# EU governance and eating disorders:  Where can feminist activism go?

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## ABSTRACT

This paper applies a constructivist approach to transnational mental health advocacy in the context of the European Union (EU).  Interaction between advocacy networks and EU governmental bodies is increasingly governed by "soft" (i.e., legally non-binding) measures including benchmarking, good or best practices, within the framework of an "open method of co-ordination", in which advocates attempt to influence state delivery of mental health services. These governance tools illustrate the spread of quality assurance practices from industry and consumer services to the realm of mental health policy in Europe.  The paper argues that this "managerial" form of governance puts mental-health advocates under increased surveillance, either by state actors or state agents (some of whom may be other advocates), while at the same time empowering them to contribute the scientific expertise as well as the principles under which their activities will be governed.  One result is that feminist advocates will face pressures both to play two potentially incompatible roles of expert *and* "outsider."  Thus, regarding the question whether the EU is a feminist ally, this paper finds that EU governance of mental health issues conditions the terms on which feminist advocates can ally with the Commission around their mental health concerns, and that EU governance principles (especially as embodied in the Lisbon strategy) shape the mobilization strategies feminist advocates can employ, *but also* that professional feminist advocates, along with other advocates, rely on and bring to EU programs the diagnostic standards used to implement those programs.  This creates a complex relation between state/EU actors and advocates.  The paper raises the concern that in the managerial framework of EU policy, feminist advocates stand to adopt a "rationality of rule" in which advocacy is restricted to building expertise in diagnostic approaches to mental health patterns that have significant yet underexplored gender dimensions to them, and in the process, to "render societies governable" rather than producing the conditions for a healthy or empowered citizenry. To the extent that these dynamics entail from their interaction with EU practices, feminist mental-health advocates will have to view such interaction with caution.

**Introduction**

Until recently, European Union (EU) social policies have been lauded for being accessible to and encouraging the participation and implementation leadership of non-state actors.[1] For example, analysts praised the open method of coordination (OMC) for its innovative form and potentially democratic effects in view of the role non-governmental organizations (NGOs) could play within it. Analysts' enthusiasm for the OMC process seems to have waned in recent years because it has not lived up to some of these potentials. This paper takes neither a skeptical nor an optimistic approach to the OMC and related "soft law" instruments of EU policy. Rather, it aims to outline the societal effects of such instruments in the area of mental health, assuming some effect but not necessarily the increased accessibility and democratic outcomes that had been hoped for. It finds that the dynamic of non-state participation in the OMC is not just that NGOs capitalize on windows of opportunity created by OMC in mental health, but also and more important, that EU policies actually have provided the catalyst for some NGOs' existence in the first place. In mental health, a newer realm of European-level activity (relative to employment or gender equality, for example), EU governance instruments not only provide interested advocates with financing and increase their social responsibility while expanding spaces for "partnership" between state and traditionally non-state actors; they provide the NGOs' *raison d'etre*: without such policies as the open method of coordination (OMC), some European-level mental-health advocacy networks would not exist.

This fact shifts the question of our panel somewhat, from whether the EU can be a feminist ally in the realm of mental health, to What exactly are the dynamics and social implications of feminist mental-health advocates' relationship to the EU and its concomitant policies in this area? To address this question, this paper adopts two analytic tools from constructivist international relations and critical constructivist comparative politics, namely, the

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[1] Zeitlin, Jonathan. 2007. Paper on global governance presented at the biennial European Union Studies Association convention, Montreal, Canada, May 2007.

concept of "governmentality"[2] and the conception of policy as a cultural rather than functional variable.  A constructivist approach is useful because it recognizes that the assumptions built in to governance processes "are themselves contestable and value laden (for example, whose standards?), and some of the procedures are methodologically problematic and uncertain (e.g. the measurement of outcomes and effectiveness)."[3]  The approach is also useful because its critical element resembles the critical element inherent in most feminist policy analyses.

This approach to questions of EU governance draws our attention to the principles that guide EU policy, because the principles tell us what actors "'do' as they engage in the processes of governing."[4]  The key principles in the Commission's approach to mental health policy include *benchmarking*, *good* or *best practices,* and the evaluative concept of *value added.*  These principles are important because they not only guide the policy implementation process but also constitute that process and the policy agents and structure along with it.  From a constructivist perspective, the principles represent cultural variables that construct society as much as they regulate the behavior of mental health professionals, state officials, or mental health advocates, including those of a feminist bent.

While the effects of these policy principles/instruments/cultural variables will vary by state institutional and cultural context, it is likely that the increasingly regional and indeed global process of designing and implementing mental health policy will encourage similar advocacy strategies across European states (including both EU member- and non-member-states).  In the language of sociologists, a sort of *isomorphism of advocacy*[5] will entail.  And in the language of governmentality,  "citizen-subjects"  will  be  produced  through  this  policymaking  and

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[2] Sending, Ole and Iver Neumann. 2006. Governance to governmentality:  Analyzing NGOs, states, and power. *International Studies Quarterly*, 50, 3 (654).  Of note here is Sending and Neumann's statement, The governmentality concept is particularly useful for this analysis because in contrast to more traditional "governance" approaches, it addresses not only "the types of actors involved and the authority they are able to bring to bear", but also the "substance…that *flows* from such authority."

[3] Flynn, Rob. 2002. Clinical governance and governmentality. *Health, risk & society*, 4, 2 (156).

[4] Sending and Neumann. 2006. Governance to governmentality: 655.

[5] This is particularly a concern of sociological institutionalists.  This is a point raised by Green, Daniel M.  2002. Constructivist comparative politics:  Foundations and framework.  In Daniel M. Green (ed.). *Constructivism and comparative politics* (p. 7).  London: M.E. Sharpe.

implementation process.    That is, governing will occur "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."[6]

Thus, in the terms of our panel, this paper finds that the EU's measures shape the mobilization strategies feminist advocates in mental health can employ:  it both gives substance to yet restricts them along the lines of what sociologists call the "managerial process."[7]   If our interest is the type of relationship that is emerging between the EU and feminist advocates (or indeed whether the EU is a feminist ally), the emergence of the managerial process is concerning, because it prioritizes disease quantification and control, and indeed political stability.  To the extent that feminists look to disrupt politics as usual, to liberate women from the control of others, and/or to alter gender structures in society, the managerial process into which NGOs are incorporated and through which they are constituted by EU mental-health policy should be viewed with caution.  Put differently, the paper raises the concern that in the context of EU policymaking processes on mental health, including specifically eating problems currently diagnosed as the "mental disorders" of individuals (such as *anorexia nervosa* and *bulimia nervosa*), feminist advocates will construct and mobilize publics by adopting a "rationality of rule" in which advocate (and eventually public) learning is limited to building expertise in mental health treatments that either have been ineffective, such as most treatments for *anorexia*, or differently and perhaps worse, have contributed to the social conditions conducive of problematic eating patterns in the first place.  That is, in the context of a *co-constitution*[8] process (or "alliance") with EU offices, feminist mental-health advocates run the risk of contributing to processes that render European societies "governable."[9]   They may run this risk in many issue-

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[6] Sending and Neumann. 2006: 661.

[7] This term comes from Flynn, Rob. 2002. Clinical governance and governmentality. *Health, risk & society*, 4, 2 (155-173).

[8] The idea of co-constitution is drawn from Green, Daniel M.  2002. Constructivist comparative politics:  Foundations and framework: 24-26.

[9] Flynn, Rob. 2002. Clinical governance and governmentality: 163.

areas, but my concern is that this is a higher risk in mental health because of the heavy influence of scientific knowledge in this policy area.

      To be sure, there is some possibility that this "managerial" process can create new forms of state-nonstate interaction, and this paper is not meant to sound only alarm bells. Additionally, the approach taken here should *not* be taken as a sign that the author does not approve of better standards of mental health care, or greater professional accountability to patients.[10] Yet there are concerns about mental health care in Europe that should be raised while the EU adopts these policy principles, and particularly because historically speaking, the study and practice of diagnosing "mental health" has not often been friendly to women or the feminine. More precisely, publics often have appropriated the diagnostic language of the mental-health disciplines in a sexist manner. Indeed, this has occurred when repudiating feminist activists themselves.[11] In the context of the EU, feminist advocates of mental health therefore should not overestimate their abilities to solve eating problems using the tools of professional and scientific expertise or within EU governance frameworks such as the Lisbon strategy and the OMC. Specifically, they should remain watchful not so much of overt moves by EU offices or member-states to "coopt" them, but rather of strong overlap in the language and knowledge they and their government counterparts adopt. Partnership between state and non-state actors is feasible—indeed, it is a core principle within the managerial context of EU policymaking. But feminist advocates should be concerned if partnership itself becomes the end rather than the means to the end of equal and healthier societies, and they should be vigilant of EU soft-law's ability to construct and constrict the substance and results of their advocacy strategies.

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[10] Flynn, 2002: 156.

[11] One obvious example is the sexist or indeed misogynist use of the diagnosis of "hysteria" as an epithet for women and indeed women activists. As Dianne Hunter noted in 1983, "in popular culture the word 'hysterical' is often used in attempts to discredit feminist expression." Hunter explains this trope as "deriv[ing] from the idea that both hysterics and feminists are 'out of control': neither hysterics nor feminists cooperate dutifully with patriarchal conventions. I think the attempted discrediting of feminists as 'hysterical' comes from a repressive impulse similar to the defense that creates hysterical symptoms in the first place: repudiation—of socially untoward feelings such as anger and resentment. Hysteria is a self-repudiating form of feminine discourse in which the body signifies what social conditions make it impossible to state linguistically." Hunter, Dianne. 1983. Hysteria, psychoanalysis, and feminism: The case of Anna O. *Feminist Studies*, 9, 3: 485.

The paper begins by discussing the principles on which EU mental health policy has been designed. This section discusses their private-sector background, the ways in which they create a "managerial process," and how mental health advocates operate within that context. It shows that advocacy groups (especially NGOs) have participated in the policy design process, and indeed the emergence of the (possibility of) an EU policy on mental health catalyzed their creation. (The policy *implementation* process is still very new and while this section begins an assessment, further assessment is needed.)

After outlining the policy instruments, principles, and forms of engagement between the EU and civil society actors, the paper explores whether these relations have shaped or will be able to shape the mobilization of broader publics around the issue of mental health (including eating disorders), and if so, what *kind* of public engagement that would look like. I argue that mental health mobilization will enlist NGOs as well as unaffiliated citizens in a process of monitoring and assessment, and that they will therefore help render themselves "governable."

Subsequently, the paper discusses how mental-health advocacy in the context of the EU may contribute to the conditions in which mental disorders including eating disorders can thrive. This section draws from the work of scientific realist Ian Hacking, which outlines several "vectors" that help create the social conditions of mental disorder, including a medical taxonomy and surveillance techniques.[12] I argue that feminist advocates can discourage women's self-surveillance of their bodies in critical ways, though they will find it harder to avoid the medical taxonomy that increasingly is being adopted as standard across Europe (and in fact globally).

The paper closes by outlining the actions feminist activists might take to alleviate such an outcome while perhaps still working within EU policymaking frameworks. There is hope, insofar as the managerial process blends agent and structure and allows them to be "co-constituted." As

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[12] Joan Jacobs Brumberg highlights Victorian notions of adolescence as crucial to the rise of anorexia nervosa. Joan Jacobs Brumberg, *Fasting girls: The history of anorexia nervosa*, (New York: Vintage), 2000, p. 124.

such, there likely is room for restructuring each along more feminist lines. It will simply need to be done with care.

## I.   The context for mental-health advocacy in the EU:  Legal and "soft law" elements

European Union mental-health policy competency is found in Article 152 of the EC-Treaty, which states, "a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities."  On the basis of this Article, a 2005 European Commission Green Paper proposed an "EU-strategy on mental health," based on the observation that mental health is increasingly a concern of policymakers, and that "a first priority is to provide effective and high-quality mental health care and treatment services, accessible to those with mental health" problems.[13]

The Green Paper cites as its inspiration the 2005 World Health Organization (WHO) European Ministerial Conference on Mental Health, though it also envisions a broader strategy for mental health that includes not only medical interventions, but also "a comprehensive approach…covering the provision of treatment and care for individuals…[and] action for the whole population in order to promote mental health, to prevent mental ill health and to address the challenges associated with stigma and human rights."  This broader approach is recommended because medical intervention "alone cannot address and change social determinants"; indeed, the Commission suggests, "many actors, including health and non-health policy sectors and stakeholders whose decisions impact on the mental health of the population", as well as patient organisations and civil society, should be involved in the strategy.[14]

The Green Paper could be read as a rather self-serving document of the Commission and the EU and its member states more generally.  For instance, it opens with the statement, "The

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[13] European Commission.  2005.  GREEN PAPER:  Improving the mental health of the population.  Towards a strategy on mental health for the European Union.  Directorate-general for Health and Consumer Protection, Unit C/2 "Health information." Luxembourg:  European Commission. 17 October 2005 (revised 8 November 2005).

[14] European Commission.  2005.  GREEN PAPER:  Improving the mental health of the population.  Towards a strategy on mental health for the European Union.  Directorate-general for Health and Consumer Protection, Unit C/2 "Health information." Luxembourg:  European Commission. 17 October 2005 (revised 8 November 2005): 5.

mental health of the European population is a resource for the attainment of some of the EU's strategic policy objectives, such as to put Europe back on the path to long-term prosperity, to sustain Europe's commitment to solidarity and social justice, and to bring tangible practical benefits to the quality of life for European citizens."[15]  But we should read this as more or at least different than merely an attempt to "capture" other actors in the EU's strategic web.  Certainly the Green Paper emphasizes member states' interests in the strategy, for example in its statement, "Given the diversity between Member States, it is not possible to draw simple conclusions or to propose uniform solutions. However, there is scope for exchange and cooperation between Member States and the opportunity to learn from each other."[16]  But it is clear that non-government mental health advocates have read the document as a window of opportunity for them to influence EU policy, and in fact the Commission has openly welcomed NGO input.  For example, the European Public Health Alliance (EPHA[17], a not-for-profit umbrella NGO) touts its member organizations' cooperating with the Commission on designing the ultimate mental health "strategy", and its Web site congratulates NGOs on their contribution to the strategy, complete with links to those contributions: "Before producing a Strategy (due to be published during the summer 2007), the European Commission has compiled the main elements received from the 234 stakeholders and individuals that responded, (*among which NGOs represent nearly half of the respondents).  EPHA is pleased to see that most of the elements of its response are reflected in the report.*"[18]

The Commission clearly sees civil society as a significant contributor to its ultimate strategy, and values the contributions it could make.  Indeed, the "consultation process" envisioned in the Green Paper could contribute to initiatives at the Community level, according to the Green Paper:  "Suggestions developed through the consultation process could identify best

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[15] European Commission.  2005.  GREEN PAPER, p. 3.
[16] European Commission.  2005.  GREEN PAPER, p. 7.
[17] The EPHA should not be confused with the EuPHA, which is an *Association*, not an Alliance.
[18] Emphasis added.  European Public Health Alliance. 2007.  "*UPDATED* Promoting mental health at EU level: The Commission consults the civil society."  Web page. Retrieved 4 May 2007 from the Web:  http://www.epha.org/a/1903.

practice for promoting the social inclusion and protecting the rights of people with mental ill health and disability."[19]   What is more, the adoption by concerned NGOs (i.e., mental health advocates) of the professional/diplomatic language of the Commission indicates a strong overlap in the two sectors' (public and civil society) approach to the issue-area of mental health.

Yet EU mental-health policy has acted as not only a window of opportunity but indeed the raison d'etre of some mental-health advocacy NGOs.  Prior to the publication of this Green Paper, the Commission had already started working within a multi-actor framework often referred to as the "open method of coordination."  To date, through this framework, Commission funds have helped sponsor several mental-health advocacy groups, including the EPHA as well as GAMIAN-Europe (Global Alliance of Mental Illness Advocacy Networks, "an international, non-profit, federation comprising users and consumers, family members, careers, health care professionals, representatives of government bodies and agencies, and other concerned parties who support or are interested in issues affecting those who suffer from a mental illness"); and many other NGOs and industry organizations.  The European Public Health Alliance cites Commission funding as a significant contributor to its activities and livelihood, tracing its history to obtaining Commission funding for a seminar that "attracted a high level audience from the European institutions and from several member states, and gave a powerful impetus to the new organisation."  EPHA and GAMIAN-Europe's input then was incorporated into several EU policy publications, including a Commission draft Directive on Data Protection and the 1994 EU Green Paper on Social Policy.[20]  Moreover, EPHA and GAMIAN both have been participants in the EU Health Policy Forum since its inception in 2001.  GAMIAN notes this prominently in its discussion of News from the European Union:  "GAMIAN-Europe has been a member of this influential Forum since its creation by the European Commission in 2001.  It brings together a

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[19] European Commission.  2005.  GREEN PAPER, p. 12.
[20] European Public Health Alliance. 2007.  "History of EPHA."  Web page.  Retrieved 4 May 2007 from the Web: http://www.epha.org/a/715.

number of key decision makers including representatives from the Commission's DG Health & Consumer Protection, DG Enterprise and DG Research, selected pan-European patient groups, a range of healthcare professionals, health insurers, academic bodies, pharmaceutical industries and associations, consumer bodies and public service unions."[21]

These facts illustrate a point Rob Flynn makes in his assessment of "clinical governance," namely, that analysts need to move "beyond a simplistic dichotomy of the state versus professional autonomy."[22] One way to do so is provided by Daniel Green, who observes that in late-modern policymaking, the state is not merely regulating an autonomous civil society; the two are co-constituted and co-constituting.[23]

Another element of this process of governance mental health in the Europe Union that deserves mention is that increasingly it has taken what Flynn calls a "managerial" form over time. For example, the EPHA and its member organizations were invited to provide feedback to the Commission on its policy papers, in the role of "consultants", and the language of total quality management and consumer services pervades the language of the Green Paper. *Best practices* are mentioned not only in the quote above, but also in reference to a plan for an EU Platform on Mental Health that would "analyse key mental health aspects, identify evidence-based practice, develop recommendations for action, also at Community level, and identify best practice for promoting the social inclusion of people with mental ill health and disability and for protecting their fundamental rights and dignity."[24] *Benchmarks* also figure in the Commission's plan, as when it outlines the goals for the "consultation process" it envisions: "One objective is to identify priorities and elements for an action plan on mental health, leading to a set of core actions in health and non-health policies together with targets, benchmarks, timelines for action and a

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[21] Global Alliance of Mental Illness Advocacy Networks. 2007. "GAMIAN Europe: News from the European Union." Web page. Retrieved 4 May 2007 from the Web: http://www.gamian-europe-history.org/.
[22] Flynn, 2002 (citing Johnson, 1995): 162.
[23] Green, Daniel M. Constructivist comparative politics: Foundations and framework. In Daniel M. Green (ed.). 2002. *Constructivism and comparative politics* (p. 7). London: M.E. Sharpe.
[24] European Commission. 2005. GREEN PAPER, p. 13.

mechanism to monitor implementation."[25] And the Green Paper repeats three times the concern to "add value" to existing policies on mental health.[26]

Meanwhile, the EPHA and its constituent organizations use the same language in describing their goals and activities within the context of EU mental health policy. For example, while describing its policy implementation activities, the EPHA notes a project ("European Mental Health Promotion Implementation (EMIP)") whose areas include "partnerships and capacity building" and whose aims include "sharing models of good practice on mental health promotion and prevention of mental ill-health" amongst eight European networks and twelve "national partners."[27] Similary, on its Web page discussing current activities, GAMIAN notes a project called, "Exchange of good practice between patients groups."[28] (A seminar within this project included several activities involving EU representatives, such as a presentation by the Health Counsellor of the German Permanent Representation to the European Union, who "outlined the role and responsibilities of the members of the Council of Europe"; another presentation by a member and a Vice Chairman of the European Parliament Committee on the Environment, Public Health and Food Safety; representatives of the Commission Directorates General on Research and Enterprise (the latter described the Commission's "Pharmaceutical Forum" to workshop participants); and finally, presentations by representatives of two advocacy groups, the Estonian Mental Health Association, and the Men's Health Forum in the UK.)[29]

Does it matter that the EU and mental health advocates have adopted the same language, principles, and practices? To consider this question, we need to understand where the common

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[25] European Commission. 2005. GREEN PAPER, p. 13. Notably, the Commission ties its goals to a larger process of mental health policymaking, begun at the global level: " The WHO Mental Health Action Plan for Europe could serve as model, together with the Action Plan "Mental Health Promotion and Mental Disorder Prevention: A Policy for Europe" developed under the EU-Public Health Programme."
[26] European Commission. 2005. GREEN PAPER, pp. 3, 7, 13.
[27] European Public Health Alliance. 2007. "Policy implementation activities." Web page. Retrieved 4 May 2007 from the Web: http://www.epha.org/a/2390.
[28] Global Alliance of Mental Illness Advocacy Networks. 2007. "GAMIAN Europe: Current activities." Web page. Retrieved 4 May 2007 from the Web: http://www.gamian-europe-history.org/.
[29] Global Alliance of Mental Illness Advocacy Networks. 2007. "GAMIAN Europe: Current activities." Web page. Retrieved 4 May 2007 from the Web: http://www.gamian-europe-history.org/.

principles, such as "good" or "best practices" and "benchmarking" come from. Benchmarking and best practices originated in U.S. corporate management philosophy after World War II, when firms adopted the goal of continuous improvement. *Benchmarking* was the establishment of quantifiable criteria for gauging firm performance toward this end. *Best practices* were those production forms practiced by the most competitive firm in a given industry or sector. Over time, these concepts changed business practices profoundly: for example, the practice of Total Quality Management (TQM) and its derivatives emerge from these concepts. [30] They also became the concern of developed state governments.[31] Rob Flynn notes that these principles, which are included in what some sociologists call "managerialism," have worked their way into clinical governance, which he sees as " one small part of a long-term programme of reform in the public sector" that "may be seen as the latest phase in the expansion of managerialism." Flynn argues, "The genealogy of clinical governance can be traced back to these generic aspects of managerialism, and specifically to 'total quality management' and similar approaches to quality assurance in industry and consumer services."[32]

Not surprisingly, EU policymaking processes have experienced the influence of these principles, especially since the late 1990s. Benchmarking became a standard EU instrument in part because of its perceived flexibility and transparency.[33] Benchmarking at the EU involves any or all of the following activities: "information provision, enabling comparisons to be made, experiences to be shared, and mutual learning to take place; identification of 'best practice', which people are encouraged to follow; and agreement on and commitment to targets, with some form of peer group review of performance."[34] The EU's "open method of co-ordination" (OMC) emerged from benchmarking and best practices. In this paper, I view the strategies outlined in the

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[30] Sklair, Leslie. 2001. *The Transnational Capitalist Class*. London: Blackwell.
[31] **Edwards and Hulme, 1996; Sklair, 2001.**
[32] Flynn, 2002: 159.
[33] **Arrowsmith *et al*. 2004.**
[34] **Arrowsmith et al. 2004: 313.**

Commission's Green Paper on mental health, and especially its encouraging consultation amongst various "stakeholders" as reflecting the OMC.

**II.     The choice for feminist mental health advocates in Europe:    Adopt or reject the expert role?**

There are at least two different ways to read the implications of a policymaking process that involves benchmarking, good or best practices, and a concern for "value added." One is that this kind of process establishes more *horizontal* relations between non-state actors, including advocacy networks, and state and supranational governments.[35]   Another, and I believe more important implication to these policy principles is that they alter the *substance* of advocacy and the form mobilization can take.   By adopting these principles, advocates engage in a "governmentality" policymaking process that involves "the disciplining and regulation of the population without direct or oppressive intervention."[36]   As Rob Flynn notes in his analysis of clinical governance processes, the process of *governmentality* encourages actors "to perceive problems in similar ways *and* accept a responsibility to seek ways of transforming their positions themselves."[37]   This effect is evident in the Commission's invitation, in its 2005 Green Paper, to "all interested citizens, parties, organisations and the European Union institutions to contribute to the preparation of a possible EU-Strategy and an Action Plan on Mental Health by commenting" on the paper.[38]   It is also evident in the EPHA and GAMIAN-Europe's accepting that same invitation/responsibility, for example, with EPHA encouraging its member organizations to respond to Commission Papers, and with GAMIAN-Europe participating in and co-hosting the EU Health Policy Forum.

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[35] **Arrowsmith et al. 2004 (citing Borrás and Jacobsson 2003).**
[36] Flynn, 2002: 163.
[37] Flynn, 2002: 163.
[38] European Commission.  2005.  GREEN PAPER, p. 13.

Indeed, these advocacy organizations play a crucial role in the governmentality process of mental health in the EU. In governmentality processes, "experts play a strategic role in producing knowledge (discourse) and schemes of action (practice)….[P]rofessionals become crucial to the state in its 'exercise of power, systems of technique and instrumentality; of notation, documentation, evaluation, monitoring and calculation', and thus render society governable."[39] As such, mental health advocates, including feminist advocates, should watch for a sort of *isomorphism of advocacy*[40] to develop while operating within the EU context, and for a more-governable (*not* more-agitated) social response or society to result.

Thus we can see a tension here for feminist mental health advocates. Specifically, feminist advocates will face two pressures in policymaking processes in the EU. The first is the pressure to act as "expert" and thus play a part in the process of managerialism or governmentality that appears to be emerging. This is a risky or at least very difficult role for feminists to play because, as we have seen above, it enlists the expert, and the objects of the expert's professional (in our case diagnostic) gaze, in the *governmentality* process, thereby rendering people "governable" rather than, say, agitated or disruptive. Such an outcome surely is contrary to those that at least some feminist advocates would hope for. Additionally, as we shall see below, feminists who adopt this role in EU mental health policy may even contribute to the conditions for mental health problems, such as the eating problems and other behavioral or mental distresses that women disproportionately exhibit (and which are labeled "*mental disorders*" despite their social components highlighted by EPHA, GAMIAN-Europe, and other mental health advocacy groups, and even by the Commission).

The other pressure is for feminist advocates to resist the governmentality process and the practice of managerialism by working from outside the language of consultation, best practices, benchmarking, etc., and by encouraging political *in*stability in the area of mental health. This too

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[39] Flynn, 2002: 163, (quoting Johnson, 1995: 23).
[40] Green, 2002: 24.

is a risky and difficult role for feminists to fill, for obvious reasons:  it looks more like second-wave than third-wave feminism, and thus potentially outmoded; it looks disruptive and possibly counterproductive—unattractive attributes to many advocacy groups, whose existence depends on funding and cooperation with many types of institutions; and it flies in the face of at least some advocacy models today.

What are the risks to society of feminists participating in yet not changing, and indeed co-constituting and yet being co-constituted by the governmentality of mental health as outlined thus far?  In the case of eating disorders in particular, feminist advocates may contribute to a system of documentation and monitoring that encourage the social conditions for the very eating disorders they hope to prevent.  The following section discusses this possibility.

## III.    How advocates can carve "ecological niches" for eating disorders

How might feminist advocates contribute to the existence of the very mental disorders, including eating disorders, against which they act?  Ian Hacking's "ecological niche" metaphor can help us understand this apparent contradiction.  Ecological niches are the social homes or nests in which mental disorders thrive.  They involve "the concatenation of an extraordinarily large number of diverse types of elements which for a moment provide a stable home for certain types of manifestation of illness."[41]  The metaphor of the ecological niche is useful because, as Hacking says, it "invites us to think of life in all its rich bio-complexity…It reminds us that there must be many relevant vectors in play" in order for a mental disorder to thrive.[42]

Two such "vectors" are a *medical taxonomy* and *surveillance techniques*.[43]  Here is where the pressure for advocates to act as experts, for example by dispersing knowledge or even diagnostic strategies, carries risk.  The activism of non-governmental mental health advocates such as the EPHA, GAMIAN-Europe, and others who act as experts by employing the knowledge

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[41] Ian Hacking, *Mad travelers:*  13.
[42] Hacking, 1998: 82.
[43] Hacking, Ian.  1998.  *Mad travelers:  Reflections on the reality of transient mental illnesses.*  Cambridge, Massachusetts:  Harvard University Press: 81-4.

of medical science, participate in a process in which "[k]nowledge interacts with us and with a larger body of practice and ordinary life," which "generates…socially permissible combinations of symptoms and disease entities."[44]  Indeed, the managerial or governmentality process outlined above appears to be precisely that kind of process.

On this view, advocacy groups can contribute to the social conditions of eating disorders through their work in EU projects and through the diagnostic tools they adopt and whose use they encourage.  Given the appropriate cultural and institutional factors—the other two "vectors" in Hacking's metaphor (respectively, a polarity of practices or concerns, e.g., concerns about and evidence of both overweight and underweight; and a systematic means of observing a phenomenon, e.g., state-mandated weigh-ins at annual visits to pediatricians)—we can find in Europe an "ecological niche" for eating disorders such as *anorexia nervosa* and *bulimia nervosa*, as well as other eating disorders.  In this light, the Commission's fourth goal in the EU mental health strategy ("Develop a mental health information, research and knowledge system for the EU"[45]) takes on a different significance.

It is worth noting here another form that knowledge takes.  We have noted above the soft-law principles of benchmarking and best practices, which encourage a more quantification-oriented assessment of mental health in Europe.[46]  An additional form of knowledge that advocates help employ in Europe is the diagnostic code.  It was noted above that the primary

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[44] Hacking, 1998: 10.

[45] European Commission, 2005: 8.

[46] A glance at GAMIAN-Europe's Web page illustrates how this approach gets at many important statistics, but overlooks other factors/vectors contributing to mental disorder.  The Web page spends considerable time discussing numbers.  Consider the following discussion of a meeting of the Mental Health Forum: "The topics discussed included the financing of healthcare systems and the disparity between the amounts Member States (MS) invest in health. Some invest more than twice as much as others across the board as others. When broken down into disease areas, the differences can be even greater. With mental health, some countries spend seven times more than some others.
The group looked at cross-border healthcare and the matching of needs to resources. For example, Belgium has 1,500 Radiologists which equates to 1 for every 6,667 citizens. In contrast, the UK has only 2,500 Radiologists for 60 million inhabitants or 1 for every 24,000 citizens….Also to be considered is how can countries that receive a considerable number of patients from abroad guarantee a fair distribution of services and how can you guarantee care in poorer, less inhabited regions?
In Latvia, many physicians and nurses seek work abroad which has an adverse impact on the domestic healthcare services. Male life expectancy is only 62 years compared to 77 years in most of Western Europe."  Global Alliance of Mental Illness Advocacy Networks.  2007. "GAMIAN Europe: News from the European Union." Web page.  Retrieved 4 May 2007 from the Web: http://www.gamian-europe-history.org/.

impetus for the Green Paper was a 2005 European Ministerial Conference on Mental Health hosted by the World Health Organization.  This is important because WHO is the framework within and through which one of the two primary mental health diagnostic standards is produced, namely, the International Classification of Diseases, currently in the process of its tenth revision (ICD-10).  The other diagnostic code is the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorder, currently in its fourth iteration (DSM-IV).  The two codes share a related history,[47] and DSM-IV categorizes eating disorders in the same three categories as ICD-10.  These disorders are located in ICD-10 Chapter V (Mental and behavioural disorders), under "Behavioural syndromes associated with physiological disturbances and physical factors" (category F50-F59).[48]

EU projects have adopted either DSM-IV or ICD-10 criteria for analytic and diagnostic purposes.  The Commission's 2005 Green Paper cites DSM criteria in a table analyzing "Estimated number of subjects in the general EU population (age 18-65) affected by mental disorders within past twelve months."[49]  And European advocacy groups encourage concerned persons to consult with clinicians and therapists who employ one of these codes (or a national version thereof[50]).  For example, "IMHPA: a European Network for Mental Health Promotion and Mental Disorder Prevention," has been working since 2003 to "develop and disseminate evidence-based mental health promotion (MHP) and mental disorder prevention (MDP) strategies

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[47] The DSM-II included categories from the ICD, and its definitions of mental disorders were linked to ICD standards—and they remain so today. "As was the case with DSM-II and III, DSM-IV [linked] the Manual with subsequent developments of the International Classification of Diseases (ICD).  While linked to the United States standard of diagnostic practice known as ICD-9 CM (Clinical Modification), DSM-IV preparation was coordinated with Chapter V of the World Health Organization's ICD-10." R. W. Hotes, "Review of American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR*. Fourth Edition, Text Revision, 9 October 2000 [document online]; available from http://mentalhelp.net/books/books.php?type=de&id=403; Internet; accessed 20 February 2005.

[48] World Health Organization, "International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Version for 2003," [document online]; available from http://www3.who.int/icd/vol1htm2003/fr-icd.htm; Internet; accessed 14 February 2005.

[49] European Commission, 2005: 16.

[50] Norman Sartorius *et al*.'s (1990) volume on traditions in psychiatric diagnosis shows that most European states have adopted some version of the ICD into their nationally-based diagnostic nomenclature.  Sartorius, Norman, Assen Jablensky, Darrel A. Regier, Jack D. Burke, Jr., and Robert M. A. Hirschfeld. 1990. *Sources and traditions of classification in psychiatry.*  Toronto: Hogrefe and Huber Publishers, on behalf of the World Health Organization.

across Europe and to facilitate their integration into countries' policies, programmes and health care professionals' daily clinical work."[51]

European mental health advocates therefore are situated in a difficult position. One, they work within a process in which they encourage the incorporation of persons *into* the diagnostic codes. Thus, in the constructivist terms employed throughout this paper, they stand to help "render" those persons "governable" in a particularly personal sense. This is the case because although the diagnostic codes with which they engage are continually in revision, certain assumptions of the ICD as well as the DSM appear to lie beyond revision, including, most important, the assumption that eating problems result from *mental disorder inherent in an individual*. The second dimension to advocates' position therefore is that despite encouraging a broader, *societal* view of mental illness, the diagnostic codes with which they engage return the policy focus *back* to the individual. Individuals are treated for mental disorders, not societies, even though, as the Commission itself puts it, medical intervention "alone cannot address and change social determinants."[52] (This may reflect a blind spot in many experts' perspectives, because they do not appear to consider their own knowledge as embedded in the social structure whose influence they wish to recognize.)

By contrast, feminist advocates in the area of mental health ought to acknowledge the ways in which "scientific knowledge about ourselves…changes how we think of ourselves, the possibilities that are open to us, the kinds of people that we take ourselves and our fellows to be.[53]

## IV.     Can feminists ally with the European Union on mental health?

This paper therefore reverses the question posed in our panel. It asks, can feminists ally with the European Union on mental health? The answer is, of course, "yes, but carefully." The

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[51] European Network for Mental Health Promotion and Mental Disorder Prevention. 2007. ""Imhpa: a European Network for Mental Health Promotion and Mental Disorder Prevention." Web page. Accessed 16 April 2007: http://www.gencat.net/salut/imhpa/Du32/html/en/Du32/index.html.
[52] European Commission, 2005: 5.
[53] Hacking, 1998: 10.

position paper that the advocacy group Mental Health Europe (MHE) published in response to the Green Paper illustrates why feminists must be careful, namely, because it illustrates the tension feminists will find in advancing eating-disorder discussion in the European context. The position paper's views therefore are worth close consideration:

> MHE also notes that medical models of mental health are still dominant in some EU countries and may obscure the social causes and contexts of mental distress. 'Mental well-being' is a more useful term to use than 'mental (ill) health' as it is something that all European citizens can readily relate to their own lives and experiences. There is an urgent need to improve mental health and well-being for all as well as to improve the quality of life for those experiencing mental illness or distress.[54]

If feminists are to advocate for persons who experience mental distress and express their distress through problematic eating patterns or other self-destructive means, they should do as MHE has done with the language of the Commission (and by implication, other official EU actors) and *rewrite* it. They should also do as MHE has done and emphasize the larger social context in which mental distress can occur. But feminists will need to do both of these things in a way that does *not* adopt an expert voice (as embodied in a diagnostic code, for example) if and when that voice stands to minimize the social dimension for the sake of diagnosis. The talk of eating disorders or other mental disorders in Europe includes an element of anxiety that will need to be attended to and tempered, because under its influence, diagnosis may seem the best treatment.

An example of this anxiety is the opening statement by participants in a large, trans-European mental health project, the European Study of the Epidemiology of Mental Disorders (ESEMeD). It states, "Mental disorders are increasingly recognized as a major source of disability in the world. The costs associated with mood and anxiety disorders are very high. Forecasted future increase in the magnitude of mental disorders will most likely be associated

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[54] Mental Health Europe. 2006. MHE Position on the EC Green Paper on Mental Health: An EU Strategy on Mental Health and Well Being. Brussels: Mental Health Europe (pp. 2-3).

with higher costs."[55]   Setting aside the framing of mental disorder as "disability" (which some constructivists would certainly challenge[56]), the anxiety reflected in this and following statements of ESEMeD reflect Rob Flynn's observations of a "common thread" in analyses of clinical governance, namely, "that at every level of civil society, complexity, fragmentation and uncertainty all place severe pressure on individuals' and groups' capacity to collaborate and their willingness to trust others."[57]   In this context, the patient being treated may not necessarily be the mentally distressed person, but rather, those around who feel anxious and look to diagnosis as remedy.   Feminist advocates will need to keep this in mind as they employ diagnostic terms, lest they advance a "vector" and help create an "ecological niche" for mental disorders.

**CONCLUSION**

The argument above suggests that scientific diagnoses of eating disorders reflect governmentality scholars' views of citizen-state relations and their conceptions of power.   It also suggests interesting questions about how governmentality processes can influence not only our political status, but also can reshape our cultures and our understandings of ourselves.   This concluding section of the paper will focus on the latter question.

Political theorists have discussed ways in which governing processes influence our sense of self.   For example, Sandra Bartky takes a phenomenological view similar to Hacking's, though with a radical feminist turn, in her discussion of the ways in which stereotyping and the internalization of stereotypes stunts female self-actualization:  "It is hard enough for me to determine what sort of person I am or ought to try to become without being shadowed by an alternate self, a truncated and inferior self that I have, in some sense, been doomed to be all the

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[55] J. Alonso, M.C. Angermeyer, J.P. Lépine. 2004. The European Study of the Epidemiology of Mental Disorders (ESEMeD) project:  An epidemiological basis for informing mental health policies in Europe. *Acta Psychiatrica Scandinavica*, 109 (Suppl. 420): 5-7.

[56] For example, Ray McDermott and Hervé Varenne view "culture as disability", arguing, "Culture is not so much a product of sharing as a product of people hammering each other into shape with the well-structured tools already available. We need to think of culture as this very process of hammering a world." McDermott, Ray, and Varenne, Hervé. 1995. Culture "as" Disability. *Anthropology & Education Quarterly*, 26, 3:  326.

[57] Flynn, 2002: 162.

time."[58]    Thus, if we view the diagnosis of eating disorders as potential sources or vectors of particular kinds of stereotypes, as anorexics or "exorexics" (that is, anorexics who exercise themselves to notable thinness), we can expect those stereotypes to influence our self-understandings.

On a slightly different tack, Susan Bordo argues that eating disorders constitute a medical definition of common western females' struggles, and that they are "utterly continuous with a dominant element of the experience of being female in this [American] culture."[59]    Bordo includes the diagnostic process in her analysis (as "the medical model"—the same term used by Mental Health Europe (MHE) above), and depicts it as a problematic force:    "The conceptualization of eating disorders as pathology has produced some valuable research.  But the medical model has a deep professional, economic, and philosophical stake in preserving the integrity of what it has demarcated as its domain, and the result has frequently been blindness to the obvious," namely, the evidence of potential eating disorders among men, in face of which western diagnostic models (used to screen for DSM-III eating disorders) remain fixated on gendered biological causes for eating disorders.[60]    Indeed, Bordo uses language that evokes the processes of governmentality when she discusses the U.S. psychiatric profession: "This is not a conspiracy; rather, each discipline teaches aspiring professionals what to look at and what to ignore, as they choose their specialties and learn what lies outside the scope of their expertise, and as they come increasingly to converse 'professionally' only with each other.[61]

As we noted above, the Mental Health Europe (MHE) study takes a similar perspective. This can give feminists hope that fellow advocates are taking what appears to be an outsider tactic and encouraging Commission adoption of it.

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[58] S. Bartky, "On psychological oppression," in S. Bartky, *Femininity and domination:  Studies in the phenomenology of oppression* (New York:  Routledge, 1990):  24.
[59] Susan Bordo, *Unbearable weight:  Feminism, western culture and the body* (Berkeley:  University of California Press, 1993): 57.
[60] Bordo, 53.
[61] Bordo, 53.

More generally, the point that Hacking, Bartky, and Bordo all suggest is that made by epistemic community theorist Peter Haas (but which needs more emphasis in governmentality scholarship), namely, that the spread of eating disorders is not apolitical, inevitable, or even natural, and that some groups have an investment in a particular interpretation of problematic eating patterns, though not necessarily in the continuance of those patterns themselves. (As a radical feminist, Bartky does indeed point to patriarchal forces attempting to keep women in socially oppressed positions.) In Haas's words, once an epistemic community has established its authority, it "stands to institutionalize its influence and insinuate its views"[62] into other arena. But these are largely inter-state policy arenas, and the epistemic community concept largely glosses over cultural processes, doing most of its explanatory work at the state decision-maker level, not the broader cultural level. This is where Hacking, Bartky, and Bordo provide some insight, and where the governmentality approach, and constructivist approaches generally, provide insight.

On this view, we can see how feminist advocates will have to walk a thin or at least difficult line between disrupting political stability in order to disrupt social conditions that contribute to eating and other mental distresses, while not disrupting so much that they appear outmoded or threaten an already-anxious public to the point of de-legitimizing themselves and their advocacy goals. In this context, feminists will have to find ways to be both expert and outsider. This is a tall order, but as seen in a few instances above, it may not be impossible. Indeed, it may help re-constitute feminist advocates and EU policy at the same time.

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[62]Peter M. Haas, "Introduction: Epistemic communities and international policy coordination," *International Organization*, 14, no. 1 (1992): 4.