Globalizing pathologies:
Mental-health assemblage and spreading diagnoses of eating disorders

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ABSTRACT
During the last two decades, psychiatric researchers have published evidence of eating disorders in regions around the world, despite previous conceptions of eating disorders as "culture-bound syndromes." This paper explores the pressures or processes encouraging this spread of diagnoses and their implications for our understanding of state mental-health policy making today. It argues that the increased willingness to diagnose eating disorders results from global-level instances of *assemblage*, that is, conglomerations or ensembles of scientific expertise, state policy, international institutions, and practices that frame interventions of a governmental or "improving" kind in a discourse that presumes a particular type of problem and entails a particular set of solutions. Specifically, the paper argues that elements of a *mental-health assemblage* are emerging at the global level, centered around the production of a core global mental disorder diagnostic code and its related research agenda, such that a broad array of actors in an increasingly broad array of world regions find it medically, politically, and economically expedient to diagnose and treat persons as suffering from eating disorders (as defined by the code). Thus eating disorders are diagnosed where once they were not. Cases include several recent instantiations of the eating-disorders research agenda in non-western, less developed states. The likely effects of these assemblages include the limitation of political agency to elites who can manage the medical, political, and economic dynamics of shifting diagnostic criteria, and the reduction of non-elites' agency to mere rejection of the "rationalization" of rule, for example by rejecting a diagnosis of mental disorder, to accepting it and thereby rendering themselves "citizen-subjects" of governance, or to embracing it and attempting resistance within that diagnosis.

Key words: assemblage, diagnosis, mental health, governmentality, global governance

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INTRODUCTION

Current psychiatric research on mental disorders suggests that the diagnosis of eating disorders has spread from developed western states to non-western and less developed states. The trend is notable, because it comes despite conventional wisdom that eating disorders are "western culture-bound syndromes associated with culture-driven factors, such as unrealistic expectations of slenderness and attractiveness, changes in the role of women, and social standards and attitudes towards obesity" (N. Shuriquie, 1999). Researchers in developed non-western states and regions nonetheless have begun to claim that eating-disorder rates rival western states' rates, and researchers in less developed non-western states are making similar claims. For example, scholarship published recently on Japan, South Korea, and Singapore populations claims increased *anorexia nervosa* and *bulimia nervosa* rates (Sonni Efron, 1997), while a study of Hong Kong-based subjects professes the "cross-cultural disease validity" of anorexia nervosa (Sing Lee, Y.Y.L. Chan, and L.K.G. Hsu, 2003: 967). Meantime, a study conducted by Turkey-based scholars of Turkish subjects observes, while "[a]norexia nervosa is an eating disorder that primarily affects female adolescents and is more commonly seen in westernized countries…nowadays it is also increasing rapidly in developing cultures such as Turkey" (O. Ozdel, F. Atesci, and N.K. Oguzhanoglu, 2003). A 2000 study done in Tehran, Iran "suggests that the prevalence of eating disorders among female adolescents in Teheran is comparable to prevalence rates reported by studies in Western societies, and [is] somewhat higher than what has been reported in other non-Western societies" (M. Nobakht and M. Dezhkam, 2000:265). Researchers observing Chinese undergraduates predict that females increasingly will be "predispose[d]…to weight control behavior and eating disorders" (Sing Lee, T. Leung, A.M. Lee, H. Yu, and C.M. Leung, 1998:77). An Egypt-based investigation of Egyptian subjects contends that "morbid eating patterns" are emerging in Egyptian society with rates similar to those in western cultures (M. Nasser, 1994). And a Jordanian survey of eating-disorders research in non-western states presents an "increasing number of new cases of anorexia nervosa and bulimia nervosa among Asian immigrants to Western countries and…consistent findings of abnormal eating attitudes and eating disorders among Asian and Arab teenagers" (N. Shuriquie, 1999:354). Finally, South Africa-based researchers recently have concluded that the "risk for eating disorders in developing countries may be increasing" (D. Wassenaar, D. le Grange, J. Winship, and L. Lachenicht, 2000:225).

What pressures or processes account for this spread of eating disorders diagnoses, and what does this case tell us about state mental health policy-making today? Specifically, what are the politics of diagnostic criteria? This paper argues that the spread in diagnoses results from global-level instances of *assemblage*, that is, conglomerations or "ensembles" (Stephen J. Collier and Aihwa Ong, 2005:4) of scientific expertise, state policy, international institutions, and other practices employed by state and non-state actors with a "will to improve" (Tanya Murray Li, 2007). *Assemblages* are sets of processes that frame interventions of a governmental or "improving" kind in a discourse that presumes a particular type of problem and entails a particular set of solutions (see for example Li, 2007; Deborah Wilson Lowry 2004). They are also, as I read the concept, a process itself: assemblage is the process of forming an assemblage; it

is the process of bringing disparate practices together as well as it is the ensemble of those pieces. The paper argues, specifically, that the elements of a *mental-health assemblage* are emerging at the global level, in the context of the production of a *global mental disorder diagnostic code* and research agendas linked to it, such that a broad array of actors, including research scientists, states, non-state advocates, and pharmaceutical corporations, in an increasingly broad array of world regions, find it medically, politically, and economically expedient or necessary to engage in the diagnosis and treatment of eating disorders as defined by that diagnostic code. As a result, eating disorders currently are being diagnosed where once they were not. The likely effects of these dynamics include the limitation of persons' political agency to mere rejection of the "rationalization" of rule, for example by rejecting a diagnosis of mental disorder, to accepting it and thereby rendering themselves "citizen-subjects" of governance, or to embracing it and attempting resistance within that diagnosis.

Methodology

The paper adopts the concept of *assemblage* because it captures the dynamic, mobile character of the forces at play, while also capturing the ways in which those forces involve practices and effort (Collier and Ong, 2005; Li, 2007). As Tania Murray Li (2007) argues, "Assemblage flags agency, the hard work required to draw heterogeneous elements together, forge connections between them and sustain these connections in the face of tension. It invites analysis of how the elements of an assemblage might—or might not—be made to cohere" (p. 264). The assemblage concept captures the eclectic agglomeration of social and political agents who aim to improve "mental health" in societies, particularly those in less developed states, and who in their intersecting paths to that goal apply psychiatric diagnostic discourse and encourage the institutionalization of psychiatric treatments and techniques in societies. By contrast, for example, the concept of *epistemic community* presumes an already relatively coherent "network of professionals with recognized expertise and competence in a particular domain, and an authoritative claim to policy-relevant knowledge within that domain or issue-area" (Peter Haas, 1992), and its primary concern is to explain inter-state cooperation and its results. Yet the cases explored in this paper are not so coherent: they include the actions of social advocates and global pharmaceutical companies as well as state leaders and "knowledge elites" such as research scientists. Nor does the core question in our cases revolve around *whether* states or knowledge elites define a problem. Rather, the core question asks what enables or encourages knowledge elites to confer a particular diagnosis where once they did not. This paper finds that global-level elements of a *mental-health assemblage* encourage the institutionalization of eating-disorders research agendas in an increasingly broad array of states. These separate instantiations of eating-disorders research and diagnosis agendas are themselves assemblages—sub-assemblages of a sort—whose dynamics deserve exploration.

Implications of the argument

What's at stake in the case of emerging mental-health assemblages in non-western, less developed states? Several concerns are highlighted in this paper. One concern, raised by *governmentality* scholars (Mitchell Dean, 1999; Rob Flynn, 2002) is that in these processes, people will assume a "mentality of rule" (Flynn, 2002, citing Turner, 1997). In other words, people will not govern themselves *for* themselves; they will do so for governance's sake. Indicators of a mentality of rule in the case of eating

disorders would include persons' self-diagnosis of "having" an eating disorder, and behaving in ways expected and/or prescribed as a result of that self-diagnosis.

Another concern is that like all assemblages, the assemblage of mental health will *render problems technical* (e.g., biomedical) (Li, 2007). Put differently, assemblages favor "expert needs discourses" (Nancy Fraser, 1989) such as diagnostic criteria. The problem is that these discourses tend to become normalizing, "aimed at 'reforming,' or more often stigmatizing, 'deviancy'" when they are institutionalized in state apparatuses (Fraser, 1989:174). Indeed, they often constitute "reprivatizing" voices that "defend the social division of discourses" and hence *defend the status quo* (Fraser, 1989:172). In many cases, the status quo is ethnically, sexually, or otherwise unequal. For persons concerned "about the reliable use of diagnostic instruments in community practice," about "the pragmatic effects of a diagnostic judgment," or about the significance of "incorporate[ing] knowledge generated at the social margins," (Byron J. Good, 1996:350), the potential for these dynamics to arise is troubling.

Outline

The following sections of the paper trace the emergence of mental-health assemblages, focusing especially on *eating-disorders assemblages*, in unexpected parts of the world. A significant dimension of these dynamics is the production, over the course of the past century, of a core *global mental-disorders diagnostic code* in psychiatric research, professional training, and health policymaking around the world. The code rests on two psychiatric diagnostic nomenclatures, namely, the International Classification of Diseases (ICD), published by the World Health Organization, and the Diagnostic and Statistical Manual of mental disorders (DSM), published by the American Psychiatric Association. The two taxonomies' definitions of eating disorders largely overlap. The two nomenclatures are used, and often are considered interchangeable, by state and private research scientists worldwide. They have emerged as the hub of a global-level mental-health assemblage. The paper outlines the codification of the diagnostic code, highlighting the actors involved in codifying it and the ways in which its codification involves several generic practices of assemblage (as outlined by Li, 2007).

Subsequently, the paper examines the spokes of the global mental-health assemblage, namely, research projects that have applied the global mental-disorders diagnostic code to policies and persons in non-western and less-developed states. The first such project is a global-level consortium of researchers, policymakers, and non-governmental mental health advocacy groups that has initiated reform of mental health programs in 16 developing states.[1] The program encourages developing states to assess their "mental health status," and has established "a global network of expertise" and generated "guidelines and examples" for states that look to improve their mental health policies (Walter Gulbinat, Ron Manderscheid, Florence Baingana, Rachel Jenkins, Sudhir Khandelwal, Itzhak Levav, F. Lieh Mak, John Mayeya, Alberto Minoletti, Malik H. Mubbashar, R. Srinivasa Murthy, M. Parameshvara Deva, Klaas Schilder, Toma Tomov, Aliko Baba, Clare Townsend, and Harvey Whiteford, 2004). Subsequent cases are regional and state instantiations of eating disorders research agendas, including projects in Chile, Hong Kong, Turkey, and Egypt.

The conclusions of these projects indicate that while different actors "cohere" around the perceived problem of eating disorders, some discourses can become hegemonic, and expert knowledge may be favored over lay or "traditional" knowledge.

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To the extent that these programs use "expert needs discourses" they will be less effective at preventing "mental disorder", and more likely to maintain the status quo. This will be the case if processes they consistently "clos[e] down debate about how and what to govern and the distributive effects of particular arrangements by reference to expertise," as often happens with assemblages (Li, 2007).

In the conclusion, the paper discusses ways in which the hegemony of expertise encouraged global mental-health assemblages can be resisted or leveraged by non-elites, including persons diagnosed with eating disorders. While the assemblage may carve "ecological niches" (Ian Hacking, 1998) in which eating-disorders diagnoses incubate and then shape conceptions of the self, study of assemblage also highlights ways in which assemblages open new avenues for redefinition and empowerment. The key to offsetting the expert-heavy tendency of the instantiations of mental-health assemblage discussed in this paper will be for non-experts and politically minded agents to adopt scientific knowledge and discourse *strategically,* even as they may join the assemblage with a "will to improve." The paper ends by discussing areas for future research.

THE GLOBAL MENTAL-DISORDERS DIAGNOSTIC CODE: HUB OF AN EMERGING GLOBAL MENTAL-HEALTH ASSEMBLAGE

In analyzing the apparent spread of eating disorders diagnoses around the world, one comes across repeated references to two diagnostic manuals, namely, the International Classification of Diseases (ICD), published by the World Health Organization, and the Diagnostic and Statistical Manual of mental disorders (DSM), published by the American Psychiatric Association. The history of their emergence reflects the generic processes of assemblage outlined by Li (2007). The ICD/DSM ubiquity in psychiatric research indicates that it now constitutes a global mental-disorders diagnostic code, and that a mental-health assemblage is emerging at the global level.

Institutionalizing the Global Mental-disorders diagnostic Code

In the 1850s, several western states acted on concerns to codify causes of death around the world. The states initiated the codification process under the aegis of the International Statistical Congress, a group of professional statisticians that had been authorized by several European states to begin standardizing cross-national data. In 1923, the League of Nations' Health Organization used the List as a base document for its own purposes, and recommended changes to the International List of Causes of Death including distinguishing new diseases. These recommendations were combined with the work of the International Statistical Institute in the proposals for the Fourth (1929) and Fifth (1938) revisions of the International List of Causes of Death (World Health Organization, 2005a:3). In other words, by the beginning of World War II, the codification of these phenomena had become a global and even global process.

Diseases were listed *separately* of causes of death by 1938, when researchers at the Fifth Revision Conference of the List "recognized the growing need for a corresponding list of diseases to meet the statistical requirements of widely differing organizations, such as health insurance organizations, hospitals, military medical services, health administrations, and similar bodies" (World Health Organization, 2005a:3). Researchers at this conference therefore wrote an independent International Lists of Diseases (World Health Organization, 2005a:7). By the 1975 Revision Conference, independent researchers and medical practitioners as well as state agencies had begun appropriating ICD categories for use in their programs (World Health

Organization, 2005b:7). Accordingly, WHO created the Family of International Classifications (WHO-FIC), whose purpose is "to promote the appropriate selection of classifications in the range of settings in the health field across the world" (World Health Organization, 2008). Potentially, any person, group, or organization can contribute to this family of classifications of health, according to WHO criteria for inclusion in the FIC (Richard Madden, Catherine Sykes, and T. Bedirhan Ustun, 2007).

The notable elements of WHO-FIC for this paper are its goals and principles for inclusion in the criteria. The goals include developing an information database of states' current and planned use of FIC classifications and compiling data on the use of WHO-FIC in both public and private sectors along several dimensions (World Health Organization, 2005b). The principles on which existing criteria are assessed for their inclusion in the WHO-FIC include "the place of a classification in relation to other areas of health or related information", as well as recognition that "additional classifications cover concepts not adequately covered by the WHO reference classifications" (Madden, Sykes, and Ustun, 2007). Proposals for a health classification's inclusion in the WHO-FIC also must meet several technical requirements, including categories that are "exhaustive and mutually exclusive", "stable", and that use terms consistently and unambiguously (Madden, Sykes, and Ustun, 2007).

Research is necessary on efforts that have been made to include already existing criteria from less-developed states into the WHO-FIC. Yet it seems clear that WHO-FIC represents a particularly pointed and institutionalized means of spreading the global mental health diagnostic code to a variety of regions of the world. It is a key spoke emanating from the hub of the code.

The spread of these diagnostic criteria since their initial codification has been quite staggering, spurred by the proactive efforts of the revision committees. By the 1975 Revision Conference, independent researchers and medical practitioners, in addition to state governments, began appropriating ICD categories to guide their practices (World Health Organization, 2005a:7). At the same time, the Revision Committee sought ways to spread its classification system by rendering it useful to "countries and areas where a detailed and sophisticated classification was irrelevant, but which nevertheless needed a classification based on the ICD in order to assess their progress in health care and in the control of disease" (World Health Organization, 2005a:7). The ICD thus becomes a code for evaluating state public-health policy at the same time that it pressures (and gives leverage for others to pressure) states to adopt modern western medical/health policies. In Li's (2007) terms, it becomes the key by which knowledge is *authorized*. Currently 198 states and non-state regional entities participate as members to the WHO; according to WHO data, approximately 160 of the 198 states and other regional political entities reporting in 2001 had implemented either ICD-9 or ICD-10 categories for mortality and morbidity (World Health Organization, 2005b).

To be sure, state diagnostic criteria are not identical (see for example Norman Sartorius *et al.* 1990). Yet the agenda of state-to-state alignments was broadened, from listing causes of death, to distinguishing and listing new diseases, to establishing international rules for selecting the underlying cause of death, to cooperating in the methods of gathering "vital and health statistics," and finally, to rendering their classification scheme useful to a broader array of states. The global mental-disorders

diagnostic code is thereby spread, its reach extended by the development, in similar and parallel fashion, of the DSM, to which we now turn.

Codifying Mental-disorder Diagnostic Standards: Links between DSM and ICD

The history of the Diagnostic and Statistical Manual of mental disorders (DSM) resembles and indeed is tied directly to the ICD's history. As with the ICD, state (in this case, US) statistical interests galvanized the codification process, such that by 1917, "a collaboration between the Committee on Statistics of the American Psychiatric Association and the [US] National Commission on Mental Hygiene aimed to gather uniform statistics across mental hospitals" (Dominic Parrott, 2005). These efforts "led to the development of several classification systems for mental disorders, including the World Health Organization's ICD-6." In 1952, the American Psychiatric Association's Nomenclature and Statistics Committee adapted the ICD-6 for its own purposes; this document became DSM-I (Parrott, 2005).

In other words, the United States' own mental-disorder classification process has been linked to the ICD's since initial codification. Updates to the ICD affect updates to the DSM, in part because the United States has based its diagnostic standards on the ICD. "As was the case with DSM-II and III, DSM-IV continued the linkage of the Manual with subsequent developments of the International Classification of Diseases (ICD). While linked to the United States standard of diagnostic practice, ICD-9 CM (Clinical Modification), DSM-IV preparation was coordinated with Chapter V of the World Health Organization's ICD-10" (R.W. Hotes, 2000).

One of the DSM's most significant changes came during the revision process of DSM-II into DSM-III, which occurred between 1974 and 1980. The revision was significant to the practice of psychiatry generally, as it shifted the DSM's emphasis from patient *assessment* to patient *diagnosis*. The first two editions were based on a psychobiological view that "mental disorders were reactions of the personality to various biological, social, and psychological factors" and "that if diagnosis was meaningful, it was secondary to the assessment of the patient as a person." DSM-I and -II "did not possess explicit definitions of disorders as a means of establishing clinical diagnoses." By contrast, DSM-III, ultimately published in 1980, reflected a new approach including "explicit diagnostic criteria, a multiaxial system, and a descriptive atheoretical approach" (Parrott, "The history of clinical psychology").

The act of divorcing diagnosis from theory has been significant for the practice of psychiatry as a science, according to Arthur C. Houts (2000). At the time DSM-I was published, and through DSM-II, mental disorders were conceived as reactions "arising from life circumstances, especially stressful events," and as problems that "could persist into the future once they were produced in otherwise 'normal' individuals" (Houts, 2000:940). By DSM-III, things had changed: "In a matter of about 10 to 15 years, basic thinking about the nature of mental disorders was transformed from a psychoanalytic-personality-development model to a more amorphous descriptive model with biological undertones…the fundamental concepts of psychoanalytic theory were expunged from the official psychiatric nomenclature" (Houts, 2000:947). Moreover, since DSM-III, the concept of what may have gone wrong inside the organism has been broadened to include "learning and habits, as well as biological mechanisms" (Houts, 2000:953). Indeed, Houts argues that cutting psychiatric typologies loose from theory has "led to an 800% increase in the number of psychiatric diagnoses over the last half-century," and he

questions the scientific merit of DSM-based psychiatric diagnosis. This is because "progress" in psychiatry has become equated with the rapid expansion of its domain. This view of progress contrasts with other sciences, "such as biology and physical chemistry," where progress was "not associated with expansions of entities named for study. In fact, and quite the contrary, progress occurred when the number of entities named for study were reduced by greater theoretically based insight into the organizational principles of the domain of study" (2000:950).

In terms of eating disorders, DSM-IV divides eating disorders into three general types, and several sub-types, according to their symptomatology (i.e., the pattern of symptoms exhibited by the medical subject): *anorexia nervosa*, *bulimia nervosa*[2], and *eating disorder not otherwise specified* (EDNOS) (American Psychiatric Association, 1994:251-2). EDNOS often involves some aspect of the other two disorders, but can include other behaviors or mental disorders; hence, it is not easily identified. Some experts call the EDNOS group "borderline eating disorders or partial syndromes" (A. Key and B. Laughey, 2003:48). DSM-IV includes *binge eating disorder* in this group, though sometimes this eating pattern is studied as a distinct eating disorder. (The U.S. Surgeon General's office identifies binge eating disorder as "a newly recognized condition" (United States Surgeon General, 2004)). Psychiatric studies often identify the DSM sub-types of anorexia and bulimia nervosa as "typical" and "atypical" (see for example Lee, Sing, Chan, Y.Y.L., and Hsu, L.K.G. 2003). ICD-10 categorizes eating disorders along the same three categories as the DSM; these disorders are located in ICD-10 Chapter V, Mental and behavioural disorders (F00-F99), under "Behavioural syndromes associated with physiological disturbances and physical factors" (category F50-F59) (World Health Organization, 2005c).

The ICD did not undergo the same sorts of challenges concurrently with the DSM, yet the close linkage between the two taxonomies is extensive. The appearance of their roughly equal global status is reinforced by WHO's adoption of DSM-IV classification criteria for its World Mental Health Survey Initiative, which surveyed mental health in fourteen states during 1993 (WHO World Mental Health Consortium, 2004). In the research analyzed for this paper, the tendency is to treat them as interchangeable (see for example Lee, Sing, Lee, A.M., Ngai, E., Lee, D.T.S., and Wing, Y.K., 2001). The following sections illustrate how researchers around the world are taking up this global diagnostic code in a wide variety of settings. In other words, sub-assemblages of a sort are forming based on the code.

GLOBAL & REGIONAL INSTANTIATIONS OF MENTAL-HEALTH ASSEMBLAGE

The following section outlines different cases of assemblage of mental health, one at the global level; the others at state level. While none of them focuses specifically on eating disorders, all echo the practices of assemblage outlined in the codification of the global mental-disorders diagnostic code, and each of them highlights in different ways some of the problems of top-heavy, knowledge-elite-drive assemblages.

The International Consortium on Mental Health Policy and Services

The International Consortium on Mental Health Policy and Services was established in 2002 on the conviction that despite "the fact that mental health and nervous system disorders are now high on the international health agenda…[, i]n most developing countries the treatment gap for mental and neurological disorders is still unacceptably

high" (Gulbinat *et al.*, 2004:5). The Consortium was established by the governments of Australia, Britain, and the US, and by the Global Forum for Health Research. It extends to 16 developing countries, and works on applied mental health systems research (Gulbinat *et al.*, 2004). Between 2002 and 2004 it produced "the key elements of a national mental health policy" for each of the 16 target states; provided "tools and methods for assessing a country's current mental health status (contexts, needs and demands, programmes, services and care and outcomes);" established "a global network of expertise, i.e., institutions and experts, for use by countries wishing to reform their mental health policy, services and care;" and generated "guidelines and examples for upgrading mental health policy with due regard to the existing mental health delivery system and demographic, cultural and economic factors" (Gulbinat *et al.*, 2004:5). The Consortium says its help is available to "countries wishing to reform their mental health policy, services and care" (Gulbinat *et al.*, 2004:5).

The Consortium takes pains to avoid appearing forceful or top-heavy in its work: groups representing the 16 target countries "refrained from offering a definition of mental health. They also felt that any attempt to define mental health needs across countries and cultures would be neither useful nor helpful," and proposed only "[t]he exchange of experience and information, particularly among countries with similar socio-cultural and socio-economic profiles" (Gulbinat *et al.*, 2004:12). Nonetheless, a review of the target countries' profiles illustrates that they have already taken up the code. For example, while the Chile mental health country profile makes no mention of the kind of diagnostic tools used by professional psychiatrists in Chile, it does note that in child and adolescent psychiatry, "the most common diagnoses encountered in children are attention deficit hyperactivity disorder, learning disorders, enuresis, adjustment disorder, intellectual disability, anxiety disorder and depressive disorder" (Carmen López Stewart, 2004:80). The Consortium's approach also overlaps with the global mental-disorders diagnostic code in that it adopts a model of mental illness in which medical professionals help individuals treat the things wrong inside them. Interestingly, it adds the view that "[o]ptimal mental health…is not only essential for individual well-being, but contributes to enhancing human capital (individual productivity) and social capital (social cohesiveness), both of which are critical for economic growth and poverty reduction" (Gulbinat *et al.*, 2004:6, citing Putnam, 1993 and World Bank, 1999).

The Consortium represents and engages in several processes of assemblage. The forged alignments seem particularly clear in the participant profile: it is sponsored by the US, the UK, and Australia, and by the Global Health Forum, whose governing body currently includes representatives from the British medical journal *The Lancet*. Additionally, members hail from Chinese, Egyptian, South African, Mexican, and Ugandan universities; (mental) health and/or development organizations in India, Brazil, Sweden, Norway, Cuba, Canada, Tanzania, and Switzerland; two non-governmental organizations (NGOs) called the Council on Health Research for Development (COHRED) and Development Alternatives with Women for a New Era (DAWN); and an NGO called Research, Action and Information Network for the Bodily Integrity of Women (RAINBO)—which is based in Africa but is governed by a nine-member Board of Trustees (five from the UK, two from the US, one from Denmark, and one from Kenya). Other members include two representatives from the World Health Organization, one representative from the World Bank, and, interestingly, a

representative of the International Federation of Pharmaceutical Manufacturers Associations (Global Forum for Health Research, 2005; Gulbinat *et al.*, 2004; Research, Action and Information Network for the Bodily Integrity of Women, 2005). However voluntary a state's acceptance of Consortium support, it seems reasonable to identify the Consortium's work as an instantiation of a global-level mental-health assemblage.

The Consortium's discussion of the treatment gap in developing states provides a good example of the *depoliticization* of issues: The group argues that "the technical knowledge on how to deal with a mental or neurological problem is insufficient to assure application of the appropriate treatment", yet their example of the case of epilepsy makes it clear that recognized technical experts hold the ability to change policies. Observing, "The large majority of patients with epilepsy remain untreated in most developing countries," the group identifies three causes of this problem: "The lack of policy on mental or neurological health; The failure of professionals in the fields of mental health and neurology to engage in the economic aspects of the health and social policy dialogue; The lack of preparation and training for leadership in policy development and dialogue. (Gulbinat *et al.*, 2004:6). Notably, no mention is made of principled resistance to such policy by government officials, refusal of family members to engage in treatment programs, or other explanations of a more or less principled nature. The core problem, according to the Consortium, is the lack of technical (professional) expertise and training. While the Consortium may concentrate on this particular dimension to the treatment gap because this is where it may have the most influence—e.g., its programs may spur better training of professional personnel—it frames the debate in a way that indicates a lack of professional training, not larger social concerns, is the problem. In this sense, while this global-level mental-health assemblage results in part from popular (state and/or professional) demand, this does not mean it has a populist bent.

The Chile Mental Health Profile

The case study of Chile published by the Consortium echoes the assemblage practices of its parent assemblage. For example, the profile recommends *forging alignments* for the purpose of implementing Chile's national health plan—i.e., encouraging "the active participation of consumer and family groups as well as mental health NGOs" and "incorporating the resources of private insurance companies and private mental health providers" in the plan's implementation. Doing these things, it says, "would not only increase the number of relatively low-cost providers but improve innovation and quality levels" (Carmen López Stewart 2004:80). Additionally, despite its attempts at cultural sensitivity, the Consortium ends up *rendering* these problems *technical*. Cultural questions are politically charged in Chile, and the Consortium report addresses these issues in its discussion of Chile's "two principal cultures," the "Chilean culture with its mix of Spanish, European and North American features" and the "Mapuche culture." The Chilean culture "defines mental health as equilibrium, quality of life and well-being" and "mainly associates mental illness with madness. There is late recognition of symptoms, stigmatization and discrimination and the family has to ask an external power, psychiatry, for social control" (López Stewart, 2004:74). By contrast, the Mapuche culture "believes that both health and mental health are dependent on the harmony and equilibrium of the universe. Behaviours that threaten this equilibrium can result in disease. Mapuche families take care of their mentally ill family member, keep

him or her integrated in the group and…are considered to 'own' the sick person and take total control" (López Stewart, 2004:74).

The Consortium recognizes the Mapuche culture's different view of mental health, and indeed recommends developing "mental health services for native people, incorporating some elements of their traditional medicine" (López Stewart, 2004:81). Yet the Consortium's overall outline of "priority needs for Chilean mental health care delivery" seems to lack recognition of how it could conflict with Mapuche or other cultural practices. The outline includes such proposals as those mentioned above, as well as extending the provision of mental health services; including programs for other mental health priorities; implementing stronger promotional and prevention programs; educating the population on mental health and the services available and to reverse stigmatization; and developing "a culture of respect for human rights, including those of people with mental illness" (López Stewart, 2004:82).

There is little discussion of eating disorders in the Consortium's work. Yet the assemblage characteristics present in the Chile profile, including the depoliticizing and rendering technical elements, along with its authorization of the global mental-disorders diagnostic code, gives the Consortium's work a professionalist and apolitical bent that portends preserving the *status quo*. For persons concerned to change social dynamics including especially the positions and experiences of persons diagnosed with mental disorder, these characteristics should be concerning.

The following section outlines specific studies of eating disorders in different states and regions around the world. This overview illustrates how assemblages of eating disorder are related, via the global mental-disorders diagnostic code, to global-level assemblage dynamics. It also highlights similar dynamics of assemblage and raises similar questions as the Consortium and its sub-programs raise, though it also underscores some potential means within assemblage of upsetting the *status quo*.

Regional Instantiations of Eating-Disorders Research Agendas

Researchers around the world consult the global mental-disorders diagnostic code as they examine eating practices. The results of this research are sometimes surprising, as evidence of eating disorders has appeared in a wide variety of states and cultures. Studies conducted in Turkey (Ozdel *et al.*, 2003), Iran (Nobakht and Dezhkam, 2000), and Egypt (Nasser, 1994) find eating disorders or "morbid eating patterns" are emerging at rates similar to those in western states. Additionally, other studies note increased eating disorder rates amongst Chinese undergraduates (Lee *et al.*, 1998), and among Asian immigrants to Western countries and "Asian and Arab teenagers" (Shuriquie, 1999).

Yet the global mental-disorders diagnostic code presents difficulties in diagnosis, particularly when used cross-culturally. A study of Indian subjects by scholars at New Delhi's All India Institute of Medical Sciences indicates the hurdles scientists face when using it. The study describes "five cases of young women who chiefly presented with refusal to eat, persistent vomiting, marked weight loss, amenorrhea and other somatic symptoms. They did not show overactivity or disturbances in body image seen characteristically in anorexia nervosa. Though finally diagnosed and treated as cases of eating disorder, they presented considerable difficulty in diagnosis" (S.K. Khandelwal, P. Sharan, and S. Saxena, 1995:132). Hong Kong-based scholars encountered similar difficulties in their study, noting, "The rationales used by anorexic patients to explain

noneating are more varied than implied in the 4th ed. of the Diagnostic and Statistical Manual of Mental Disorders and the ICD-10" (Lee *et al.*, 2001:224). And scholars at the University of New South Wales and Peking University (including some of the same as from the Hong Kong study) also encountered problems. Their study of Chinese schoolchildren found "a surprisingly high level of weight-related concerns among schools across mainland China," but also some difficulty in identifying girls who were underweight when "applying the standard Western procedure for categorizing body mass index" (G.F. Huon, Qian Mingyi, K. Oliver, & Guanglan Xiao, 2002).

Of interest is the way in which researchers have proposed to resolve the diagnosis problem. Some scholars suggest opening the explanation to cultural dynamics. For example, the Egyptian study discusses "sociocultural reasons" for the "atypical presentation" of anorexia nervosa in Egyptian populations (Nasser, 1994). A transcultural study cited above (using ICD-10 classifications) and reviewing research in Japan, Cairo, Israel, South-East Asia, and other primarily non-western locales as well as London observes, "It is plausible that eating disorders have a sociocultural cause" (Shuriquie, 1999). This study concludes that exposure to "Western values" explains several dynamics, including increasing numbers of new cases of anorexia and bulimia among Asian immigrants to western countries, and abnormal eating attitudes and eating disorders among Asian and Arab teenagers. In fact, it argues, "The idea that Arab females might be experiencing a conflict between influential Western values and Arabic and Islamic traditions may explain the emergence of illnesses which have, until recently, been non-existent" (Shuriquie, 1999). Another tack is to render the question a technical one, for example, by broadening the symptomatology of a disorder. In this vein, the Hong Kong scholars cited above suggest a "broadened conceptualization of anorexia nervosa," which "may enhance an understanding of patients' illness experiences and enliven research on eating disorders" (Lee *et al.*, 2001:224).

The problem is that these researchers' conclusions reflect little on the implications that a "broadened conceptualization" of a particular eating disorder might have for future cases of disturbed eating patterns. The concern is not so much that broadening conceptualizations will encourage disturbed eating patterns or increase their likelihood, but rather that they will contribute to dynamics in which a broader (or different) range of human action becomes pathologized, i.e., considered the manifestation of an individual person's disease—and that the social status quo remains unchallenged.

An example of this kind of approach is a study surveying several cross-cultural and international studies of eating disorders. It argues, "A major step toward the development of a truly international diagnostic approach to bulimia nervosa and anorexia nervosa is a heightened awareness among practitioners of the possibility of both [disorders] among minority and non-Western populations." Accordingly, it suggests,

> [F]ear of fatness in the anorexia nervosa diagnostic criteria…may not be necessary in international classification systems, where it may be replaced instead by terms such as 'distorted body image,' 'refusal to gain weight,' and so forth. Although researchers…have argued that it is important to maintain the distinction between 'true' anorexia and atypical anorexia, such distinctions unfortunately focus the argument on the 'true' diagnosis of individual patients, rather than on natural history and appropriate treatment of the condition within and among

cultures and may impede understanding of the role of culture in patient attributions. (C. Ritenbaugh, C. Shisslak, N. Eufel, and T. K. Leonard-Green, 1996)

Attending to cultural influences on eating patterns certainly seems like good science. However, this suggestion fails to mention ways of changing a cultural *status quo*: treatment of individuals with mental "disorders" remains the ultimate aim, and "the social division of discourses" is defended: the "expert needs discourse" of the diagnostic code likely will reinforce the cultural *status quo* (Fraser, 1989:172). It is unclear how the erasing the distinction between 'true' anorexia and atypical anorexia, or incorporating different terminology, such as "'distorted body image,'" or "'refusal to gain weight,'" can do other than encourage more diagnoses and treatments of eating disorders, and reinforce the socio-political status quo. Nor does this suggestion reflect a sense of the researcher herself as culturally situated. Thus, the passage repeats the processes of assemblage such as *rendering technical* and depoliticizing.

Nonetheless, there is evidence that psychiatric researchers are moving in the other direction, *away* from encouraging more diagnoses of disorder, and *toward* viewing "eating disordered" persons as the norm rather than the exception. For example, the author of the transcultural study cited above notes, "it may even be argued that eating disorders are simply extensions of normal and socially acceptable modes of behaviour" in western culture (Shuriquie, 1999). Of course, the implication is that the entirety of western culture is "disordered." While this observation *reassembles* again (Li 2007:265), its purpose is not entirely apolitical: the study's argument that eating disorders are a society-wide phenomenon could easily be taken as a cue for political action. (Indeed, these observations are encouraging in that they reflect feminist analyses of US eating disorders patterns, and particularly the argument that eating disorders are "utterly continuous with a dominant element of the experience of being female in this [western] culture" (Susan Bordo, 1993:57). The observations in fact highlight new ways to work within assemblages, counteract the potentially damaging "pragmatic effects of a diagnostic judgment," and perhaps even "incorporate knowledge generated at the social margins" (Good, 1996:350).)

The question is, how is such a research program to be implemented? The prospect for this kind of reform is quite daunting, given that reforming the diagnostic code in the ways the two studies above suggest is a tall order in itself. There is resistance within the scientific community to that kind of code reform (as the blocked quote above indicates); much more seems at stake if we ask diagnosticians not only to address cultural influences *including their own actions* in diagnosis. It is true that both the ICD and the DSM are continually being revised: The DSM revision period has even been lengthened beyond the former 10-year period so as to accommodate the volume of feedback it receives with each edition. But arguing for reform of ICD and the DSM codes, from a position in a non-western state, while imbued in a particular scientific tradition, using research methodology that privileges diagnosis over assessment, while knowing the history of these two diagnostic manuals, and having practitioners adopt a reformed code that critiques their own actions, seems a very difficult, highly political, and daunting prospect. Nonetheless, there is evidence of creative diagnostic activity at work.

Evidence of Resistance to the Eating Disorders Research Agenda

Is there evidence of resistance to the eating-disorders research agenda, and/or to the code on which it is based? There are two potential kinds of answer to this question. The first is an answer that looks for organized social activism or movements within the research community, or within a larger social grouping that understands or perceives the edges of the eating disorders research agenda and takes steps to promote an "alternative" agenda. This area deserves more research than has been possible in preparation of this paper.

The second kind considers the possibility that eating "disordered" persons themselves provide direct evidence of resistance to the eating disorder research agenda and the many social assumptions of individuality, femininity and masculinity, body mass/structure/type, "attitudes" towards eating (or the framing of human relations to food as "attitudes"), and myriad other assumptions made within the eating disorders research agenda. On this view, it is not at all surprising that eating "disordered" persons are notoriously difficult to treat, that they resist treatments for their behaviors, or that some individuals progress "from less to more severe disturbances in eating behavior" (C.M. Shisslak, M. Crago, and L.S. Estes, 1995:209). Such an interpretation of the actions of those persons diagnosed with eating disorders is admittedly crude. Yet it gets to some under-discussed questions regarding the relation of humans to their bodies and to the societies that contribute to the construction of those bodies. Starvation, body-hatred, death, and the other human events and actions contained within this research agenda ought to remain foremost in any study, just as that agenda deserves continual refiguring, re-examination, and reconstruction. One way to accomplish this is to consider the phenomenon of eating disorders itself as evidence of resistance to interpretations of it. Thus, a US-Hong Kong-based research team studying eating disturbances "in both Eastern and Western societies" suggests that in a globalizing world, women find themselves "straddling two worlds, be it generational, work-family, cultural, or traditional and modern, [and thus] may employ food denial as an instrumental means of negotiating the transition, disconnection, and oppression that they uniformly endure" (M.A. Katzman & Sing Lee, 1997). Indeed, these authors argue, "by construing anorexia nervosa as a body image disorder or Western culture-bound syndrome, extant models miss the broader contexts and varied meanings of food refusal" (p. 385). Of course, this approach requires addressing the possibility that researchers themselves play the role of a de-territorialized authority that contributes to the "transition, disconnection, and oppression that [women] uniformly endure."

CONCLUSION

This paper has proposed that we apprehend the apparent spread of eating disorders as a result of globalization–not as the globalization of "western culture" *per se*, but rather as a phenomenon of globalization defined as the spread of western culture via the medium of scientific knowledge. So long as that scientific knowledge, embodied in the global mental-disorders diagnostic code, explains human behavior as the result of the mental illness of an individual, it seems likely we will see the persistence and even the broadcast of eating disorders diagnoses around the world. With the broadcast of eating disorders diagnoses, how will girls and women conceive of themselves relative to their social and political surroundings? The paper intends to outline some possible answers to these questions.

The first answer, mentioned throughout this paper, is that in areas where a mental-health assemblage instantiates, the status quo will maintain. To the extent that the status quo in many societies is unequal in a variety of ways, but nearly always consistently in terms of sex/gender dynamics, the emergence of a mental-health assemblage, for example through the institutionalization of an eating-disorders research agenda, is not necessarily good news for the women and girls that will most often fall under its diagnostic lens.

The second answer, mentioned in the introduction to this paper, is that individual members of societies will learn to govern themselves along lines or agenda not of their own making. That is, mental-health assemblages will render societies "governable," and only mental health authorities will be able to manage the consequences. To the extent that states implement "national health plans" such as the one initiated recently by Chile, we can expect persons to begin self-diagnosis, self-surveillance, and even self-treatment, through such efforts as "health management." In food-related activities, we can expect persons to engage in all manner of dieting exercises. Meanwhile, again, the social status quo likely will maintain.

Assemblage does not necessarily inevitably result in undemocratic forms, though this can be a likely outcome. There is certainly an expert-heavy tendency of the mental-health assemblages discussed in this paper. But our review of instantiations of mental-health assemblage, such as the eating disorders studies outlined above, also highlights ways in which assemblage opens new avenues for redefinition and empowerment. Medical researchers' attention to cultural influences in explaining eating disorders is the most obvious such opening. The key to offsetting this tendency will be for non-experts and politically minded agents to adopt scientific knowledge and discourse *strategically,* even as they participate in assemblage with a "will to improve." This resistance strategy seems promising because, as other studies of assemblage highlight, it is surely unhelpful to suggest rejecting all or certain contemporary medical diagnostic techniques, as doing so "will fail to change the embedded power relations and interests" permeating assemblages (Lowry, 2004). To paraphrase Lowry (2004), discontinuing mental health programs, undermining community care networks, and banning pharmaceuticals are not viable solutions to the question of how power, autonomy, and the status of the "mentally ill" (and in our specific case, persons diagnosed with eating disorders) might be altered. If "'discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, [and] moral and philanthropic propositions'" comprise the *mental-health assemblages* examined in this paper, and if those elements are also "key characteristics of contemporary societies generally," then attempts to improve societies' mental health policies or regimes must be strategic about knowledge, and must understand power and in more complex, creative, and fluid ways" (Lowry 2004).

An example of this kind of approach is presented by Kim Hopper (1991). Discussing the critical commentary of anthropologists about cross-cultural research into schizophrenia,[3] Hopper argues, "This critical commentary all but ignores the received wisdom of chronicity as the natural trajectory of schizophrenia. A natural alliance awaits realization between clinicians—newly alerted to ill-understood factors affecting course and outcome—and fieldworkers—bent on close ethnographic analysis of the configurations and roles of beliefs, work, kin-based support, the uses of public space, and 'the natives'' own understanding of what ails them" (p. 299). It is true that some

researchers hold schizophrenia as an almost unique mental condition (see for example Hacking, 1998). Yet the collaboration Hopper suggests seems to take into account the cultural *situatedness* of diagnosticians while also respecting non-technical expertise.

Another suggestion comes from Byron J. Good, who worked in the DSM-IV Culture and Diagnosis Group tasked with reviewing the cultural dynamics and effects of diagnosis. Good's epilogue on a collection of studies published by this group implies that in the process of engaging in research into culture and diagnosis, the findings of the group were not entirely incorporated into DSM revision work: "It is frankly troubling that concerns about the development of reliable research instruments by much of the leadership of the psychiatry profession should not be matched by concern about the reliable use of diagnostic instruments in community practice" (Good, 1996). One could read this as an example of the anti-politics of assemblage, that is, processes of "closing down debate about how and what to govern and the distributive effects of particular arrangements by reference to expertise"—though in this case, the implication is that the research group's expertise was not so much overruled as it was simply not appreciated (Li, 2007:264). What is important is Good's insight from the group's work, namely, that "the disqualification of certain forms of scientific evidence, and the reluctance to incorporate knowledge generated at the social margins are issues of power" (Good, 1996:350). As a result, Good suggests incorporating insights "from the margins" into the DSM-IV. He argues that engaging in the reliable use of diagnostic instruments in community practice "takes psychiatric research to everyday uses of language, to the pragmatic effects of a diagnostic judgment, to the effects of using the label antisocial personality disorder for minority youths (while refusing to label racism as a personality disorder)" (Good, 1996). Nonetheless, Good argues that "the door has been opened" on these issues, "and it will not close until much more substantive materials on culture and ethnicity are made part of the diagnostic manual."

In other words, Good envisions a sort of bottom-up practice within the profession of psychiatry that passes information *from* the clinicians making diagnoses *to* the research scientists who design diagnoses. This, he believes, will lead to better diagnostic criteria. Of course, Good's vision does not involve a bottom-up dialogue between the entire psychiatric profession and its subject population—i.e., its potential patients. Thus, on Good's view, the expert-heavy nature of assemblage would remain intact. Moreover, it does not seem quite clear whether even the kind of collaboration Hopper outlines can alleviate the governmentality effect of rendering societies "governable." The "natural alliance" she discusses is still between experts—though this time, it is not an alliance between clinicians and psychiatric researchers, but rather between psychiatric researchers and anthropologists. The subject population would largely remain subject.

Thus, a primary conclusion of this paper is that mental-health assemblages not only reinforce medical experts' and institutions' influence, but in fact *encourage non-experts to apply the knowledge concepts developed by experts*. This finding reflects the findings of studies that define global governance as a process of *governmentality*, in which government occurs "increasingly…*through* affected individuals rather than on them as they [are] increasingly conceptualized as key actors to ensure both effectiveness in program-delivery and to confer legitimacy on governmental practices" (Ole Sending and Iver Neumann 2006:661). The overlap with governmentality scholarship is not surprising, as assemblage is a set of processes that contributes to processes of

governmentality. Yet rather than adopt the governmentality concept wholesale, the concept of assemblage is more specific, as it highlights the ways in which the "contingency," "fissiparousness," and fragility of the affiliations made through the "will to improve" shape the resulting "formations" of governmentality (Li 2007).

Another conclusion of this paper is that although the concept of assemblage "flags agency" and "invites analysis of how the elements of an assemblage might – or might not – be made to *cohere*" (emphasis added, Li 2007:264), analysis of global mental-health assemblage illustrates the difficulties of *offsetting* expert discourse and expert solutions. The mental-health assemblages outlined in this paper closely connect the people perceived to suffer from eating disorders with "institutions of knowledge production and utilization" (Fraser 1989:172). Presumably, they will be less able to advocate alternative diagnoses or alternative analyses of the social dynamics involved in diagnosis. This point deserves further research, however.

Another suggestion of this paper is that there is a political economy of eating disorders diagnoses[4] in which governmental actors, non-state actors, and private-sector forces *have interests* in problematizing human behavior, forging alignments, and assembling solutions to the perceived/constructed problem. The interests are politically and economically significant: government actors by nature experience pressures or feel obligations to satisfy needs (Fraser, 1989); likewise, non-state actors experience pressures or feel obliged to advocate on behalf of those who are diagnosed as possessing the problem or behaving in ways that are defined as problematic, and corporations' and research institutions' existence depends on responding to perceived governmental mandates, public needs, and/or market demands.

Further, while the assemblage/governmentality approach does afford better access to the content and "mentalities" of governing processes, including global-level processes, the approach is unclear whether and to what extent civil-society members can enact or resist mentalities of government. Governmentality scholarship needs to theorize the gradations of eligibility for objectifying (achieving and enacting) government. This paper helps to do that, but only to the extent that it suggests expert civil-society members have access to scientific language which allows them to figure themselves as "outside" language. If it is true, as Good notes in the quote above, that engaging in the reliable use of diagnostic instruments in community practice "takes psychiatric research to everyday uses of language," it is the clinicians—arguably the most likely of members of the psychiatric profession to advocate on behalf of persons diagnosed as mentally disordered—who can control the use of language. As Flynn says, they will be the ones to manage the shift in "mentalities" where assemblage takes hold (Flynn, 2002). Meanwhile, patients' and other non-elites' agency will remain (or even be reduced to) mere rejection of the "rationalization" of rule, or to accepting it and thereby rendering themselves "citizen-subjects" of governance. In the specific case of eating disorders, patients will be reduced to resisting a diagnosis. Further research is needed into whether such resistance is possible, under what conditions, and where it is occurring. A fruitful avenue seems to be "anti-a/b" research that treats anorexia and bulimia as entities outside the person (Richard Maisel, David Epston, and Ali Borden, 2004). Certainly this research agenda seems to be engaging in strategic use of knowledge, and understands power by taking the diagnosis and using it against the diseases diagnosed.

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[1] Some of the states included in this Consortium are Bulgaria, Chile, Georgia, India, Kenya, Lithuania, Malaysia, Nepal, Pakistan, Philippines, Thailand, Uganda, and Zambia.

[2] DSM-IV identifies five required symptoms of bulimia nervosa: 1) "Recurrent episodes of binge eating" (where binge eating is both "eating, in a discrete period of time…an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances" and "a sense of lack of control over eating during the episode"); 2) "Recurrent compensatory behavior in order to prevent weight gain"; 3) 1 and 2 "both occur, on average, at least twice a week for 3 months"; 4) "Self-evaluation is unduly influenced by body shape and weight; and 5) "The disturbance does not occur exclusively during episodes of Anorexia Nervosa." Subtypes of bulimia nervosa include the purging type and the nonpurging type (where fasting or excessive exercise rather than purging are used as "compensatory behaviors"). American Psychiatric Association, 252.

[3] This commentary includes "charges of ethnocentrism and category errors in the psychiatric research enterprise itself, especially the inapplicability of its disease taxonomy to some non-Western cultures, to translation difficulties, the suspect and 'thin' quality of questionnaire-generated accounts of illness, disregard for variant understandings of the 'self', and the naïveté of treating culture as a set of variables" (Hopper, 1991: 299).

[4] Thanks to the IPS anonymous reviewer for framing the issue in this useful manner.