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ORIGINAL ARTICLE

Control Freak/Control Freaks:

Toward a Multilevel Interactionist Schema for Demystifying the Relationship between Eating Disorders and Control

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Abstract

The claim that eating disorders (EDs) are about control has been repeated so frequently that it has become a truism. However, because the concept of control is rarely defined or operationalized in discourses about EDs, there are ongoing limitations to its explanatory power in everyday and clinical settings. Recently, critical scholars have also acknowledged that accentuating control framings without specifying what people who are socialized as ED patients seek to control can have deleterious implications for how we are perceived and our institutional trajectories (Branley-Bell et al., 2023). Therefore, with this piece, I hope to offer some conceptual clarity about what it could mean to refer to control as a key element of EDs, particularly for those who are diagnosed with co-occurring obsessive compulsive symptoms. My desire in doing so is not to reify ED and other psychiatric diagnostic categories. Rather, it is to propose that the pursuit of control through eating rules and rituals does not significantly depart from other forms of meaning-making through which western societies operate. Though they may represent an intensification or escalation of the impulse to impose order onto constellations of random events, the psyches of many ED patients nonetheless reflect the patterned institutional arrangements that structure all of our daily lives - psychiatry included. To evince this claim, and as an entry into critiquing hegemonic understandings of EDs through a lens of Mad Studies, I will draw from autoethnographic anecdotes to relay how the processes of ED diagnosis and treatment have societal control functions that are similar to the individual control functions of the disorders themselves. They too are attempts to organize and systematize the interminable contradictions of capitalist society - contradictions that are irreconcilable, no matter how valiantly the individual patient or the treatment apparatus they are embedded in tries. As such, I will argue, the symptomology of EDs and treatment for them can be mutually reinforcing in their content and objectives. At worst, treatment can exacerbate eating and related conditions because the

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expectation of full recovery is an outward manifestation of the internal rigidity that motivates treatment seeking to begin with.

Introduction: Situating Control Within the Individual

I am in freefall. Careening through space. Searching for something - anything - to hold onto.
There are only shapes.
Arks. Orbs. Spheres. Cylinders. Sunspots, moonbeams, shooting stars and lighting bolts.
They dance past me, dissolving as I touch them. They are pure ephemera.
I need [them] to be Real.

In the simplest, most neutral terms, I am a visual thinker. Thinking through visual processing is common in the general population. It is in no way pathological. The extent to which I am solely a visual thinker, however, and the frequency with which my visualizations feel material, imbued with kinesthetic qualities that seize, squeeze, and suffocate me from within, may be idiosyncratic. As a child, long before my first encounter with the mental health system, there were the shapes. The shapes were scary. The shapes made me sad. I saw the shapes as they latched onto my neck, wriggling into my auditory canal and down my throat before taking up residence in my belly. Also, as a child, I had lingering ear infections. I was debilitated by tummy aches. I could not articulate how my physical and other forms of dis-ease were intertwined, and I sought to manage them by mastering attendant cognitive processes. First, and without having to exert significant effort, I mastered language. Practicing verbalization did not usurp the shapes, but it did allow me to feign normalcy while concealing how chaotic and frightening my interiority was. Next, and more ambitiously, I sought to master subjectivity itself. I soon realized that by devising ornate numerical schemas that correlated to every thought, feeling, and act, I could play a sort of psychic Tetris that made existence tolerable. Numbers, then and now, were a container and a cage - for the shapes, yes, but also quite literally given my decades-long history of psychiatric incarceration since.

My preoccupation with numbers was first made legible to biomedical psychiatry through a diagnosis of anorexia. A period of sudden weight loss at age eleven led me to an adolescent eating disorder (ED) clinic, where my conversations with the staff dietician, psychotherapist, and physician revolved almost exclusively around body image. While I do not minimize the salience of body weight and shape as a gendered, racialized, and classed marker of symbolic power (Warin, 2010), and it would be disingenuous to claim to be unconcerned with my appearance, the allure of what gets medicalized as anorexia *for me* is that it is an ontological status of eternal quantification. Its variables - calories ingested; calories expelled; minutes until one next eats; minutes spent eating; steps taken; steps not taken, and so on - intersect into multidimensional mind maps that can be arranged and amended infinitely, affording me agency over what would otherwise be an impossibly unwieldy visual-affective sense of embodiment. My weight loss was thus a tertiary symptom of the complex relationship between an underlying experience of Mad subjectivity and the equivalently Mad strategy produced to cope with it. And, because it coincided with thinking and seeing clearly for the

first time, others' insistence that I was sick confused me. Likewise, I could not understand why my eventual weight gain was interpreted as an indicator of health. It was associated with serious decline. Nonetheless, I was deemed in remission as soon as I stopped displaying physical signs of self-starvation. I was also discharged from the clinic having never once described the shapes, just as they returned with unprecedented ferocity.

As this anecdote suggests, I do not disagree that EDs are about control. Yet because the term "control" is often cloaked in generalizations, I remain frustrated by ongoing limitations to its explanatory power in everyday and clinical settings. Accentuating control framings without specifying what people who are socialized as ED patients seek to control can have deleterious implications for how we are perceived and our institutional trajectories (Branley-Bell et al., 2023). Therefore, with this piece, I hope to offer some conceptual clarity about what it could mean to refer to control as a key element of EDs, particularly for those who are diagnosed with comorbid psychiatric conditions. My desire in doing so is not to reify ED and other psychiatric diagnostic categories. Rather, it is to propose that the pursuit of control through eating rules and rituals does not significantly depart from other forms of meaning-making through which western societies operate. Though they may represent an intensification or escalation of the need to impose order onto constellations of random events, the psyches of many ED patients nonetheless reflect the patterned institutional arrangements that structure all of our daily lives - psychiatry included. To evince this claim, and as an entry into critiquing hegemonic discourses about ED recovery through a lens of Mad Studies, I will also relay how the processes of ED diagnosis and treatment have societal control functions that are similar to the individual control functions of the disorders themselves. They too are attempts to organize and systematize the interminable contradictions of being a person living in an advanced capitalist society - contradictions that are irreconcilable, no matter how valiantly the individual patient or the treatment apparatus they are embedded in tries. As such, the symptomology of EDs and treatment for them can be mutually reinforcing in their content and objectives. At worst, treatment can exacerbate eating and related conditions because the expectation of full recovery is an outward manifestation of the internal rigidity that motivates treatment seeking to begin with.

Control Motivations as a Source of Ego-Dystonicity: Bridging Multiple Units of Analysis

Following my brief enrolment at the clinic, I complied with the staff's instructions. It was difficult to relinquish control over what I consumed, which here denotes adhering to the meal plan they gave me, for reasons that had little to do with my subsequent weight gain. Specifically, without the heuristic I relied on to self-regulate, my visualizations quickened. They were regularly accompanied by somatic blitzkriegs, and I endured dramatic, cyclical fluctuations in my moods and energy levels. I do not believe my erraticism was seen by onlookers, in part because it mirrored that of my household. To most observers, I was highly capable, if periodically withdrawn or exuberant depending on the context.

Before long, though, I consciously chose to revert to active anorexia. I resumed counting and reactivated what Drew McEwan, writing about what is medicalized as obsessive-compulsive disorder (OCD) and drawing from La Marr Jurelle Bruce's "madtime" (p. 32), describes as a

"paradoxical temporality marked by repetition" (p. 34). McEwan juxtaposes her internal acceleration when she is ensnared in ritual compulsions with how their enactment delays forward progression through her daily activities. She knows her behaviour is self-defeating, but she is unable to abstain from it regardless. Similarly, anorexia's counting altered my temporality while engendering in me McEwan's "doubled perspective" (p. 38). I vividly recall being immobilized in my seventh-grade classroom desk as the lunchtime bell rang, too deluged with the frantic need to add, re-add, and re-re-add my caloric intake to join my classmates outside. By now, I had some inkling that while I could control my visualizations (the shapes) and physiological reaction to them with counting, the counting itself was becoming uncontrollable. I was experiencing what is clinically known as "ego-dystonicity" (p. 38), or the dissonance of witnessing my conduct as being inconsistent with who I was or wanted to be. Despite this, I could not opt out of the counting: Already, acquiescing to the messiness that surfaced in its absence had proven unsustainable.

My ego-dystonic dilemma was not unlike the one woven throughout the history of psychiatry. A detailed genealogy of psychiatry is well beyond the scope of this piece, but its development into a medical proto-specialty has been plagued by the stubborn question of whether it can achieve its stated purpose of curing mental pain (Stein et al., 2022). Some of the strongest challenges to its efficacy have been issued by insiders (Kendler et al., 2022). For instance, the failure of 19th century researchers to locate mental disorders in the brain led to a schism between those who predominantly viewed Madness in affective terms (what would become psychoanalysis) and those who were convinced that the anatomical bases of Madness would eventually be revealed (Baker et al., 2002). Clinicians in the first camp denounced the second's inhumane treatment of "the insane," advocating to eliminate physical restraints, seclusion, and other practices that aggravated the "violence of [one's] symptoms" (Kendler et al., 2022, p. 332). On the other side of the argument, the "moral therapy" that curried favour in early European and American asylums was dismissed as sentimental and impractical (Charland, 2007; Goldstein, 1987; Luchins, 1989). Both factions were accused of undermining clinical outcomes and the profession's legitimacy. Later, in the 1960s, psychiatry's split subjectivity was perhaps best exemplified when a group of prominent practitioners broke from their contemporaries to join a burgeoning antipsychiatry movement (Grob, 2011). "The notion of mental illness," declared (in)famous Hungarian-American provocateur Thomas S. Szasz, shortly before accepting a tenured position in medicine at the State University of New York, "has outlived whatever usefulness it might have had… it now functions merely as a convenient myth" (1960, p. 113). Szasz's controversial legacy, and indeed the legacy of what is still a diffuse and heterogenous coalition of theoreticians, practitioners, consumers, survivors, and (ex-)patients, cannot be neatly summarized (Benning, 2016; Rissmiller & Rissmiller, 2006; Whitley, 2012). What is undeniable is the first two decades of the antipsychiatry movement laid bare many practicing psychiatrist's doubts about their methodologies and the ideological underpinnings of the profession writ large (Beveridge, 2022). Even those who are remembered as moderate reformists made lasting contributions: They highlighted a range of under-acknowledged issues like how power asymmetries in the practitioner-patient dyad create the conditions for iatrogenic (unintentional) injuries to proliferate (Ajel, 1971; Illich, 1976).

After two tumultuous decades, the tensions raised by the antipsychiatry movement were not resolved so much as muted. The psychoanalytic tradition receded alongside the modernization of psychiatric nosology, which brought psychiatry's systematic classification of mental disorders in line with species taxonomies from the biological sciences (Galatzer-Levy & Galatzer-Levy, 2007; Shorter, 1998; Stein et al., 2022). From this, the third version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), published in 1980, introduced "operational definitions" for criteria-based diagnostic categories (Aftab & Ryznar, 2020; Nordgaard & Parnas, 2013). Proponents of the landmark text submitted that having uniform and consistent categorical boundaries for each disorder would enhance the objectivity and reliability of the diagnostic process (Andreasen, 2006; Aragona, 2015). As a result, diagnostic tools that once contained complicated clinical descriptions were abridged into rating scales and checklists (Nordgaard et al., 2018). These became the primary teaching sources for medical students, guaranteeing that future generations of psychiatrists would be less exposed to the thorny theoretical disputes that incited the most dissent. Concurrently, advances in neuroscience revived biological psychiatry's search for the molecular substrate of mental disorders (Harrington, 2019; Troisi, 2022). When combined with the arrival of diagnostic end points in the DSM-III and the advent of personalized pharmacotherapy, researchers and practitioners alike were immersed in an incentive structure that prioritized efficiency and cost-effectiveness over therapeutic rapport (Ban, 2006; Cosgrove & Krimsky, 2012; Mayes & Horwitz, 2005). Those who resisted these shifts by sounding the alarm about the outsized influence of the pharmaceutical industry, insurance companies, and government bureaucrats over them were drowned out by the chorus of voices equally excited by their promises (Brown, 1979; Goldstein, 1994; Healy, 1999). At no point did critical psychiatrists and psychiatric abolitionists disappear. However, they were relegated further to the margins as debates about the DSM grew narrower, focused on making minor adjustments to its existing content versus whether or not its paradigmatic presuppositions were *a priori* valid.

To make sense of why the biomedical model of psychiatry attained dominance over its competitors, and to tie this back to my thesis, it is worthwhile here to distinguish between control motivations at the individual unit of analysis and the interpersonal, institutional, and systemic ones. As an individual, McEwan characterizes OCD's ego-dystonicity as being propelled by "an irrational overapplication of a rational logic" (p. 39). Confirming she has turned off the stove is rational. Agonizing it is still on after she has checked, and having to tap the stove in multiples of eight to attenuate her infatuation with it, is not. She connects control to temporality by explaining that obsessive thoughts and compulsive behaviours keep her trapped in an actionable, albeit vexing, present. Because obsessions are grounded in memory distortions and compulsions are by definition incompletable, when merged they allow her to evade the danger and uncertainty of a never realized future (pp. 40-41). Comparably, for me, counting is a useful tactic for self-soothing. Feeling forced to count at the expense of everything else because I may not have done it correctly, on the other hand, amplifies the problems it was supposed to solve. Where I diverge slightly from McEwan is that my version of madtime is less about deferring the future than it is about ensuring I can have one. Her feeling of impending danger, which could materialize if she forgets to perform a concrete task like turn off the stove, is a persistent feature of my present when the shapes are not repressed. Essentially, counting is a less ambiguous source of worry than

the hallucinatory kaleidoscope that comprises my baseline. It has a control effect because it provokes a second layer of anxiety to distract me from the first.

In inexact but analogous ways, the disjuncture between professional psychiatry's express and latent functions represents an irrational overapplication of a rational logic. When assessed uncritically, the goal of curing mental pain is benevolent. If this was psychiatry's only goal, and if it was one that could elicit, in McEwan's words, "the satisfactory completion of an intended action" (p. 39), the profession would not be so notoriously ego-dystonic. That it has remained visibly insecure about its shortcomings long after the biomedical model emerged as the clear theoretical victor speaks to its rarely uttered control motivations. Psychiatry's embrace of reductive scientism did not occur in a vacuum. While it was undergoing its "operational revolution" in the 1980s, other revolutions were happening simultaneously. Chief among them was western nation-states' adoption of a neoliberal style of capitalism, one that expanded the reach of the market through privatization, deregulation, and globalization while reducing social welfarism (Harvey, 2005). With this came rising inequalities and protest movements fomented around combatting them. Several streams of scholarship have traced the evolution of the mental health system within this milieu. Medical sociologists, for example, have elucidated how and why social deviance that was considered sinful or criminal got redesignated as psychiatric in nature during the neoliberal turn (Bull, 1990; Conrad, 1992; Crawford, 1978; Gallagher & Ferrante, 1987; Schneider, 1978). In their seminal text on the matter, Peter Conrad and Joseph Schneider tease out a labelling-interactionist and conflict theory of medicalization to assert that inscribing the responsibility for health and illness within the individual depoliticized them; an imperative for elites as capitalism's crisis tendencies got harder to ignore (1992). In the same vein, political economists broadly contend that psychiatry has naturalized oppression: It has severed suffering from the material conditions that birth it (Moncrieff, 2009; Moncrieff, 2011; Thomas et al., 2020), colluded with capital to prescribe treatments that align with the market logics (Davies, 2022), and converted the chronically unwell into an immiserated underclass that the healthcare, criminal-legal, academic, and not-for-profit sectors extract from as a source of profit (Frazor-Carroll, 2023; Puar, 2017; Vierkant & Adler-Bolton, 2022). Synthesizing Marxist analyses of psychiatry as an agent of ideological social control from the DSM-III onward, Bruce M. Z. Cohen (2016, p. 93) concludes that it has

> depoliticised fundamental inequalities of capitalism while proliferating neoliberal values through its classifications and philosophies on 'treatment.' The pretext of scientific authority on the mind has allowed the psy-professions to enforce ruling class values and norms as consensual and taken-for-granted assumptions of human behaviour.

Nikolas Rose takes this one step further, alleging that psychiatry's growing fixation on risk prediction and prevention is how it strives to control disquietude about capitalism's ominous future (1998a; 1998b). Taken together, and setting aside their distinct units of analyses, these interpretations of psychiatry's temporally-mediated control motivations bear striking parallels to McEwan's and my own. Given how removed they are from the

express function of curing mental pain, is it any wonder practitioners who have sworn an oath to do no harm are of two minds about the route their profession is taking?

Doubling Down: Semantic Satiation and the Dialectic of Control

Like psychiatry, as a teenager I maintained a "relentless commitment to the performance of [my] own knowledges" (Guilfoyle, 2013, p. 88). I doubled down on counting, going from calculating the calories in whole foods - an apple - to dividing foods into sections - skin, outer flesh, inner flesh, outer core, inner core, juice, seeds, stem, etc. - such that it became a job so arduous and byzantine it could never be completed. Bodily mechanisms such as breathing and blinking were also captured by my counting framework. Throughout, I was sharply aware this would not bring about relief. All evidence to date demonstrated that counting begot counting, but seeing myself be controlled by my method of control was not the same as finding an escape hatch. What is more, the only interventions available duplicated my symptoms. I was admitted to a specialized ED inpatient ward at the age of seventeen. It could have been a chance to separate myself from my control-based traits, except all of the most egregious ones were personified in my environment. This is a common grievance among feminist and poststructuralist theorists and clinicians: Because treatment prohibits spontaneity and is rooted in surveillance, it can be a substitute for and fortify patients' eating-related neuroses (Boughtwood & Halse, 2009; Holmes, 2021; Scott et al., 2013; Treasure et al., 2011). As a case in point, my every waking second while in hospital was scheduled with military precision. The consumption of meals and snacks was monitored by staff who vocalized their suspicion of me, and my moods, speech, weight, vital signs, sleeping habits, and bowel movements were tracked and documented. Meanwhile, my treatment readiness, defined as my willingness to finish meals on time and in the proper order, accede to pocket and bag checks, and let staff watch me use the bathroom, was quantified on my patient chart and leveraged to deny my requests for greater autonomy. I was disturbed by this hostile regime because it operated so much like my intrasubjective one. I ultimately left early, against medical advice, having been branded as non-compliant.

Retroactively, I appreciate why the central consequence of my hospitalization was that I clung tighter to anorexia than before. Bourdieusian inquiries into the above dynamic emphasize that being entrenched in a field or "habitus" that ratifies sickness as one's dispositional and existential essence encourages us to "do" and "be" it better (Darmon, 2016; O'Connell, 2021; Musolino et al., 2015). Complementarily, Foucauldian studies stress how unseen power hierarchies get internalized in treatment, subtly coercing patients to become self-disciplining subjects (Bell, 2006; Guilfoyle, 2009; Rinaldi et al., 2016). When we are inadequately resourced to recover, especially as we receive conflicting messages about our dual culpability and weakness, we may parrot disparaging accounts of who we as eating disorder patients "are" (Lester, 2016; Malson et al., 2004; Saukko, 2008). While this literature resonates about my later years, discussed below, I did not exit treatment for anorexia having been indoctrinated into my eating disorder. I was not a "docile body" (Foucault, 1977; Weber, 2021) nor had I been duped into placing inordinate importance on my aesthetic presentation. Returning to the link between ego-dystonicity and control, I have already said that counting (which here is a proxy for anorexia) is a second order symptom. It is one I use to induce anxiety as a distraction from the shapes, and before treatment I was

cognizant of its control effect as perverted and problematic. I suspect I felt less ego-dystonicity about counting during and after treatment because treatment, as a battle ground, induced yet another layer of anxiety that distracted me from the counting. If anything, retreating to the privacy of counting was my only reprieve after my enemy combatants had been externalized as staff members. In a protracted state of arousal, the opportunity for reflection had been all but eradicated.

In the coming months, the more resolutely I upheld the counting, the more I was coded as terminally anorexic and the more justified involuntary treatment seemed to practitioners. In the other direction, the more I was acted upon, the surer I was that my control efforts were preferable to theirs. There was continuity in our respective approaches. Citing clinical investigations into OCD, McEwan delineates how prolonged focus on a ritual alienates the one conducting it from its original meaning. The inertia of ritualism creates "semantic satiation," or dissociation from the ritual's express function as well as the ability to perceive its latent functions over time (Fadda et al., 2019, as cited in McEwan, 43). This is an apt rendition of counting rituals at the individual unit of analysis: Post-hospitalization, I was stuck in a feedback loop. The concept of semantic satiation can also be applied at the interpersonal, institutional, and systemic units of analysis, though. Interpersonally, the ritual of being diagnosed with a psychiatric condition is meticulously scripted. Practitioners make diagnoses by following a structured interview guide that corresponds to the DMS's major disorder classes, but as a text that is predicated on previous versions of itself, the DSM, now in its fifth iteration, is entirely self-referential. It confers authority to itself. This is why Michael Guilfoyle discusses it as an instrument of psychiatric "knowledge conservation" (2013) and why Dorothy Smith credits texts like the DSM with organizing the social world into an interconnected totality by transmitting information about appropriate behaviour from the general to the hyper-local (1990). At the institutional unit of analysis, the semantic satiation of the diagnostic and treatment processes has been especially obvious since the publication of the DSM-III. Pathways to healing outside of pharmacotherapy have been disenfranchised, and the bulk of public funding for research on mental disorders has been allocated to cataloguing their molecular, genetic, and neural signatures (Breggin, 2007; Markowitz & Friedman, 2020; Torrey et al., 2021). In 2016, in a telling display of institutional ego-dystonicity, twenty members of the National Advisory Mental Health Council published an editorial criticizing the National Institution of Mental Health (NIMH) for over-investing in neuroscientific "breakthrough" research (Lewis-Fernández et al., as cited in Torrey et al., 2021). The authors expressed frustration that the NIMH devoted so much of its budget to innovations that "may be generations away" (p. 508) in lieu of alleviating suffering in the present. These comments, which evoke debates of centuries past, underscore how psychiatry's "stilted, unidimensional, and mechanistic world-view" (Pam, 1995) has deformed its institutional memory, instilling in it "a smugness that stops the very engine of scientific progress…" (McLaren, 2007, p. 20). In other words, psychiatry is as captive to madtime as I am. At the systemic level of analysis, as psychiatry has conserved and reproduced its own epistemologies vis a vis the DSM and neurobiological research, it has become increasingly dissociated from its express function of curing mental pain. It has also been alienated from the ability to perceive iatrogenic injuries interpersonally and from the repercussions it has as an agent of social control under neoliberalism. It is in a multi-level

feedback loop of its own, compulsively retreading well-worn ground absent meaningful discoveries to instigate forward progression.

Zooming back in, the collapse of my feedback loop into psychiatry's created an ouroboros - a snake eating its own tail - that coiled and contorted ever-inward. Both of us were unable to step outside of our own vantage points to contemplate whether the knowledge base from which we generated more knowledge and action was corrupted. The dialectical properties of our enmeshment are notable for the purposes of this piece: Locked in a fight for control, as we were steadily more detached from the fulfilment of ritual completion, the more irrationally obstinate we became. Practically, for me, this looked like inventing a host of new control behaviours with effects that were proportional to the degree of control psychiatry already had over me because of the behaviour that came before it. For psychiatry, this presented as an endless game of diagnostic catch up. My newest behaviour was filtered through the lens of the DSM and taken not as a sign that more labels would not improve my situation, but as one that my one, true label had yet to be unearthed. The control grip psychiatry had on me was consolidated as my conduct grew more aberrant. My conduct grew more aberrant as the control grip psychiatry had on me was consolidated.

Escalating Injustices: Evading Psychiatric Control through (Misguided) Individual Control Efforts

My initial slippage out of counting/anorexia came from starting to binge and purge. Clinical researchers refer to movement within or between ED subtypes and diagnoses as diagnostic crossover. It is unusual for people with binge eating or bulimic disorders to fall below the body mass index (BMI) threshold requirement for anorexia, but longitudinal studies estimate between 20% and 50% of non-remitting patients diagnosed with anorexia transition into binge eating with or without compensatory purging over the lifespan (Eddy et al., 2008; Eckert et al., 1995; Serra et al., 2021; Tozzi et al., 2005). This trend has been attributed to age of first diagnosis (van Son et al., 2010; Wentz et al., 2009), genetic, metabolic, and neurologic modulators (Bulik et al., 2022; Ehrlich et al., 2010; Kahl et al., 2004), strained familial relations (Micali et al., 2017; Tozzi et al., 2005**)**, exposure to traumatic events and post-traumatic stress disorder (Day et al., 2023; Micali et al., 2017; Trottier & MacDonald, 2017), sexual problems (Fichter et al., 2006), other psychopathologies (Castellini et al., 2011; Stice et al., 2013; Sommerfeldt et al., 2024; Tenconi et al., 2006; Waller et al., 2003), and the blunt biology of starvation (Polivy & Herman, 1985; Serra et al., 2021; Stice et al., 2008), but systematic reviews of the literature note these hypotheses are educated guesses, at best (Berkman et al., 2007; Keele & Brown, 2010; Richard et al., 2005; Steinhausen, 2002). There is no single predictor of diagnostic crossover. Unfortunately, this admission also tends to be where epistemic humility on the part of researchers begins and ends. For all of their heated deliberation about the DSM's ED classification scheme, most retain the pervasive belief that body management practices are undertaken in pursuit of the thin ideal as western cultural norms are "inscribed onto the body" (Channa et al., 2015, p. 361) - a belief that is even more pronounced in clinical practice (Burns, 2009; Lester, 2004; Pike & Borovoy, 2004). It is unsurprising, then, that I was not approached with curiosity or compassion when I initiated bulimia. If I had been, I might have said this about it: The punishment meted out for counting was severe. It was so

severe, in fact, that counting became my sole companion. I could not surrender it, and when it became apparent that I would have to or be institutionalized indefinitely, bulimia was the compromise I made under duress. I habituated to it with ease. Whereas trying to induce a control effect through counting was Sisyphusian, binging redirected my control efforts from the cognitive to the corporeal. There were no more mental equations that evaporated the moment the last digit was tallied, re-triggering the compulsion to count again. All I saw was a clean, blank canvas as I gorged until my stomach nearly ruptured, breaking the dissociative spell. I would then sprint to the bathroom and proceed with an act that was tactile, pacifying, and finite. Bulimia, as an aggressively physical endeavour that has a clearly demarcated beginning and end, was how I achieved "the satisfactory completion of an intended action" at last.

Many bulimics report that binging and purging elicits dizzying activation followed by exhaustion and release (Eli, 2015). It is cathartic and sublime, which may be why bulimic patients exist in the clinical imaginary as pathologically pleasure-seeking. We are stereotyped as defeated anorexics; possessed by all the vanity of our anorexic peers without the same fortitude or impulse control (Eli, 2017; Saguy & Gruys, 2010; Squire, 2003). This stereotype is ironic given the intricate control efforts that pushed me to bulimia, but it offers insight into how the DSM transforms value-laden interpretations of behaviour into "the currency of facts" (Smith, 1978). I was medically underweight and I binged and purged. This alone garnered an anorexia, binge-purge subtype diagnosis. It did not matter that I did not technically meet the diagnostic criteria for anorexia or bulimia, which require a patient's self-evaluation to be "unjustifiably influenced by body weight and shape" (American Psychiatric Association, 2013) because to psychiatry, I was not Nicole (who saw shapes, who counted because she saw shapes, who starved because she counted, who binged and purged because she was penalized for starving): I had been abstracted into the "objectified form" (Smith, 1996) of an ED patient exhibiting a classic case of diagnostic crossover. Having been slotted into this predetermined subject position, my Mad reading of bulimia as a natural extension of anorexia (as a natural extension of counting, as a natural extension of living with shapes for which there was no treatment) was incommunicable and incoherent.

A core tenet of the medical social control literature is that psychiatric diagnoses are difficult to reject because of their ideological circularity (Burstow, 2017, p. 33, as cited in Schott & Langan, 2024): The rejection of a diagnosis is absorbed by the diagnosis as a symptom of it (e.g., as "treatment resistance," or when one is said to "lack insight into their condition" when they disown the condition) (Martin, 2007, as cited in Schott & Langan, 2024). This "tautological trap" (Schott & Langan, 2024) is often interrogated in relation to philosopher Miranda Fricker's much elaborated on concept of "epistemic injustice," defined as the wrongs done to someone "specifically in their capacity as a knower" (2007, p. 1). The first species of epistemic injustice, testimonial injustice, is enacted when the patient's self-knowledge is obstructed during discursive exchanges (pp. 9-17). The second, hermeneutical injustice, takes place because the patient does not have access to self-knowledge other than what is provided by the experts (pp. 147-169). These twin injustices, as well as the institutionalized network of mutual support bolstering them, are why another recurring theme in the literature, referenced via Bourdieu and Foucault above, is that psychiatric patients unwittingly become agents of our own subjugation. We are recruited into

psychiatry's knowledge conservation practices as we come to think of ourselves in diagnostic terms (Guilfoyle, 2013). Crossing over into a bulimic sub-category of anorexia profoundly reoriented my status within the medical system. I was no longer seen as fragile and restrained, which are lauded as virtuous traits in young women despite the deployment of the anorexia diagnosis when we exhibit too much of either (Bordo, 1993; Brumberg, 2000; Halse et al., 2007; LaMarre et al., 2022; Till, 2011). I had been degraded, and my supposed bulimic temperament invited even harsher scrutiny and more assertive interventions. I mark this as a turning point for two reasons: One, it was when my family members were also recruited into the psychiatric project. My family home became a replica of the ED inpatient ward, with surveillance and regulatory mechanisms such as locked fridges and room and bag checks instituted as mandatory practices. Two, it was here that my subjectivity had finally been so eroded by sustained epistemic injustices that I succumbed to medicalization. I ceased trying to converse with psychiatry or my family except in biomedical language, and the multifaceted identity I worked so hard to preserve as an anorexic was subsumed by my binge-purge, subtype diagnosis and its connotations. In a strict Parsonian sense, I submitted to the sick role (1951; 1975).

Embracing the narrative that I was inherently unwell changed my understanding of control and my control motivations. I had been given permission to unleash the extreme somatic and psychic volatility the shapes induced. Having left behind the guise of normalcy - and with the ego-dystonicity I felt at not engineering it through counting/anorexia - my only goal became obliterating the distress of being controlled by psychiatry and my family in their bid to cure me. To this end, my next control effort was uncontrolled alcohol consumption. This statement is oxymoronic when taken at face value. However, being inebriated had polymorphic control effects. It erased my short-term memory, interceding in the shame I felt at how adjected I had become. In turn, I was liberated from the claustrophobic pressures of madtime - suspended in a perpetual present over which I was the sovereign authority. I could expedite or slow time by tempering my drinking speed, and when the present got too devastating, I could dose myself unconscious. Additionally, the sheer volume I consumed was physically calamitous. I did not experience typical hangovers because I was never sober. Rather, I purposely poisoned myself, drowning my nausea, splitting headaches, and, soon, excruciating withdrawal, in more alcohol. These adverse symptoms made it impossible to entertain anything but the animalistic urge to keep going. I was blacked out in the truest sense of the word - totally inoculated from my psychic and outer worlds.

Of course, the outer world was not inoculated from me. Fricker (2007) writes that isolated instances of testimonial injustice become systematic because identity-based prejudices "track" people through various domains of social activity. "Being subject to a tracker prejudice renders one susceptible not only to testimonial injustice but to a gamut of different injustices, and so when such a prejudice generates a testimonial injustice that injustice is systematically connected with other kinds of potential or actual injustices" (p. 27). I have covered how prejudices about anorexia as a weight management practice led to isolated instances of testimonial injustice during the scripted rituals of ED diagnosis and treatment. I have also explained how these isolated testimonial injustices were connected to hermeneutical and "actual" injustices. I was not equipped with alternate self-knowledge

to understand or advocate for myself when I crossed over into the anorexia, binge-purge subtype diagnostic category (a hermeneutical injustice). As my underlying control motivations were progressively obscured, I was increasingly vulnerable to forced ED treatment (an actual injustice). Paradoxically, though, it was the very injustice of having my EDs read as the feminine pursuit of thinness that shielded me from the injustices that were set into motion when I was diagnosed with a comorbid alcohol use disorder (AUD) and I began being involuntarily institutionalized on adult psychiatric wards, not children's ED ones. I was almost always admitted after explosive family conflicts resulted in police arrests. Coming-to in handcuffs, locked in a padded room with my clothes removed, was humiliating the first time it happened. By the second, third, fifth, and tenth times, and after the other practices that future psychoanalysts appraised as inhumane in the early 20th century were incorporated into my routine, I felt nothing at all. I had been reduced to a purely biological organism - a "neurochemical other" (Ettorre, 2015) whose faulty brain licensed bodily detention so I did not pollute the body politic as a whole.

Relinquishing Control: A Conclusion of Sorts

By age 19, I was homeless. I was sent to a shelter after two rounds of abstinence-based AUD treatment and untold involuntary psychiatric hospitalizations failed. I have provided a detailed account of this event elsewhere (Luongo, 2021a). It began with a hospital-based psychiatrist instructing my parents to let me "hit bottom" so I would take "personal responsibility" for my illnesses. I have also chronicled the diagnoses I received in rapid succession once my deviance as a substance (ab)user superseded my gender and socioeconomic background, and my "excessive appetite" (Orford, 2000, as cited in Ettorre, 2015) was no longer construed as an appetite for thinness - bipolar disorder, types one and two, a host of dissociative disorders, borderline personality disorder, somatoform pain disorder, stimulant use disorder, and opioid use disorder, among others (Luongo, 2021a). Most of my published writing to date has engaged theoretically with the injustices that transpired when my identity was "spoiled" by these later labels which are, all told, more serious and stigmatized than anorexia and bulimia (Luongo, 2021b). In the last several years, the relevance of my EDs has also been supplanted by my employment at a national drug policy advocacy organization, where I am necessarily occupied with opposing criminal-legal sanctions for deviance. It is easy to minimize the injustices levied at anorexics and bulimics when they are contrasted with the overt housing and employment discrimination, incarceration, and death endured by criminalized drug-using populations. However, given the contours of this special issue, with this piece I have wanted to return to my origins as an ED patient. I have been inspired to think about how criticisms of ED treatment could map onto Mad studies projects, and I have confronted how my socialization as an ED patient "tracked" me, and was thus systematically bound, to becoming a homeless, psychotic substance (ab)user. In doing so, I have asked myself whether my ED diagnoses were a catalyst for the others. While I have grappled with this before (Luongo, 2018), I had yet to draw a straight line from my childhood control efforts, through the control efforts of the ED treatment apparatus, to the SUD and psychiatric ones. Straight lines are still something I struggle with.

I will never know for sure if the years I cycled through involuntary psychiatric hospitalizations, homeless shelters, and abstinence-based substance use disorder (SUD) treatment could have been avoided. If, when I lost weight as an eleven-year-old, I had the discursive resources to describe my control motivations, I might not have been inappropriately implicated in the rituals of ED diagnosis and treatment. Likewise, if psychiatry had been flexible enough to course correct when its interpersonal control efforts inflamed mine, I might have been more circumspect about drinking alcoholically. This could have prevented the onset of what I believe were trauma-related psychotic symptoms and my devolution into crack cocaine and opioid addictions as a homeless young person. It is tempting to speculate about alternative scenarios, but by now I hope to have relayed why they were not plausible. Biomedical psychiatry, by virtue of its institutional and systemic-level control functions, is wedded to binary logics of sanity and Madness (Kafai, 2012, at cited in McEwan, 2023). Its very survival is contingent upon concealing and confining the social pathologies it purports to cure. To conceive of Madness as an expansive cluster of experiences, and to concede that many people inhabit a "mad border body" (Kafai, 2012, as cited in McEwan, 2023) that defies categorization as normal or abnormal, could render the profession obsolete.

For my part, extracting myself from the psychiatric project has entailed radically reformulating my relationship with sanity and Madness. I have come to know myself as fluid; as oscillating between psychic states that are more and less troublesome depending on myriad extraneous and internal factors. In one final paradox, it is only by abandoning normalcy that I have steeled myself against the nihilism of brain disease paradigms, and have managed to delete control behaviours from my repertoire like an archaeologist digging through layers of sediment. I will never uncover an unsullied, authentic self, but abstinence from psychoactive substances dulls the voices I hear, which permits me to contain the binging and purging, which, with the benefit of hindsight, makes counting feel less vital. I still see shapes, though. I probably always will. In the simplest, most neutral terms, I am a visual thinker. The distinction between my visual thinking as a child and young adult and my visual thinking today is the distance I have from the shapes when they threaten to engulf me. They are real without being my entire reality. I have also recognized them as messengers. The shapes wax and wane in tandem with environmental inputs, growing more energetic and emphatic when I am agitated by external stimuli. As I have learned to work with my Madness, I have acquired the ability to pause when I feel myself entering a state of hyper-reality. I can thank the shapes for their protective features while gently casting them aside. This is probably as sane or normal as I will ever get.

My revised relationship with the shapes also puts them in direct conversation with the social world. Both behave in patterns that can be predicted with moderate certainty, and both are nonetheless punctuated by wild, anarchic bursts, reminding us of our most sophisticated modelling efforts are error-prone. On days where the shapes are ungovernable, I ride them as waves, trusting they will crest and I will return to equilibrium. Inevitably, I do. To close this piece, then, I might prescribe for psychiatry the adoption of a similar attitude toward societal governance. Mental pain will never be terminated. It is part and parcel of the human condition. And, sometimes people's mental pain evolves into something so rebellious and recalcitrant that communal support, if they have it, will not

suffice. For these people (and I count myself among them) professional help could be warranted in theory. However, as I have spelled out above, as a keen observer of the psychiatric profession I am not confident it is up to the task of reliably answering the call to reduce mental pain for suffering populations. For every individual cure it bestows, there are countless others who get churned through a meat grinder built of institutional and systemic level control motivations only to be spat out as husks, affixed with more labels and no closer to knowing ourselves or addressing the societal disfunction that is inextricable from our pain. Some psychiatrists know this. I read them, have met them, and even built uncomfortable alliances with a few of them. They are in some ways the most incomprehensible to me. I often wonder if there will ever be the critical mass of ego-dystonicity within the profession to tip the scales in favour of the sea change that would bring its express functions closer to its latent ones. Given that psychiatry is about as rational as the political economic system that made it, and based on how other sectors are responding as multiple, intersecting crises lay bare capitalism's fault lines, I am not overly optimistic about this prospect. One might say that psychiatry lacks insight into its condition. It is in denial. Because I am intimately familiar with having gone so far down a path that reversing is unthinkable, I have sympathy for psychiatry. It is difficult to leap off a moving train after you have boarded, irrespective of how close to the cliff's edge one is. With this small act of "recovering [my] story" (Costa et al., 2012), I have tried to lead by example.

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