. 1978. *Psychosomatic families: Anorexia Nervosa in Context*. Cambridge, MA: Harvard University Press.
- Mitchison, D., Hay, P., Slewa-Younan, S. & Mond, J. 2014. 'The Changing Demographic Profile of Eating Disorder Behaviors in the Community'. *BMC Public Health* **14**:943.

- Mody, P. 2020. 'Kinship Care'. In *Spaces of Care* (eds.) L. Gelsthorpe, P. Mody & B. Sloan, 183-200. Oxford: Hart.
- Mol, A. 2002. *The Body Multiple: Ontology in Medical Practice*. Durham, NC: Duke University Press.
- Mol, A. 2008. *The Logic of Care: Health and the Problem of Patient Choice*. New York: Routledge.
- Mol, A., Moser, I., & Pols, J. (eds.). 2010. *Care in Practice: On Tinkering in Clinics, Homes and Farms*. New York: Columbia University Press.
- Molinari, A. 2017. 'IL FAUT BIEN MANGER: Etnografia di un Centro per Disturbi Alimentari'. PhD Thesis, Università degli Studi di Milano-Bicocca.
- Mollona, M. 2005. 'Factory, Family and Neighbourhood: The Political Economy of Informal Labour in Sheffield'. *Journal of the Royal Anthropological Institute* **11**(3), 527-48.
- Montgomery, H. 2008. *An Introduction to Childhood: Anthropological Perspectives on Children's Lives*. UK: Wiley Blackwell.
- Mosley, P.E. 2009. 'Bigorexia: Bodybuilding and Muscle Dysmorphia'. *European Eating Disorders Review* **17**(3), 191-198.
- Moulding, N. 2003. 'Constructing the Self in Mental Health Practice: Identity, Individualism and the Feminization of Deficiency'. *Feminist Review* **75**, 57-74.
- Muehelebach, A. 2011. 'On Affective Labor in Post-Fordist Italy'. *Cultural Anthropology* **26**(1), 59-82.
- Muehlebach, A. 2012. *The Moral Neoliberal: Welfare and Citizenship in Italy*. Chicago: The University of Chicago Press.
- Muehlebach, A. 2013. 'The Catholicization of Neoliberalism: On Love and Welfare in Lombardy, Italy'. *American Anthropologist* **115**(3), 452-465.
- Murray, S.B. & Anderson, L.K. 2015. 'An Introduction to the Special Issue on Innovations in Family Therapy for Eating Disorders'. *Eating Disorders* **23**(4), 279-80.
- Musolino, C., Warin, M., Wade, T. & Gilchrist, P. 2015. '“Healthy Anorexia”: The Complexity of Care in Disordered Eating'. *Social Science & Medicine* **139**, 18-25.

- Musolino, C., Warin, M., Wade, T. & Gilchrist P. 2016. 'Developing Shared Understandings of Recovery and Care: A qualitative study of Women with Eating Disorders who Resist Therapeutic Care'. *Journal of Eating Disorders* **4**, 36.
- Musolino, C., Warin, M., & Gilchrist, P. 2018. 'Positioning Relapse and Recovery Through a Cultural lens of Desire: A South Australian Case Study of Disordered Eating'. *Transcultural Psychiatry* **55**(4), 534–50.
- Myers, N.L. 2015. *Recovery's Edge: An Ethnography of Mental Healthcare and Moral Agency*. Nashville, US: Vanderbilt University Press.
- Niewöhner, J. 2011. 'Epigenetics: Embedded Bodies and the Molecularisation of Biography and Milieu'. *BioSocieties* **6**, 279–98.
- Niola, M. 2015. *Homo Dieteticus: Viaggio nelle Tribù Alimentari*. Bologna: Il Mulino.
- O'Connor, R. A. & Van Esterik, P. 2008. 'De-medicalizing Anorexia: A New Cultural Brokering'. *Anthropology Today* **24**(5), 6–9.
- Ochs, E. & Izquierdo, C. 2009. 'Responsibility in Childhood: Three Developmental Trajectories'. *Ethos* **37** (4), 391–413.
- Oeye, C., Bjelland, K.A. & Skorpen, A. 2007. 'Doing Participant Observation in a Psychiatric Hospital: Research Ethics Resumed'. *Social Science & Medicine* **65**, 2296-2306.
- Orbach, S. 1986. *Hunger strike: The Anorectic's Struggle as a Metaphor for Our Age*. London: Faber.
- Otto, H. & Keller, H. 2014. *Different Faces of Attachment: Cultural Variations on a Universal Human Need*. Cambridge: Cambridge University Press.
- Otonello, P. 1937. 'Contributo alla Delimitazione Clinica dell' Anoressia Mentale'. *Rivista di Patologia Nervosa* **50**, 353.
- Palazzo, C. 2020, February 16. 'I sogni del nostro Lorenzo, ucciso a vent'anni dall'anoressia e dalla legge', *La Repubblica*, retrieved from:
https://torino.repubblica.it/cronaca/2020/02/16/news/il_nostro_lorenzo_ucciso_a_vent_anni_dall_anoressia_e_dalla_legge_-248707314/?ref=search

- Palazzo, C. 2020, February 18. 'Famiglie sole davanti all'anoressia? Sì, in Piemonte mancano le strutture', *La Repubblica*, retrieved from:
https://torino.repubblica.it/cronaca/2020/02/17/news/_famiglie_sole_davanti_all_anoressia_si_in_piemonte_mancano_le_strutture_-248841972/?ref=search
- Pearce, J.M.S. 2004. 'Richard Morton: Origins of Anorexia Nervosa'. *European Neurology* **52**(4), 191-2.
- Pinto, S. 2011. 'Rational Love, Relational Medicine: Psychiatry and the Accumulation of Precarious Kinship'. *Culture, Medicine and Psychiatry* **35**, 376–95.
- Pinto, S. 2014. *Daughters of Parvati: Women and Madness in Contemporary India*. Philadelphia: University of Pennsylvania Press.
- Pols, J. 2015. 'Towards an Empirical Ethics in Care: Relations with Technologies in Health Care', *Medicine, Health Care and Philosophy* **18**, 81–90.
- Porta, S. (Simonis Portiis) 1951[1551]. *De Puella Germanica, que Fere Biennium Vixerat sine Cibo, Portuque (Disputatio)*. Firenze: L. Torrentini.
- Porter, T.M. 1995. *Trust in Numbers: The Pursuit of Objectivity in Science and Public Life*. Princeton: Princeton University Press.
- Prince, R. 1985. 'The concept of Culture-bound Syndromes: Anorexia Nervosa and Brain-fag'. *Social Science & Medicine* **21**(2), 197–203.
- Probst, M., Vandereycken, W., Van Copenolle H. & Pieters, G. 1995. 'Body Size Estimation in Eating Disorder Patients: Testing the Video Distortion Method on a Life-size Screen'. *Behavioural Research and Therapy* **33**, 985-990.
- Probst, M., Vandereycken, W., Vanderlinden, J. & Van Copenolle H. 1998. 'The Significance of Body Size Estimation in Eating Disorders: its Relationship with Clinical and Psychological Variables'. *Eating Disorders* **24**, 167-74.
- Rabinbach, A. 1992. *The Human Motor: Energy, Fatigue, and the Origins of Modernity*. Berkeley: University of California Press.

- Raevuori, A., Keski-Rahkonen, A. & W Hoek, H. 2014. 'Review of Eating Disorders in Males'. *Current Opinion in Psychiatry* **27**(6), 426–30.
- Rilke, R.M. 1962[1934]. *Letters to a Young Poet*. New York: Norton & Company.
- Ritenbaugh, C., Shisslak, C. & Prince, R. 1996. 'A Cross-cultural Review in Regard to DSM-IV'. In *Culture and Psychiatric Diagnosis: A DSM-IV Perspective* (eds.) J. E. Mezzich, H. Fabrega, A. Kleinman & D. Perron, 171-186. Washington, D.C.: APA Press.
- Robbins, J. 2004. *Becoming Sinners: Christianity and Moral Torment in a Papua New Guinea Society*. Berkeley: University of California Press.
- Robbins, J. 2008. 'On Not Knowing Other Minds: Confession, Intention, and Linguistic Exchange in a Papua New Guinea Community'. *Anthropological Quarterly* **81**(2), 421-29.
- Robbins, J. 2013. 'Beyond the Suffering Subject: Toward an Anthropology of the Good'. *Journal of the Royal Anthropological Institute* **19**, 447-62.
- Robinson, G. 1972. 'The Story of Parentectomy'. *Journal of Asthma Research* **9**(4), 199-205.
- Rose, N. 1990. *Governing the Soul: The Shaping of the Private Self*. London: Routledge.
- Rose, N. 1996. *Inventing Ourselves: Psychology, Power and Personhood*. Cambridge: Cambridge University Press.
- Rosen, D.S. 2010. 'Identification and Management of Eating Disorders in Children and Adolescents'. *Pediatrics* **126**(6), 1240-53.
- Rossini, R. 1959. 'Brevi Considerazioni in Tema di Patogenesi e di Inquadramento Nosografico dell'Anoressia Mentale'. *Rivista Sperimentale di Freniatria* **83**, 36.
- Ruff, G.A. & Barrios, B.A. 1986. 'Realistic Assessment of Body Image'. *Behavioural Assessment* **8**, 237-52.
- Ruggiero, G.M. & Prandin, M. 2003. 'Tradition, Transition, and Social Cognition in Italy: Are they Correlated with Eating Disorders?'. In *Eating Disorders in the Mediterranean Area: An Exploration in Transcultural Psychology* (ed.) G. Ruggiero, 148-64. New York: Nova Science Publishers.

- Ruggiero, G.M., Prandin, M. & Mantero, M. 2001. 'Eating Disorder in Italy: A Historical Review'. *European Eating Disorders Review* 9, 292-300.
- Ruggiu, V. 2016. 'Eccellenze Rare, Altrove si Finisce in Psichiatria', in 'Disturbi Alimentari: Curarsi è un'Odissea', special issue of *La Repubblica*, 12 August 2016.
- Rusconi, A. 2004. 'Different Pathways out of the Parental Home: A Comparison of West Germany and Italy'. *Journal of Comparative Family Studies* 35(4), 627-48.
- Russell, G., Szmukler, G., Dare, C. & Eisler, I. 1987. 'An Evaluation of Family Therapy in Anorexia Nervosa and Bulimia Nervosa'. *Archives of General Psychiatry* 44(12), 1047-56.
- Russell, G. 1979. 'Bulimia Nervosa: An Ominous Variant of Anorexia Nervosa'. *Psychological Medicine* 9(3), 429-48.
- Rynkiewicz, M.A. & Spradley, J.P. 1976. *Ethics and Anthropology: Dilemmas in Field Work*. New York: Wiley.
- Sachdev, P., Mondraty N., Wen W. & Guilford K. 2008. 'Brains of Anorexia Nervosa Patients Process Self-images Differently from Non-self images: an fMRI study'. *Neuropsychologia* 46, 2161-8.
- Saraceno, C. 2004. 'The Italian Family from the 1960s to the Present'. *Modern Italy* 9(1), 47-57.
- Saraceno, C. 2011. 'Beyond Care. The Persistent Invisibility of Unpaid Family Work'. *Sociologica - Italian Journal of Sociology* 1, 1-15.
- Saraceno, C. 2015. 'Trends and Tensions within the Italian Family'. In *The Oxford Handbook of Italian Politics* (eds.) E. Jones & G. Pasquino. Oxford: Oxford University Press, 465-79.
- Scheper-Hughes, N. 1987. "'Basic Strangeness": Maternal Estrangement and Infant Death – A Critique of Bonding Theory', In *The Role of Culture in Developmental Disorder* (ed.). M. C. Super. New York: Academic Press.
- Schilder, P. 1935. *The Image and Appearance of the Human Body*. London: Kegan Paul.
- Schmidt, U., R. et al. 2016. 'Eating Disorders: The Big Issue'. *The Lancet Psychiatry* 3(4), 313-15.

- Schwartzmann, H. 1978. 'The Invention of Childhood'. In *Transformations: the Anthropology of Children's Play*. New York: Plenum Press.
- Selvini-Palazzoli, M. 1963. *L'Anoressia Mentale*. Milano: Feltrinelli
- Selvini-Palazzoli, M. 1965. 'Interpretation of Mental Anorexia'. In *Anorexia Nervosa* (eds.) J. Meyer & H. Feldmann. Stuttgart: Thieme.
- Selvini-Palazzoli, M. 1978. *Self-starvation: From the Intrapsychic to the Transpersonal Approach to Anorexia Nervosa*. London: Chaucer.
- Signorini, A., De Filippo, E., Panico, S., De Caprio, C., Pasanisi, F. & Contaldo, F. 2007. 'Long-term Mortality in Anorexia Nervosa: A Report after an 8-year Follow-up and a Review of the Most Recent Literature'. *European Journal of Clinical Nutrition*, **61**, 119–22.
- Slade, P.D. & Russel G.F.M. 1973. 'Awareness of Body Dimensions in Anorexia Nervosa: Cross Sectional and Longitudinal Studies'. *Psychological Medicine* **3**, 188-199.
- Smink, F.R.E., van Hoeken, D. and Hoek, H.W. 2012. 'Epidemiology of Eating Disorders: Incidence, Prevalence and Mortality Rates'. *Current Psychiatry Reports* **4**(4), 406-14.
- Smith-Morris, C. 2010. 'The Chronicity of Life, the Acuteness of Diagnosis'. In *Chronic Conditions, Fluid States: Chronicity and the Anthropology of Illness* (eds.) L. Manderson & C. Smith-Morris, 21-37. New Brunswick: Rutgers University Press.
- Sontag, S. 1978. *Illness as Metaphor*. New York: Farrar, Straus and Giroux.
- Squire, S. 2003. 'Anorexia and Bulimia: Purity and Danger'. *Australian Feminist Studies* **18**(40), 17-26.
- Stevens, J. 2021, November 28. 'I was at war with my body': My Year as a Day Patient on an Eating Disorders Ward', *The Guardian*, retrieved from: <https://www.theguardian.com/society/2020/nov/28/i-was-at-war-with-my-body-my-year-as-a-day-patient-on-an-eating-disorders-ward>
- Stevenson, L. 2014. *Life Besides Itself: Imagining Care in the Canadian Arctic*. Berkeley: University of California Press.

- Strathern, M. 1988. *The Gender of the Gift: Problems with Women and Problems with Society in Melanesia*. Berkeley: University of California Press.
- Strathern, M. 2009. 'Using Bodies to Communicate'. In *Social Bodies* (eds.) H. Lambert and M. McDonald 148-169. New York and Oxford: Berghahn Books.
- Strathern, M. 2018. 'Persons and Partible Persons'. In *Schools and Styles of Anthropological Theory* (ed.) M. Candea, 236-246. London and New York: Routledge.
- Street, A. 2014. *Biomedicine in an Unstable Place: Infrastructures and Personhood in a Papua New Guinean Hospital*. Durham, NC: Duke University Press.
- Sturm, B.A. 2004. 'Ethics and Care: An Ethnographic Study of Psychiatric Community Health Nursing Practice'. *Archives of Psychiatric Nursing* **XVIII**(3), 106-115.
- Swartz, L. 1985. 'Anorexia Nervosa as a Culture-bound Syndrome'. *Social Science & Medicine* **20**(7), 725-730.
- Tait, G. 1993. "'Anorexia Nervosa": Asceticism, Differentiation, Government'. *Journal of Sociology* **29**(2), 194-208.
- Tanassi, L.M. 2004. 'Compliance as Strategy: The Importance of Personalised Relations in Obstetric Practice'. *Social Science & Medicine*, 2053-69.
- Taylor, J.S. 2005. 'Surfacing the Body Interior'. *Annual Review of Anthropology* **34**, 741-56.
- Ticktin, M. 2011. *Causalities of Care: Immigration and the Politics of Humanitarianism in France*. Berkeley: University of California Press.
- Touyz, S. & Hay, P. 2015. 'Severe and Enduring Anorexia Nervosa (SE-AN): In Search of a New Paradigm'. *Journal of Eating Disorder* **3**, 26.
- Trace, S.E., Baker, J.H., Penas-Lledo, E. & Bulik, C.M. 2013. 'The Genetics of Eating Disorders'. *Annual Review of Clinical Psychology* **9**, 589-620.
- Treasure, J. 2010. 'Introduction'. In *The Clinician's Guide to Collaborative Caring in Eating Disorders* (eds.) J. Treasure, U. Schmidt & P. Macdonald. Hove: Routledge.

- Treasure, J., Stein, D. & Maguire, S. 2015. 'Has the Time Come for a Staging Model to Map the Course of Eating Disorders from High Risk to Severe Enduring Illness? An Examination of the Evidence'. *Early Intervention in Psychiatry* **9**(3), 173–84.
- van der Geest, F. & Finkler, K. 2004. 'Hospital Ethnography: Introduction'. *Social Science & Medicine* **59**, 1995-2001.
- van der Geest, S. 2007. 'Is it Possible to Understand Illness and Suffering?'. *Medische Antropologie* **19**(1), 9-21.
- van Dongen, E. 2002. 'Theatres of the Lie: Crazy' Deception and Lying as Drama'. *Anthropology & Medicine* **9**(2), 135-51.
- van Ginkel, R. 1998. 'The Repatriation of Anthropology: Some Observations on Endo-ethnography'. *Anthropology & Medicine* **3**, 251-67.
- Vandereycken, W. & van Deth, R. 1994. *From Fasting Saints to Anorexic Girls: The History of Self-starvation*. London: Athlone.
- Vandereycken, W., Depreitere, L. & Probst, M. 1987. 'Body-oriented Therapy for Anorexia Nervosa Patients'. *American Journal of Psychotherapy* **41**(2), 252-9.
- Vermeulen, E. 2004. 'Dealing with Doubt: Making Decisions in a Neonatal Ward in the Netherlands'. *Social Science & Medicine* **59**, 2071-85.
- Vilaça, A. 2002. 'Making Kin out of Others in Amazonia'. *The Journal of the Royal Anthropological Institute* **8**(2), 347-65.
- Vogel, E. 2018a. 'Operating (on) The Self: Transforming Agency through Obesity Surgery and Treatment'. *Sociology of Health & Illness* **40**(3), 508–22.
- Vogel, E. 2018b. 'Metabolism and Movement: Calculating Food and Exercise or Activating Bodies in Dutch Weight Management'. *BioSocieties* **13**(2), 389–407.
- Warin, M. 2005. 'Transformation of Intimacy and Sociality in Anorexia: Bedrooms in Public Institutions'. *Body & Society* **11**(3), 97-113.
- Warin, M. 2010. *Abject Relations: Everyday Worlds of Anorexia*. USA: Rutgers University Press.

- Warren, C.S., Schafer, K.J., Crowley, M.E.J., & Olivardia, R. 2013. 'Demographic and Work-Related Correlates of Job Burnout in Professional Eating Disorder Treatment Providers'. *Psychotherapy* **50**(4), 553–64.
- Weiss, G., 1999. 'The Abject Borders of the Body Image'. In *Perspectives on Embodiment: The Intersections of Nature and Culture* (eds.) G. Weiss & Fern, H., 41–60. London: Routledge.
- Welbourn, R.B. 1992. 'The Emergence of Endocrinology'. *Gesnerus* 49(2), 137-50.
- Wilson G.T. 1999. 'Cognitive Behavioral Therapy for Eating Disorders: Progress and Problems. *Behaviour Research and Therapy* **37**, S79.
- Wind, G. 2008. 'Negotiated Interactive Observation: Doing Fieldwork in Hospital Settings'. *Anthropology & Medicine* **15**(2), 79-89.
- Winnicott, D.W. 1957. *The Child and the Family*. London: Tavistock.
- Winnicott, D. W. 1965. *The Family and Individual Development*. London: Tavistock.
- Yanagisako, S., 2003. *Producing Culture and Capital: Family Firms in Italy*. Princeton University Press.
- Yates, A., 1989. 'Current Perspectives on Eating Disorders: History, Psychological and Biological Aspects', *J. Am. Acad. Child Adolesc. Psychiatry* **28**(6), 813-28.
- Yates-Doerr, E. 2012. 'The Weight of the Self: Care and Compassion in Guatemalan Dietary Choices'. *Medical Anthropology Quarterly* **26**(1) 136–58.
- Zaman, S. 2004. 'Poverty and Violence, Frustration and Inventiveness: Hospital Ward Life in Bangladesh'. *Social Science & Medicine* **59**, 2025-36.
- Zaman, S. 2008. 'Native Among the Natives: Physician Anthropologist Doing Hospital Ethnography at Home'. *Journal of Contemporary Ethnography*, **37**(2), 135-154.
- Zelizer, V. 1985. *Pricing the Priceless Child: The Changing Social Value of Children*. New York: Basic Books.
- Zigon, J. 2007. 'Moral Breakdown and the Ethical Demand: A Theoretical Framework for an Anthropology of Moralities'. *Anthropological Theory* **7**(2), 131-50.

Appendices

Appendix 1: Authorization Letter

[Redacted]
[Redacted]

[Redacted]
[Redacted]

Io sottoscritta [Redacted], Responsabile della Rete dei Servizi DCA della [Redacted]
dichiaro di approvare la presenza e la ricerca della studentessa Giulia Sciolli presso i nostri centri
per la sua tesi di Dottorato presso l'Università di Cambridge.

La sua ricerca è in linea con i principi etici dei nostri Centri e saremo felici di collaborare con il
suo studio, permettendole di partecipare alle attività previste e di parlare con i membri dello staff
e le pazienti che esprimeranno interesse.

Per quanto riguarda le pazienti, anche coloro al di sotto dei 18 anni che saranno interessate a
partecipare potranno farlo senza il bisogno di ottenere il consenso dei genitori, in quanto in grado
di prendere questo tipo di decisione.

Inoltre ogni paziente – e i genitori se minorenne – prima dell'accesso al centro è tenuta a firmare
un documento che consente alla possibile presenza di studi di ricerca.

[Redacted] li 22/3/2018

La Responsabile

[Redacted]
[Redacted]
[Redacted]

Authorization Letter (translated in English)

I the undersigned [REDACTED], Clinical Director of the Eating Disorder Treatment Network [REDACTED] declare to approve the presence of the student Giulia Sciolli in our facilities to conduct research for her PhD in Social Anthropology at the University of Cambridge.

Her research is in line with our ethical guidelines and we are happy to collaborate with her study. We give her permission to participate in the activities of the centre and to talk to the staff members and the patients who will be willing to do so.

Patients who are under 18 years of age will also be able to participate without the need to obtain specific consent from their parents, since they are capable of taking this kind of decision. Moreover, before admission, every patient – and the parents if the patient is under 18 – has to sign a document that consents to potential research studies being conducted during their stay.

[REDACTED], 22nd March 2018

Dr [REDACTED]
Clinical Director of the
Eating Disorder Treatment Network
[REDACTED]

Appendix 2: Samples of information sheets and informed consent form

Information Sheet for Patients (translated in English)

You will be given a copy of this information sheet.

Title of the project: Striving for Good Care in Eating Disorder Treatment

This study has been approved by the Research Ethics Committee of the Department of Social Anthropology at the University of Cambridge.

Name of the Researcher: Giulia Sciolli

Work Address: Department of Social Anthropology, Free School Lane, Cambridge, CB2 3RF

Contact Details: gs591@cam.ac.uk; 3483231781

Hi, my name is Giulia Sciolli. I am doing a PhD in Social Anthropology at the University of Cambridge, and I would like to invite you to take part in my research study. Before you decide whether you would like to participate, it is important that you know why I am carrying out this research and what it will involve. Please take time to read this information and discuss it with others if you want. It is completely up to you to decide whether to take part or not: if you decide not to take part it is totally fine; if you decide to take part you will be asked to sign a consent form, but if you change your mind at any point you are free to withdraw without giving a reason. If there is anything that is not clear, or if you would like more information, please feel free to ask me in person or contact me by phone/email.

What is this study about and why is it important?

The aim of this research is to understand what treating eating disorders entails, what healthcare workers 'need to do' in order to provide good treatment, and how they experience their job tasks. At the same time, I am interested in how patients experience treatment. I am therefore particularly interested in understanding your experiences in this treatment centre. The insights gained from this research will help contribute to fill the gap in current anthropological literature, which has been mainly focused on explaining the causes of eating disorders, and much less so on treatment and recovery, especially on how to make treatment 'work'. The findings of this research might also be used outside academia to promote positive changes in treatment policies and practices.

I will be staying in the treatment centre as a volunteer and participate in different group activities, by observing what goes on during them and engaging with some of the more practical activities. On top of that, I would be really happy to talk to you individually about your own experiences. I hope you will be interested in participating, but if for any reason you not only do not want to talk to me but you also do not want any of your information becoming part of my research, just tell me and I will exclude your presence from my notes and data.

Who am I recruiting?

- Any member of staff;
- Patients who have been diagnosed with anorexia or bulimia nervosa;

What will happen if you decide to participate?

If you want to participate, we will arrange a time when we can talk about your experience with an eating disorder and of being in treatment here and in other places you might have been. It will not be a matter of filling out a questionnaire or a test, but a conversation to understand your views and listen to what you want to tell me, while I will take notes. There are no correct or incorrect answers. You can decide where you prefer to talk.

What are the benefits in participating?

There are no immediate benefits in participating, but your participation will contribute to raising issues that might help other people struggling with eating disorders, and also help healthcare workers find better ways to deal with the difficulties of this job. Still, I hope your involvement will be a source of interest and enjoyment for you as well. If you give me your email address, I will also provide you with a copy of the dissertation as soon as it will be released.

Are there any risks in participating?

There are no anticipated risks in participating. Everything you will tell me will be kept strictly confidential and your name will not appear anywhere in the resulting dissertation. If you start feeling uncomfortable while talking to me and wish to stop, you are always free to do so.

Anonymity and confidentiality

All your personal data will be collected and stored in accordance with the EU's General Data Protection Regulation coming into force on 25 May 2018, and with concomitant updates to the Data Protection Act in the UK and in Italy. The results of the research will be reviewed by professors at the University of Cambridge as part of completing a PhD in Social Anthropology and potentially published, but you will not be identifiable from such publications.

All personally identifying information will be removed from my notes and analysis by either omission or the use of a pseudonym (a fake name). Nobody apart from the researcher will be able to access this information. You can decide to withdraw your data from the project at any time up until it is transcribed in the final report, which will be in the Spring of 2020.

Information Sheet for Staff Members (translated in English)

You will be given a copy of this information sheet.

Title of the project: Striving for Good Care in Eating Disorders Treatment.

This study has been approved by the Research Ethics Committee of the Department of Social Anthropology at the University of Cambridge.

Name of the Researcher: Giulia Sciolli

Work Address: Department of Social Anthropology, Free School Lane, Cambridge, CB2 3RF

Contact Details: gs591@cam.ac.uk; 3483231781

Hi, my name is Giulia Sciolli. I am doing a PhD in Social Anthropology at the University of Cambridge, and I would like to invite you to take part in my research study. Before you decide whether you would like to participate, it is important that you know why I am carrying out this research and what it will involve. Please take time to read this information and discuss it with others if you want. It is completely up to you to decide whether to take part or not: if you decide not to take part it is totally fine; if you decide to take part you will be asked to sign a consent form, but if you change your mind at any point you are free to withdraw without giving a reason. If there is anything that is not clear, or if you would like more information, please feel free to ask me in person or contact me by phone/email.

What is this study about and why is it important?

The aim of this research is to understand what treating eating disorders entails, what healthcare workers 'need to do' in order to provide good treatment, and how they experience their job tasks. At the same time, I am interested in how patients experience treatment. I am therefore particularly interested in understanding your work experiences in this treatment centre. The insights gained from this research will help contribute to fill the gap in current anthropological literature, which has been mainly focused on explaining the causes of eating disorders, and much less so on treatment and recovery, especially on how to make treatment 'work'. The findings of this research might also potentially be used outside academia to promote positive changes in treatment policies and practices.

I will be working as a volunteer in the treatment centre and participate in different group activities, by observing what goes on during them and engaging with some of their more practical parts. On top of that, I would be really happy to talk to you individually about your views and your experiences with patients. I hope you will be interested in participating, but if for any reason you not only do not want to talk to me but you also do not want any of your information becoming part of my research, just tell me and I will not consider your presence during my observations.

Who am I recruiting?

- Any member of staff;
- Patients who have been diagnosed with anorexia or bulimia nervosa;

What will happen if you decide to participate?

If you want to participate, we will arrange a time when we can talk about your experiences with patients. It will not be a matter of filling out a questionnaire or a test, but a conversation to understand your views and listen to what you want to tell me. You can decide where you prefer to talk. If you are ok with it, I will record our conversation so that I do not need to keep scribbling down while we talk, and I will reduce the risk of missing something from what you say. However, if you prefer not to be recorded, just tell me when I ask you.

What are the benefits in participating?

There are no immediate benefits in participating, but your participation will contribute to raising issues that might help other people struggling with eating disorders, and also help other healthcare workers find better ways to deal with the difficulties of this job. Still, I hope that your involvement will be a source of interest and enjoyment for you as well. If you give me your email address, I will also provide you with a copy of the dissertation as soon as it will be released.

Are there any risks in participating?

There are no anticipated risks in participating. Everything you will tell me will be kept strictly confidential and your name will not appear anywhere in the resulting dissertation. If you start feeling uncomfortable while talking to me and wish to stop, you are always free to do so.

Anonymity and Confidentiality

All your personal data will be collected and stored in accordance with the EU's General Data Protection Regulation coming into force on 25 May 2018, and with concomitant updates to the Data Protection Act in the UK and in Italy. The results of the research will be reviewed by professors at the University of Cambridge as part of completing a PhD in Social Anthropology and potentially published, but you will not be identifiable from such publications.

Recorded interviews will be transcribed and the tape will then be wiped clear. All personally identifying information will be removed from the written transcripts by either omission or the use of a pseudonym (a fake name). Nobody apart from the researcher will be able to access this information. You can decide to withdraw your data from the project at any time up until it is transcribed in the final report, which will be in the Spring of 2020.

Informed Consent Form (translated in English)

Please complete this form after you have read the Information Sheet and/or listened to an explanation of the research.

Title of the Project: Striving for Good Care in Eating Disorder Treatment

This study has been approved by the Research Ethics Committee of the Department of Social Anthropology at the University of Cambridge.

Thank you for your interest in taking part in this research. Before you agree to take part, the person organising the research must explain the project to you.

If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Participant's Statement

I,

- have read the notes written above and the Information Sheet, and understand what the study involves.
- understand that if I decide at any time that I no longer wish to take part in this project, I can notify the researchers involved and withdraw immediately.
- understand that the information I have submitted will be published as a dissertation and I will be sent a copy. Confidentiality and anonymity will be maintained and it will not be possible to identify me from any publications.
- consent to the processing of my personal information for the purposes of this research study.
- agree that my non-personal research data may be used by the researcher for future research. I am assured that the confidentiality of my personal data will be upheld through the removal of identifiers.
- understand that such information will be treated as strictly confidential and handled in accordance with the EU's General Data Protection Regulation coming into force on 25 May 2018, and with concomitant updates to the Data Protection Act in the UK and in Italy.
- agree that the research project named above has been explained to me to my satisfaction and I agree to take part in this study.

Signed:

Date: