Globalizing Pathologies: Mental Health *Assemblage* and Spreading Diagnoses of Eating Disorders

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Psychiatric researchers recently have published evidence of eating disorders in regions around the world, despite previous conceptions of eating disorders as ''culture-bound syndromes.'' What pressures or processes encourage this apparent spread of eating disorders diagnoses, and what do they tell us about state mental health policy? This paper argues that the spread of diagnoses results from global-level instances of *assemblage*: conglomerations of scientific expertise, state policy, international institutions, and practices employed with a will to improve the lives of perceived sufferers of mental disorder. Cases of global mental-health policy illustrate the ways in which mental health assemblage produces a ''distrust in the 'self-governing' governed.''

Current psychiatric research on mental disorders suggests that the diagnosis of eating disorders has spread from developed Western states to non-Western and developing 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'' (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 developing 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 (Efron 1997), while a study of Hong Kong–based subjects professes the ''cross-cultural disease validity'' of anorexia nervosa (Lee, Chan, and Hsu 2003:967). Meanwhile, 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'' (Ozdel, Atesci, and Oguzhanoglu 2003). A 2000 study conducted 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 somewhat higher than what has been reported in other non-Western societies'' (Nobakht and Dezhkam 2000:265). Researchers observing Chinese undergraduates predict that females increasingly will be ''predispose[d]… to weight control behavior and eating disorders'' (Lee, Leung, Lee, Yu, and 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 (Nasser 1994). 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'' (Shuriquie 1999:354). Finally, South Africa-based researchers recently have concluded that the ''risk for eating disorders in developing countries may be increasing'' (Wassenaar, le Grange, Winship, and Lachenicht 2000:225).

   What pressures or processes account for this spread in eating disorders diagnoses, and what are their implications for our understanding of state mental health policy? This paper argues that the spread in diagnoses results from global-level instances of *assemblage*, that is, conglomerations or ''ensembles'' (Collier and Ong 2005:4) of scientific expertise, state policy, international institutions, and other practices employed by state and nonstate actors with a ''will to improve'' (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 Lowry 2004; Li 2007). They are also 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. This paper argues that the elements of a *mental health assemblage* are emerging at the global level, centered around the production of a *transnational mental disorder diagnostic code* and its related research agenda, such that research scientists, states, nonstate advocates, and pharmaceutical corporations, among others, 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 paper adopts the concept of *assemblage* because it captures the dynamic character of the forces at play, while also capturing the ways in which those forces involve effort (Collier and Ong 2005; Li 2007). As Tania Murray Li argues, ''Assemblage flags agency, the hard work required to draw heterogeneous elements together…. It invites analysis of how the elements of an assemblage might—or might not—be made to cohere'' (Li 2007:264). The assemblage concept captures the eclectic agglomeration of social and political agents who aim to improve ''mental health,'' particularly in developing states, and who in their intersecting paths to that goal apply psychiatric diagnostic discourse and encourage the institutionalization of psychiatric diagnoses and treatments 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'' (Haas 1992), and its primary concern is to explain inter-state cooperation and its results.[1] Yet the cases outlined here are not so coherent (social advocates' actions are involved), nor do they answer the question *whether* states or knowledge elites define a problem. Rather, they encourage insight into how and why knowledge elites confer a particular diagnosis where once they did not, and insights into the products of assemblage. This paper's hypothesis is that the apparent spread of eating-disorders diagnoses

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[1]Some scholars have examined the epistemic community concept with an eye to the knowledge and relations they produce. Coe and Bunnell's (2003) insight that epistemic communities can constitute a ''hegemonic-discursive domain'' that ''delimits a range of international media, educational, and policy networks through which… technical… knowledge is propagated and dispersed,'' is especially helpful (p. 450). While this insight helps us understand how the knowledge produced through epistemic communities can become dominant within a larger cultural (and not simply decision making) context, the assemblage concept seems more easily adapted to the micro-level analysis that this paper requires.

indicates the emergence of a global-level *mental health assemblage*, which has encouraged (and continues to promote) the institutionalization of eating-disorders research agendas in an increasingly broad array of states, and that these specific instantiations of eating-disorder research and diagnosis agendas are themselves (sub-)assemblages.

What's at stake in the case of emerging mental health assemblages in non-Western, developing states? Several possible implications are highlighted in this paper. One concern, raised by *governmentality* scholars (Dean 1999; Flynn 2002; Duncan 2003), is that processes of governance such as assemblage will link persons' self-subjection with regulation; that is, that persons will assume a ''mentality of rule'' (Turner 1997 in Flynn 2002). In our cases, indicators of a mentality of rule include persons' self-diagnosis of ''having'' an eating disorder, and behaving in ways expected and/or prescribed as a result of that self-diagnosis. Put differently, these assemblages and sub-assemblages may produce a ''distrust in the 'self-governing' governed'' through the ''pervasive idea'' (Duncan 2003:472–473) that certain persons, in particular sociocultural conditions, are prone to mental distress and disorder.

A related concern has to do with the role of experts in assemblages. Medical ''experts play a strategic role in producing knowledge (discourse) and schemes of action (practice)'' in assemblages such as those discussed in this paper. A likely result of this role is that professional members of ''civil society'' will enjoy a privileged position relative to other civil society actors, and this position will enable them to *manage* the shift in ''mentalities'' where assemblage takes hold (Flynn 2002). As Rob Flynn argues, through governmentality, ''professionals become crucial to the state in its 'exercise of power, systems of technique and instrumentality'… and thus render society governable'' (Flynn 2002:163). Resistance to the power of professionals would thus become difficult, because as Pat O'Malley observes, in assemblage processes, resistance and rule are co-constituted: ''government and resistance articulate, mingle, and hybridize, so that resistance cannot readily be thought of as external to rule'' (O'Malley 1996:310).

A third concern derives from one of the generic processes of assemblage, namely, the process of *rendering problems technical* (Li 2007). Assemblages favor ''expert needs discourses'' (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). In other words, apprehending the apparent spread of eating-disorders diagnoses as a global-level mental health assemblage raises the possibility that contrary to its ''will to improve,'' its results are variations on the very mental health policies, such as stigmatizing and institutionalizing persons, that so violate the spirit of the assemblage and the work of creating it. For persons concerned about ''the pragmatic effects of a diagnostic judgment,'' or about incorporating ''knowledge generated at the social margins'' (Good 1996:350), the potential for such dynamics is troubling.

The following sections of the paper trace the emergence of mental health assemblages in unexpected parts of the world. A significant dimension to these dynamics is the production, over the course of the past century, of a core *transnational mental disorders diagnostic code* in psychiatric research, professional training, and health policymaking around the world. The code rests on two psychiatric diagnostic nomenclatures: the World Health Organization's (WHO) International Classification of Diseases (ICD), and the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of mental disorders (DSM). State and private research scientists worldwide use the two nomenclatures, often interchangeably. It is thus not surprising that their definitions of eating disorders largely overlap. Their emergence as part of a global-level mental health assemblage is important to our cases because they form the core of the

eating disorders research agendas examined in this paper. The paper traces the codification of the diagnostic code and the ways in which it resembles a Guattarian ''dominant economic semiotic system'' that produces new markets for bodies (see Bogard 1998).

Subsequently, the paper examines research projects that have adopted this code for use with non-Western, developing state populations. These projects include a global-level consortium of researchers, policymakers, and non-governmental mental health advocacy groups that has set up mental health programs in 16 developing states.[2] The project encourages developing states to assess their ''mental health status,'' and has established ''a global network of expertise'' and generated ''guidelines and examples'' for states who look to improve their mental health policies (Gulbinat, Manderscheid, Baingana, Jenkins, Khandelwal, Levav, Mak, Mayeya, Minoletti, Mubbashar, Murthy, Deva, Schilder, Tomov, Baba, Townsend, and Whiteford 2004). Other cases include regional and state instantiations of eating disorders research agendas, including projects in Chile, Hong Kong, Turkey, and Egypt. These projects highlight that while different actors ''cohere'' around the perceived problem of eating disorders, some discourses can become dominant, and expert knowledge may be favored over lay knowledge. This has significance for these states' political and professional dynamics. To the extent that such programs intend to upset the status quo, their use of expert needs discourses not only would render them less effective, but could contradict their very purpose by producing the knowledge and language necessary to perpetuate what Gille Deleuze and Félix Guattari ([1980] 1987:228) call ''micro-fascisms''—that is, the ''petty exclusions, cruelties, and insipid moralisms'' of daily life (Bogard 1998:68). This will occur if processes of assemblage defend the status quo and ''clos[e] down debate about how and what to govern and the distributive effects of particular arrangements by reference to expertise,'' as Li (2007) suggests.

The conclusion discusses ways in which the expertise-heavy dynamics of the global mental health assemblage may be resisted. It recognizes that even as these assemblages may carve ''ecological niches'' (Hacking 1998) in which eating disorders diagnoses incubate, they open new avenues for redefinition and empowerment. Offsetting the expert-heavy tendency of these mental health assemblages thus requires that non-experts and politically minded agents adopt scientific knowledge and discourse *strategically,* even as they may join the assemblage with a ''will to improve.''

The Transnational Mental Disorders Diagnostic Code: A Core Element of the Global Mental Health Assemblage

Examining the apparent spread of eating disorders diagnoses around the world reveals repeated references to the WHO's International Classification of Diseases (ICD), and the APA's Diagnostic and Statistical Manual of mental disorders (DSM). The history of their emergence reflects the generic processes of assemblage outlined by Li (2007). This section covers the emergence of these two nomenclatures as a *transnational mental disorders diagnostic code.* Analyzed through the assemblage concept and the epistemology on which it rests, this transnational mental-disorders diagnostic code takes on the character of a ''dominant economic semiotic system,'' that is, a system that involves ''the creation of markets of the most heterogeneous sorts—markets for labor, ideas, images, discourses, fashions, bodies'' (Guattari and Alliez 1984 and Guattari and Negri 1985 in Bogard 1998:72).

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[2]Some states included: Bulgaria, Chile, Georgia, India, Kenya, Lithuania, Malaysia, Nepal, Pakistan, Philippines, Thailand, Uganda, and Zambia.

Institutionalizing the Transnational Mental Disorders Diagnostic Code

In the 1850s, several Western states began 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. By 1893 the successor to the Congress, the International Statistical Institute, had established the International List of Causes of Death classification scheme and its 10-year revision procedure. While the project originally was centered in France and Austria, it soon included statisticians in the United Kingdom, Canada, and the United States, whose professionals had the wherewithal and whose bureaucracies the capacity for such research. By 1899, the American (US) Public Health Association had submitted recommendations for revisions to the project leader, and the International Statistical Institute invited US cooperation in the revision cycles. 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 transnational process.

Diseases were listed *separately* of causes of death by 1938, when researchers at the Fifth Revision Conference "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). Their efforts were integrated into the work of the Sixth Decennial Revision Conference, conducted in 1946 under the auspices of the new World Health Organization (WHO). During this conference, participants also agreed on international rules for selecting the underlying cause of death, and recommended the adoption of a comprehensive program of international cooperation in the field of vital and health statistics, including "the recommendation that governments establish national committees on vital and health statistics to coordinate the statistical activities in the country, and to serve as a link between the national statistical institutions and the World Health Organization" (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). This Conference also 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 2005b:7). (The DSM adopted a similar transcultural framework around the same time.) Accordingly, WHO has created a feedback mechanism reporting the extent to which the Family of International Classifications (FIC) has been implemented. WHO–FIC implementation committees' current goals include developing an extensive information database of states' current and planned use of FIC classifications, to compile data on the use of WHO–FIC in both public and private sectors along several dimensions (World Health Organization 2005b). WHO–FIC implementation committees also are designing "plans and projects for a wider application and implementation of WHO–FIC in all Member States" (World Health Organization 2005b:3).

This history of process and practice reflects the generic assemblage processes of assemblage: for example, the process of developing the taxonomies involves *forging alignments*, that is, ''the work of linking together the objectives of the various parties to an assemblage, both those who desire to govern conduct and those whose conduct is to be conducted'' (Li 2007:265). The ICD/DSM codification process and its continued iterations have forged alignments among state policy-makers, statisticians, physicians, health insurance organizations, hospitals, military medical services, health administrations, and similar bodies. Notably, there is little mention of participating non-expert citizens, whose conduct (that is, health) is in question and whose conduct regarding their health increasingly comes into question. Additionally, steps in the process of codifying the transnational mental disorders diagnostic code, such as the WHO–FIC mechanism, look very much like the assemblage process of *authorizing knowledge*, that is, ''specifying the requisite body of knowledge; confirming enabling assumptions; containing critiques'' (Li 2007:265).

The codification of the transnational mental disorders diagnostic code also has *rendered technical*, that is, it has ''extract[ed] from all the messiness of the social world, with all the processes that run through it, a set of relations that can be formulated as a diagram in which problem (1) plus intervention (2) will produce (3), a beneficial result'' (Li 2007:265). This occurred in several instances: states addressed the problem of death of members of their populations through statistical analysis and codification of causes of death, through statistical identification of new diseases, and through establishing rules for selecting the underlying cause of death.

The spread of these diagnostic criteria since their initial codification has been quite staggering, spurred by processes of de-colonization in the 1940s through the 1970s as well as the proactive efforts of the revision committees. Through these processes, the ICD became a code for evaluating state public-health policy at the same time that it could pressure states to adopt modern Western medical/health policies. Again, in Li's terms, it became the key by which knowledge is authorized. As a result, currently 198 states and nonstate 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). Additionally, 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 spread of the transnational mental disorders diagnostic code is pushed further by the development, in similar and parallel fashion, of the DSM.

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. Its codification also includes the processes of forging alignments, authorizing knowledge, and of course, rendering technical. 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'' (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 directly influenced the ICD's first definitions of mental disorders, while the ICD process set the context of the DSM's first edition. ICD and DSM definitions of mental disorders have been linked since their 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'' (Hotes 2000).

One of the DSM's most significant changes came during 1974–1980 revision process of DSM-II into DSM-III. 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 reflected a new approach including ''explicit diagnostic criteria, a multiaxial system, and a descriptive atheoretical approach'' (Parrott 2005).

The act of divorcing diagnosis from theory has been significant for the practice of psychiatry as a science, according to Arthur C. Houts (2000). In DSM-I and 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, ''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… [and] 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).

In terms of eating disorders, DSM-IV divides eating disorders into three general types and several sub-types, according to their symptomatology (the pattern of symptoms exhibited by the medical subject): *anorexia nervosa, bulimia nervosa,*[3] and *eating disorder not otherwise specified* (EDNOS) (American Psychiatric Association 1994:251–252). EDNOS often involves some aspect of the other two disorders, but can include other behaviors or mental disorders; hence its name. Some experts call the EDNOS group ''borderline eating disorders or partial syndromes'' (Key and 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 US 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 et al. 2003). ICD-10 categorizes

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[3]DSM-IV identifies five required symptoms of bulimia nervosa: (1) ''Recurrent episodes of binge eating''; (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 (fasting or excessive exercise are used as ''compensatory behaviors'') (American Psychiatric Association 1994:252).

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).

   While the ICD did not experience the same sorts of challenges coterminously with the DSM, the close linkage between the ICD and the DSM remains apparent: WHO cites the DSM as ''another standard classification of mental disorders used by mental health professionals,'' and it makes direct reference to the DSM as a significant diagnostic standard in its own mental health programs and documents (World Health Organization 2005d). 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, Lee, Ngai, Lee, and Wing, 2001). The following cases illustrate how researchers are taking up this transnational diagnostic code around the world. As we shall see, they are the result of assemblage: multiple sub-assemblages or instantiations of ''the processes of machinic production'' or ''the functionalization of desire and libido, [including] the assemblage of bodies and body parts into operational units'' (Guattari and Alliez 1984 and Guattari and Negri 1985 in Bogard 1998:72).

Global and Regional Instantiations of Mental Health Assemblage: Operationalizing the Dominant Semiotic Code

The following section outlines two cases of assemblage of mental health, one at the global level, the other at state level. While neither focuses specifically on eating disorders, both echo the practices of assemblage outlined in the codification of the transnational mental disorders diagnostic code, and each highlights in different ways the process of functionalizing the desires of the body.

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…. In most developing countries the treatment gap for mental and neurological disorders is still unacceptably high'' (Gulbinat et al. 2004:5). It was established by the governments of Australia, Britain, and the United States, and by the Global Forum for Health Research (2005) and extends to 16 developing countries, studying applied mental health systems (Gulbinat et al. 2004). Between 2002 and 2004 it produced ''the key elements of a national mental health policy'' for each of the target states; provided ''tools and methods for assessing a country's current mental health status''; established ''a global network of expertise, that is, 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 takes pains to avoid appearing forceful or top-heavy in its work, and clearly has a workshop orientation; no pressure is evident that participant countries take up the transnational diagnostic code. In fact, groups representing the 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 the "exchange of experience and information, particularly among countries with similar sociocultural and socio-economic profiles" (Gulbinat et al. 2004:12). Nonetheless, a review of the target countries' profiles shows no need to pressure them to take up the code: they have already done so. For example, while the "Chile mental health country profile" makes no mention of the 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" (López Stewart 2004:80). The Consortium's approach also overlaps with the transnational mental disorders diagnostic code in adopting a model of mental illness in which medical professionals help individuals treat the things wrong inside them.

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 United States, the United Kingdom, 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 (2005), which is based in Africa but is governed by a nine-member Board of Trustees (five from the United Kingdom, two from the United States, 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 (Gulbinat et al. 2004). 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.

It is thus not surprising that the Consortium *renders technical* and *engages in anti-politics* by reposing political questions as matters of technique, closing down debate about how and what to govern and the distributive effects of particular arrangements by reference to expertise, and encouraging citizens to engage in debate while limiting the agenda (Li 2007). Its discussion of the treatment gap in developing states provides a good example of this depoliticization process:

> That the technical knowledge on how to deal with a mental or neurological problem is insufficient to assure application of the appropriate treatment is clearly demonstrated in the case of epilepsy. Although cost-effective treatment for more than 80% of those suffering from epilepsy has been available for several decades (that is, Phenobarbital for less than US$5 per person per year), the large majority of patients with epilepsy remain untreated in most developing countries. When the reasons for this failure are analyzed, three causes become evident: 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)

Among the explanations for under-treatment of epilepsy patients, 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—for example, its programs may spur better training of professional personnel—it frames the issue in a way that indicates the lack of professional training, not larger social concerns, is the problem.

Finally, a most interesting element of the Consortium's work is its 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'' (Putnam 1993 and World Bank 1999 in Gulbinat et al. 2004:6). This observation resembles a Deleuze-Guattarian ''process of machinic production,'' in which motivational forces are created, maintained, and redirected, and bodies and body parts are assembled into operational units (see Bogard 1998:72) for use in the new markets created by dominant economic semiotic systems.

The Chile Mental Health Profile

The Chile mental health profile 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—it encourages ''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 its implementation. Doing so ''would not only increase the number of relatively low-cost providers but improve innovation and quality levels'' (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 Chile profile 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 profile 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). This would seem to give the Mapuche community an opportunity to avoid the dominance of the transnational mental health diagnostic code. Yet the outline of ''priority needs for Chilean mental health care delivery'' overlooks tensions with Mapuche cultural practices. It proposes 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).

The assemblage characteristics of this profile, along with its inability to escape the dominant economic semiotic system of the transnational mental disorders diagnostic code, gives it a professionalist and apolitical bent that portends

preserving the status quo—or more precisely, maintaining certain social hierarchies even as the discursive domain shifts. 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, conceptualized as assemblages. This overview illustrates the studies' relation, via the transnational mental disorders diagnostic code, to global-level assemblage dynamics. It raises similar questions as those raised by the work of the Consortium discussed above, while underscoring potential means within assemblage of challenging dominant economic semiotic systems.

Regional Instantiations of Eating-Disorders Research Agendas

Researchers around the world consult the transnational mental disorders diagnostic code as they examine eating practices. As we have seen, the results of this research are sometimes surprising, as evidence of eating disorders has appeared in a wide variety of states and cultures. Yet the transnational mental disorders diagnostic code presents difficulties in diagnosis, particularly when used cross-culturally, as several studies indicate. A study of Indian subjects by scholars at New Delhi's All India Institute of Medical Sciences 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'' (Khandelwal, Sharan, and Saxena 1995:132). Similarly, Hong Kong-based scholars also encountered diagnostic difficulties, noting, ''The rationales used by anorexic patients to explain noneating are more varied than implied in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders and the ICD-10'' (Lee et al. 2001:224). And scholars examining 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'' (Huon, Mingyi, Oliver, and Xiao 2002).

Of interest is the way in which the researchers have proposed to resolve these diagnostic problems. 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) that reviews 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.'' The study reasons 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 considers ''The idea that Arab females might be experiencing a conflict between influential Western values and Arabic and Islamic traditions'' as an explanation of ''the emergence of illnesses which have, until recently, been non-existant'' [sic] (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 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 suggested solutions reflect little on the implications that a ''broadened conceptualization'' of a particular eating disorder might have for future cases of disturbed eating patterns. Our concern is not so much that broadening conceptualizations will encourage disturbed eating patterns or increase their likelihood, but rather that they contribute to dynamics in which a broader/different range of human action becomes pathologized, that is, considered the manifestation of an individual person's disease—and that the ''complicity'' of the science in this process will make it that much harder to resist.

One example of how researchers might pathologize a broader range of human action is a survey of cross-cultural and international eating-disorders research, which encourages ''the development of a truly international diagnostic approach to bulimia nervosa and anorexia nervosa.'' Recognizing such problems of diagnosis as those discussed above, it recommends a change in terminology:

> [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. (Ritenbaugh, Shisslak, Teufel, and Leonard-Green 1996)

Attending to cultural influences on eating patterns certainly seems like good science. However, it is unclear how the erasing the distinction between ''true'' and ''atypical'' anorexia, or incorporating the terms ''distorted body image'' or ''refusal to gain weight'' instead of ''fear of fatness,'' can do other than encourage more diagnoses and treatments of eating disorders, and reinforce the cultural status quo. Nor does this suggestion reflect a sense of the researcher as culturally situated. Rather, as Deleuze-Guattarian scholarship might argue, it reflects *developed* societies' tendency to rigidify or ''overcode'' societal segments, ''to saturate them with significance and control, to 'normalize' them'' (Foucault 1982 in Bogard 1998:71). *Through the study's suggestions, the mentally disordered and the normal are produced.*

Nonetheless, there is evidence that psychiatric researchers are considering their cultural situatedness and the ways in which their work can be used against its spirit. The question is how such a research program would be implemented. One clue is in the Deleuze-Guattari tradition, which suggests political resistance targeted at ''social assemblage[s]'' that tend to rigidify or ''overcode'' sociocultural ''dualisms'' such as technologies built on binary logics (Deleuze and Guattari [1980] 1987:210 in Bogard 1998:69). The *implementation of* the transnational mental disorders diagnostic code, particularly since DSM-III, certainly seems rife for such a dualistic overcoding.

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 global-level assemblage. So long as the scientific knowledge embodied in the transnational mental disorders diagnostic code uses assemblage processes and new technologies to describe human behavior, it seems likely we will see the individual members of societies learning to govern themselves along lines or agenda not of their own making. That is, markets for bodies and minds will emerge, in which mental

health assemblages render societies ''governable,'' and mental health authorities alone 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 efforts like ''health management.'' In food-related activities, we may expect persons to engage in all manner of dieting exercises. Meanwhile, again, social status quo or binary segmentation will maintain, even as discursive domains shift.

Assemblage does not 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 a 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.'' The strategy could build on Deleuze-Guattarian thought, which argues, ''Not only must we focus on the structures of segmentarity, which can be considered in relation to the economic problems of the State—the problems of centralization, linearization, binarization. We must also account for dominant economic semiotic systems, the problems involved in the creation of markets of the most heterogeneous sorts'' (Bogard 1998:72). 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 Deborah Wilson 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,[4] 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.

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[4]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… disregard for variant understandings of the 'self', and the naïveté of treating culture as a set of variables'' (Hopper 1991:299).

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—though in this case, the implication is that the research group's expertise was not so much overruled as it was simply not appreciated. 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 the resistance to the dominant economic semiotic system. Of course, this vision does not involve a bottom-up dialogue between the entire psychiatric profession and its subject population—its potential patients. Thus, on Good's view, the expert-heavy nature of assemblage would remain intact. Hopper's suggested collaboration model suffers the same problem: 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.

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" (Sending and Neumann 2006:661). The overlap with governmentality scholarship is not surprising; assemblage has been conceived as a set of processes that contributes to processes of governmentality (Li 2007). Yet rather than adopt the governmentality concept wholesale, this paper has adopted *assemblage* 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" (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. Though this point certainly deserves further research, one fruitful avenue seems to be "anti-a/b" research that treats anorexia and bulimia as entities outside the person (Maisel, Epston, and Borden 2004). The agenda engages a

strategic use of knowledge, by externalizing the diagnosis and using it against the itself. Just as assemblage is ''given a new technical understanding and advanced methods of supervision,'' so is the person diagnosed as mentally disordered.

Another implication of this paper is that there is a political economy of eating disorders diagnoses[5] in which governmental actors, nonstate 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.

Yet the assemblage/governmentality approach affords access to the question whether and to what extent civil-society members can enact or resist mentalities of government. While expert civil-society members have access to scientific language which allows them to figure themselves as ''outside'' language, the assemblage and governmentality literature shows ways in which that dominant economic semiotic system is not easily resisted. If it is true 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. The assemblage and governmentality literature's insight here is that even as clinicians likely will manage shifts in ''mentalities'' where assemblage takes hold, ''in advanced (or 'neo-') liberal society,'' these clinicians are simply part of larger processes of governmentality, where ''new methods of governing the medical profession entail[l] the alignment of managerial and clinical rationalities, so that doctors are 'enrolled' into a system of governance'' (Osborne 1993 in Flynn 2002:164). Nonetheless, the dynamics of assemblage are so fluid that patients' and other non-elites' ability to resist the ''rationalization'' of rule will emerge every time new segmentations of their lives emerge. Again, the a/b research mentioned above seems to hold possibility for productive resistance. It may well be true, as Deleuze and Guattari observed, that ''The mouth of the anorexic wavers between several functions: its possessor is uncertain as to whether it is an eating-machine, an anal-machine, a talking-machine, or a breathing-machine (asthma attacks). Hence we are all handymen: each with his little machines.'' (Deleuze and Guattari [1972] 1977:1–2 in Bogard 1998:67). Yet if ''the anorexic'' sees anorexia as separate of her, perhaps the ''little machines'' will stall, and her body will be ''liberated, to become a force of joy and affirmation'' (Bogard 1998:68). The potential for this to happen will depend on the specific conditions under which the sub-assemblages of the global mental health assemblage emerge, and on their participants' and subjects' vigilance. Those conditions and that brand of vigilance deserve further research.

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[5]Thanks to an IPS anonymous reviewer for framing the issue this useful way.

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