A Historical Lineage of Sad and Mad Women

Women’s affective states have a long history of being pathologized under names like neurasthenia, hysteria, and schizophrenia. In culture, the sad and mad woman has appeared as various popular figures: the Victorian madwoman, the hysterical, the schizophrenic, and the Prozac-consuming American woman of the 1990s, to name a few. The question of how specific pathologizations relate to contemporary gender relations runs through all of these iterations of mad and sad women. Some feminist scholars have argued that definitions of mental illness have been directly linked to conventional understandings of femininity and masculinity, and that any norm violation has been understood as madness. And others have pointed to the biological reactions of some historical patients to highlight the “realness” of their symptoms.

In this chapter I trace a brief history of how women’s mental health has been pathologized in the American and European West. I hope to show that mental illness diagnoses are neither completely discursive (socially and linguistically constructed) nor fixed neurological truths (biological facts of life that always look the same), but emerge and take shape in a complex interplay between sociocultural discourses and an ever-developing medical science.

In charting this brief history I draw heavily on scholars like Elaine Showalter and Lisa Appignanesi who mark the turn from the eighteenth to the nineteenth century (1700 to 1800) as the start of the modern conception of mental illness and health in distinctively gendered ways. This turn of the century is significant for multiple reasons, one of them of course...
being the dawn of Enlightenment ideas and the birth of the human sciences that introduced new ways of organizing the world and knowledge about it. The decades around the French revolution marks an epistemic shift in medicines, sciences, and penitentiary systems of the West.

Here I follow Foucault’s conceptualization of the epistemological shift of this turn of the century, which when it came to penitentiary systems, involved a move from punishing the body of the criminal to disciplining the soul. According to Foucault, the change in the judicial system from publicly torturing its criminals to confining them with the purpose of rehabilitating or “curing” them, only had the appearance of being more humane. The control exercised over the individual through the enactment of disciplinary practices is just as efficient, if not more so, than the control of the body, because it initiates a deeper and more long-lasting grip on the soul. When self-discipline has been properly internalized (supposedly in a successful process of rehabilitation), the powers that be have a hold on the individual, who will adjust his behavior in accordance to what best suits the dominant power structures. The concepts of governmentality and biopolitics that were developed later in Foucault’s career build on these analyses of penitentiary systems. Governmentality furthers our understanding of how the internalization of discipline works and takes hold of the individual at the level of subject formation. In relation to mental health and illness, governmentality allows us to think about how the social/political affects the organization of our psyches.

Foucault also delineates this shift from “outwardly” to inwardly discipline in relation to sexuality and madness. In broad strokes, what is described here is how views and conceptualizations of the criminal, the mad, and the abnormal came to be constructed within the “new” human sciences in post-Enlightenment Europe. A “medical gaze” was being established in the new medical clinics, and the mad were to be not just managed but also understood. Crucial to this was the establishment of a firm binary between reason and unreason, civilized and uncivilized. The poles in this binary were presented as objectively true, free of any agendas. Part of this new knowledge regime was the establishment of sciences that “uncovered” already existing truths. What Foucault so crucially showed was that these new epistemologies were not simple discoveries of a firm and already existing order of things, but were in themselves acts of ordering things.

In regard to psychology and psychiatry this meant the establishment of a field of knowledge which could display an ultimate picture of how the
psyche functions and subsequently prescribe it treatments to cure or better its makeup. But looking at the history of these disciplines, it quickly becomes clear that the truth that it has presented as absolute has contingently changed with contemporary power structures.

**The Victorian Madwoman**

One of the most significant changes brought on by the “new” epistemology of the psyche at the turn of the century was the move from the lunatic-as-animal to the lunatic-as-human, from nonperson to person. Where the mad had previously been seen as “unfeeling brutes, ferocious animals that needed to be kept in check with chains,” they were now regarded as sick human beings who might be returned to sanity under the correct care.⁸

This shift affected both popular imagination and actual practices of caring for the mentally ill. As a result of this ideological change English social reformers began to build asylums “in which paternal surveillance and religious ideals replaced physical coercion, fear and force.”⁹ The attitude toward, and treatment of, the mentally ill thus went from being one of sensational disgust to protective pity. Just as the criminal justice system underwent an overhaul from public punishments like torture and executions to “sophisticated” retributions aimed at rehabilitation, so the psychiatric establishment went from shunning the mad as definite outcasts to treating them as patients in need and in hope of saving.

Importantly, Showalter positions this shift next to another ideological change, when “the dialectic of reason and unreason took on specifically sexual meanings, and … the symbolic gender of the insane person shifted from male to female.”¹⁰ Reason became synonymous with men and masculinity and unreason with women and femininity. In the move toward less violent and more reparative care of the mentally ill, the subject in need of caring confinement became primarily female, and the treatment of her was in the hands of men and male doctors. In this way, the shift in psychiatric care was one of many arenas in which rationality became associated with men and irrationality with women. It was the rationally sound mind that had the capacity to control and cure the irrationally mad one.

Showalter describes the change in the symbolic conceptualization of the lunatic in the eighteenth century: “in the course of the century … the appealing madwoman gradually displaced the repulsive madman, both as a prototype of the confined lunatic and as a cultural icon.”¹¹ Showalter illustrates this change in cultural perception by showcasing two statues of
madmen that had represented the figure of lunacy from the seventeenth century on, but were removed from the public by the early nineteenth century. Caius Gabriel Cibber’s statues “Raving Madness” and “Melancholy Madness” (both made in 1677), depicted two men in the nude, half-lying on the ground, one aggravated and bound in shackles and the other in an infantilized position of weakness. The statues were placed at the entrance of the Bethlem (known as Bedlam) Hospital in London, one of the first and most notorious asylums in England. These statues were the most famous representations of madness at the time. Showalter describes them as marking “the lunatic’s entrance into the netherworld of the insane.” But in 1815 the statues in front of Bedlam were replaced by figures of women, representing “a youthful, beautiful, female insanity.” From now on, the representation of madness “was becoming feminized and tamed, no longer wild, raving and dangerous, but pathetic.” The popular image of psychic ills was no longer that of a madman, but of a madwoman.

One part of this shift was the prevalence of stories of frail women being mistreated in asylums, which reached the public and changed the opinion about the treatment of the mad toward the end of the eighteenth century, inspiring legal and institutional reforms. For example, Showalter recounts the story of a Quaker widow who died under inexplicable circumstances in the York asylum, resulting in the official outrage of a wealthy philanthropist who started the York retreat, “an asylum that pioneered the humane care of the insane.” This illustration implies that the victimized madwomen who inspired public concern belonged primarily to the upper middle class. Perhaps not unsurprisingly, the abuse of the wealthy attracted more attention than the mistreatment of the ostracized poor. But in accordance with the newfound rational value of human life, the penniless were not shut out from the compassionate treatment of the mad, they were just carefully segregated within the institutions.

Patients were geographically separated within the asylum based on gender and class. The intellectual rehabilitation activities created for the patients were also divided by class, with the richer clientele being treated to lectures by local experts on poetry and biology, while the “paupers” were left to lecture each other. Class structures were thus deliberately reproduced down to a tangible and material level. The insane of all classes could be cured, but no illusions of social mobility were allowed to take hold. In accordance with what Showalter calls “psychiatric Darwinism,” which appointed biological and genetic predispositions as causes of mental
illness, the notion that mental health could correspond to socioeconomic status was completely ignored.

One of the most popular diagnoses during the Victorian era was also closely tied to class. Neurasthenia, coined in 1869 by George M. Beard, referred to “the morbid condition of the exhaustion of the nervous system” and grew out of the “American way of life, with its race for money and power, its excessive pursuit of capital and technological progress.” It was often middle-class women who dared to pursue “masculine” activities like intellectual thinking who received the diagnosis, which followed an idea of the nervous system as possessing a finite amount of nervous energy that could more easily be depleted than replenished. The demands of the new world could easily exhaust women’s frail nerves and the cure prescribed was often a totalizing rest that urged the patient to abstain from all activity, exercise, and work. Charlotte Perkins Gilman’s now classic novel *The Yellow Wallpaper* (1892) depicts the experience of fulfilling such a cure, and exemplifies how the very rest ordained to calm the nerves could be what furthers the patient’s descent into madness.

Socially mobile middle-class women thus found themselves in a double bind, where the culture at large championed dynamism and speed, but demanded that women comply and acquiesce. As a response to these contradictions, women frequently developed “nervous troubles which the doctors then linked to their specifically female functions rather than to the overall conditions of their lives.”

**Ophelia, Crazy Jane, and Lucia**

In Victorian England the madwoman was culturally and artistically represented and perpetuated in three major forms: as “the suicidal Ophelia, the sentimental Crazy Jane, and the violent Lucia.” Ophelia, the love-interest of Shakespeare’s Hamlet, “goes mad” and drowns herself after finding out that her potential husband has killed her father. Showalter describes the two other figures as derivations of Ophelia. Crazy Jane was the recurring fictional figure of a penniless maid who “goes mad” when her lover leaves her. She was “a touching image of feminine vulnerability and a flattering reminder of female dependence upon male affection.” If Crazy Jane represented an unthreatening female madness, a mostly passive yearning for love gone wrong, Lucia or Lucy was her vicious antonym that embodied “female sexuality as insane violence against men.” Originating from Walter Scott’s novel *The Bride of Lammermoor* (1819), Lucy had had to
give up on the man she loved to marry another, and on the wedding night
she “goes mad” and brutally murders her new husband. Lucy’s story
became a wildly popular theme in nineteenth-century opera, coming to
represent a female flight from the shackles of contemporary femininity.
The violent madness she fled into was seen by some feminists as an empow-
ering moment that the female opera-goer could experience indirectly, thus
herself feeling a sense of liberation from her confined everyday existence.

The idea that a fictional female character gone mad could function as a
moment of empowering identification for the contemporary woman
appears in multiple feminist readings of women and madness in the cul-
tural imaginary. Sandra Gilbert and Susan Gubar’s The Madwoman in the
Attic is perhaps the most famous work to argue such a stance. Referencing
Mr Rochester’s wife who is hidden away in the attic in Jane Eyre, Gilbert
and Gubar interpreted her as “the author’s double, an image of her own
anxiety and rage” against patriarchy.23

Gilbert and Gubar defined a female literary tradition in nineteenth-
century writing and discerned a recurring theme of psychological ailments
across genres and geographical locations. Some of the recurring tropes
were images of “enclosure and escape, fantasies in which maddened dou-
bles functioned as asocial surrogates for docile selves, metaphors of physi-
cal discomfort manifested in frozen landscapes and fiery interiors … along
with obsessive depictions of diseases like anorexia, agoraphobia, and claus-
trophobia.”24 Rather than reading this as a simple reflection of the reality
of female lives at the time, Gilbert and Gubar see the narratives of madness
as ways in which the authors could symbolically act out a refusal of patri-
archal norms. The character on the page functioned as the author’s dou-
bble, enabling her to express dissatisfaction and rage at the conventions she
had limited capacities to protest in everyday life.

Gilbert and Gubar’s text has taken an almost canonical position in femi-
nist literary scholarship, inspiring numerous analyses of female narratives
of madness as radically empowering. In this framework female “madness
signified anger and therefore, by extension, protest.”25 But it has also
inspired critiques such as Marta Caminero-Santangelo’s The Madwoman
Can’t Speak: Or Why Insanity is Not Subversive.

Caminero-Santangelo shows that the glorified figure of the madwoman,
whether she’s fragile and in need of saving or self-destructively and out-
wardly violent, is almost always white. The privilege of adopting a “mad”
persona to protest a patriarchal structure is primarily awarded to white,
middle-class women. In response to countless feminist readings of white
women’s stories, she brings in works by women of color writers like Toni Morrison, Helena Maria Viramontes, and Cristina García to diversify the analysis of “madness-narratives.”

Drawing on Toni Morrison’s *The Bluest Eye, Sula,* and *Beloved,* Caminero-Santangelo argues that madness, rather than being subversive, may actually be seen as a capitulation to an oppressive hegemony. The act of “going mad” might function as a rebellious “giving up” on the expectations placed upon you by a male-dominated world for the white Bourgeois subject. But for the nonwhite subject, “going mad” is not a refusal of outside expectations, it is a fulfillment of them. For the protagonists in Morrison’s novels, “madness consists not of subversion but rather of surrender to the representations of others; madness constitutes the inability to construct a counternarrative of any sort.” This racial bias can be seen in the contemporary representations of mental illness as well, where the subject who speaks openly about her troubles tends to be white and middle or upper class, and posits some level of respectability.

**The French Hysteric at the Salpêtrière**

In Paris in the early nineteenth century, the physician Philippe Pinel opened the Salpêtrière hospital “as an asylum in the modern sense, whose first principle was the treatment of madness.” The mad were not only to be confined or handled, but also to be understood and taken care of, which was a novel approach at the time.

Pinel himself has been given almost cult-like status in the history of (French) psychiatry due to his role after the Revolution in unchaining “the lunatics at the Bicêtre and the Salpêtrière, a politically symbolic act like the freeing of the prisoners in the Bastille.” He is shown in Tony Robert-Fleury’s painting “Pinel Freeing the Insane” (1876) which depicts multiple madwomen being unshackled under the oversight of Pinel. This painting represents “the turning point … which Pinel is said to have effected in the mythology of madness.” The painting hung in the lecture hall of the Salpêtrière where Jean-Martin Charcot conducted his now infamous public lectures on hysteria. During the winter of 1885–1886 Sigmund Freud attended these lectures and in writing about them mentioned the painting, describing it as a reminder of the revolutionary aspects of treating the mentally ill. The anecdote of this one art piece illustrates not only the influence of Pinel, but also the far-reaching ambitions of the new humane psychiatry or “moral therapy.” Like the change in the penal
system from physical punishment to mental discipline, the mad were to be freed from the status of prisoners and become patients possible to cure.

Showalter’s reading of “Pinel Freeing the Insane” calls out the gendered nature of the operation—men representing the voice of reason, able to free and help the irrational and helpless madwomen. This is the same mechanism as in the shift in England from the lunatic being exemplified by a repulsive man to a victimized woman. The new lunatic was a hysterical woman who could be cured by a male doctor. Under the guise of a more humane and rational approach to the mad, a new epistemology of madness was established.

At the Salpêtrière the methods by which this new body of knowledge was “uncovered” was particularly interesting because its main protagonist—neurologist Jean-Martin Charcot—made use of visual materials and photography to establish the bulk of his scholarship. The role of visual performance at the Salpêtrière was exemplified in Charcot’s weekly public lectures in which he hypnotized patients in front of an audience to illustrate the different phases of hysteria, and in the rigorous photographic documentation of his work. He even had a photographer set up residency in the hospital, complete with a studio to capture the attacks of the hysterics. In this way the notion of hysteria was from the beginning an extremely mediated one, it existed in its purest form only in front of an audience or a camera.

**Hysteria: A Female Ailment**

Hysteria is one of the psychological ailments most connected to the female gender in the Western cultural imaginary. The Salpêtrière had a special wing for male hysterics, but this fact has not survived in the popular imagination, and its male manifestation was largely reconceptualized as shell shock after World War I. The word hysteria is even derived from the Greek and Latin word for uterus or womb, reflecting the long-held notion that it was caused by the female reproductive organs. Georges Didi-Huberman suggests that hysteria (in the nineteenth century) was the symptom “of being a woman.” He recounts how Freud, in 1888, described hysteria as a “bête noire”—a thing that one highly dislikes, is even disgusted by; it “represented a great fear for everyone.” These were the sentiments that fueled the male doctors’ studies of hysteria, and they reveal a simultaneous fear, disgust, and fascination with not only the disease, but also the entire female reproduction system. Didi-Huberman
explains: “The bête noire was a secret and at the same time an excess. The bête noire was a dirty trick of feminine desire, its most shameful part ... Hysteria almost never stopped calling the feminine guilty.”

Didi-Huberman thus connects hysteria to the very definition of femininity, suggesting that the diagnosis itself was part of male fear of female sexuality.

Charcot’s major contribution was a psychological theory of hysteria, which held that the disease was caused by emotion, but manifested itself in actual physical symptoms. He ‘proved’, “through careful observation, physical examination, and the use of hypnosis ... that hysterical symptoms ... were genuine, and not under the conscious control of the patient.”

Didi-Huberman delineates how Charcot took the multiple expressions of hysteria, such as “spasms, convulsions, blackouts, semblances of epilepsy, catalepsies, ecstasies, comas, lethargies, deliria,” assigned them an order and combined them into “a general type that can be called ‘the great hysterical attack’.” He defined four stages of this attack: “the epileptoid phase,” which resembled an epileptic seizure; “clownism,” which involved exaggerated contortions; “attitudes passionnelles,” in which the patient reenacted events and emotions from her life; and “delirium,” when the patient starts hallucinating and talk incoherently.

The stages of the complete attack were displayed in Charcot’s public lectures, in which he brought in a patient, hypnotized her, and simulated the various phases for the audience to see. These lectures were attended by a diverse collection of people, not only medical students but authors, journalists, actors, and socialites. One of the recurring patients was Blanche Wittman, who was particularly good at displaying the various phases of the attack. She gained celebrity status as one of Charcot’s “star hysterics.”

There was a performative element in these displays, but to what degree the patients consciously emulated the movements that were expected of them is unclear. Showalter points out that the patients were surrounded by images of how hysterical attacks were supposed to play out, which influenced their performance under hypnosis.

**The Role of Photography**

At the time of Charcot’s glory days at the Salpêtrière photography was making its entrance on the world scene as the true depicter of “objective reality.” Didi-Huberman writes that photography “always says more than the best description; and, where medicine is concerned, it seemed to fulfill
the very ideal of the ‘Observation’.”

This trust in the medium made photography “the paradigm of the scientist’s ‘true retina’” during the nineteenth century. To photographically record the research on hysteria that Charcot was undertaking was thus an obvious decision. Through photography the essence of hysteria was to be documented and categorized, to be made part of a proper science.

One of the (many) things about this that seem remarkable today is the way this documentation took place. For example, the photographic technology of the time was not sophisticated enough to snap an image immediately, meaning that the patients had to hold the pose that displayed their hysterical symptoms for the entirety of the exposure time, which could be several minutes long.

The photographs of Charcot’s patients were compiled into three volumes of a book titled Photographic Iconography of the Salpêtrière (Iconographie photographique de la Salpêtrière) (1875-1880). The star patient of the Iconography was Augustine, a 15-year-old girl who had had her first hysterical attack at age 13, after being raped by her employer who was also her mother’s lover.

Augustine appears in multiple photographs in the Iconography, displaying all the stages of the hysterical attack, as well as variations on the expressions of each phase (see Fig. 2.1). Showalter describes Augustine as the perfect hysteric for Charcot’s methods. Emphasizing the performative aspects of the photographic documentation, she states that “among her gifts was her ability to time and divide her hysterical performances into scenes, acts, tableaux, and intermissions, to perform on cue and on schedule with the click of the camera.”

If the madwoman in England during the nineteenth century was embodied by Ophelia and Crazy Jane, in France she was represented by Charcot’s hysterics at the Salpêtrière, among them Augustine. In one sense Ophelia and Augustine were fundamentally different—the former being fictional and the latter an actual young woman sent to Charcot for treatment. But the sensational nature of Augustine’s case made her more of a cultural figure than an individual person. She was and is the prime example of nineteenth-century hysteria, an icon of this stage in the “mythology of madness.” This is probably why her case has been studied so frequently by feminist scholars, many reading it as a male doctor manipulating a young woman to perform symptoms to support his theories, and others as a complex mix of “real” and made-up symptoms.
Showalter’s stance on the male influence on hysterics has been critiqued as overtly simplistic by scholars like Elizabeth A. Wilson, who calls out Showalter for ignoring the biological aspects of “madwomen.” Wilson calls Showalter’s analysis of hysteria an example of “the manner in which a retreat from biology became naturalized early in the feminist interest in hysteria.” Describing Showalter’s analysis of Charcot’s treatment of hysteria as a simple suppression of female resistance, Wilson points out that some of the physical ailments suffered by the hysterics are too complex to be dismissed as socially constructed symptoms. Wilson focuses on an event in which Augustine temporarily lost the ability to see color, instead seeing...
everything in black and white. Showalter’s analysis argues that this occurrence was a result of Charcot’s sensationalist photographic methods, which finally “took its toll on her psyche.” Wilson counters this conclusion by asking “what kind of biological material ... stops processing color under the sway of a photographic seduction? Why is the astonishment of Augustine’s symptom attributed only to Charcot and not also to the remarkable, hysterical vicissitudes of Augustine’s eyes and brain?”

A photograph from the *Photographic Iconography of the Salpêtrière* shows Augustine’s body, stiff as a board, suspended between two chairs that support only her head and feet. Such imagery makes it hard to dismiss the biological aspects of hysteria. Instances like this, where hysteria contorts the body into unimaginable poses, warrant examination of the physiological as well as psychological functions involved.

But perhaps it is the assumption of a clear differentiation between the biological and the social that contributes to both of these readings. The fact that Augustine and the other hysterics developed physiological symptoms does not have to be read as an affirmation of the “reality” of their hysterias, but rather as signs of the complex interplay between mental and physical functions. Within an affect theoretical framework, we might instead understand the hysterical reactions as examples of how the social (language-based and discursive) impacts us at the level of our biological responses.

**The Birth of Psychoanalysis**

The hysterics at the Salpêtrière often shared a sexually traumatized past and lived a highly sexually charged present. Charcot did not focus explicitly on this aspect of the disorder, but his most famous student, Freud, tried to understand the sexual genesis of the condition and placed conflicted sexuality at the root of severe illness. Inspired by Charcot, Freud’s early case histories share many similarities with the hysterics of the Salpêtrière. But whereas Charcot did not listen to what the female patients had to say and favored experimental treatment with hypnosis, pressure techniques, and drugs, Freud paid attention to how they themselves talked about their afflictions. Freud and his mentor Josef Breuer pioneered the psychoanalytic treatment of hysteria with the case of Anna O. With her, dialogue took the place of observation. Instead of detached examination Breuer and Freud talked directly to the hysteric. They concluded that Anna O’s hysterical symptoms were reactions to her oppressive,
traditional, upbringing and lack of intellectual stimulation. The cure that Breuer prescribed was daily talking and listening, an early form of psychoanalysis.\textsuperscript{56}

Breuer and Freud thus placed the cause of hysteria more in social circumstances than in biological predisposition. Showalter writes that they appeared “to lay the groundwork for a culturally aware therapy that took women’s words and women’s lives seriously, that respected the aspirations of New Women, and that allowed women a say in the management of hysterical symptoms.”\textsuperscript{57} It seemed that the introduction of talk-based therapy allowed women who suffered hysterical symptoms to finally speak for themselves and articulate their own thoughts and emotions.

With Charcot the unconscious began to be theorized, and with Freud and his contemporaries at the turn of the twentieth century it took on “a key role in understanding both madness and ordinary everyday behaviour,” restructuring the way we understand the human psyche and subjectivity.\textsuperscript{58} With the advent of psychoanalysis, a language of psychosexuality was established at a time when sexuality became increasingly important in Western lives. One’s sexuality was a key indicator of the kind of person one was, normal or perverted, sane or mad. And as Foucault has shown, this organizing principle of subjectivity often involved a problematization of the sexuality of women, homosexuals, and children.\textsuperscript{59} Ideas about sexual repression, the unconscious and the family were circulating among several scholars in the early days of the twentieth century, but “what Freud gradually and magnificently added was a narrative and theories which provided pattern, motive forces and surprising explanations that did away with moralizing punishments and liberated sexuality.”\textsuperscript{60} For Freud, contemporary sexual morality, lack of libidinal satisfaction and ignorance about sex, produced anxiety and illness. The problem, in other words, was the repressing mores of society rather than inherent vices. Freud also crucially showed that conflicts of sexuality in childhood not only shaped those who suffered enough to find their way to the couch of a psychoanalyst, but also affected all individuals, even the presumably “healthy” ones.\textsuperscript{61}

The cultural image of the madwoman changed as well. The upper middle-class or wealthy woman who was sent to (or voluntarily visited) the psychoanalytic clinic was very different from the working-class woman interned at the Salpêtrière. Anna O. came from a wealthy, Orthodox Jewish, family. Her brother was sent off to university while the intellectually gifted Anna had to stay home and tend to domestic chores. Several of Freud’s patients at the time had similar backgrounds and intellectual
abilities. His and Breuer’s theory was that it was the culture which confined these women to the boredom of domestic life that caused their hysteria. Within this framework the hysterics was not a fascinatingly repulsive and incontrollable figure, like at the Salpêtrière, but a likeable and admired one. Compare the social circumstances of Freud and Breuer’s hysterics to Augustine’s. The latter was a live-in maid in a wealthy household, whose head patriarch sexually abused her at age 13. Both of these social circumstances support a theory of social and cultural context as causes of hysteria, but it is telling that the view of the hysterics as sympathetic and admirable is only awarded to the wealthy one.

**From Hysteric to Schizophrenic**

The fascination with hysteria largely faded in the period after World War II, with schizophrenia taking its place. Statistically, schizophrenia did not primarily afflict women, as hysteria did, but was equally prevalent in women and men. This did not affect the fact that the figure of the female schizophrenic in mid-twentieth-century culture became what the hysteric was in nineteenth-century culture. Showalter explains that “modernist literary movements have appropriated the schizophrenic woman as the symbol of linguistic, religious, and sexual breakdown and rebellion.” This is why, for Showalter, the disease “offers a remarkable example of the cultural conflation of femininity and insanity.”

Some schizophrenic symptoms, particularly “passivity, depersonalization, disembodiment, and fragmentation” have been read as a direct reflection of women’s social situation. Some feminist scholars have argued that schizophrenia is the perfect literary metaphor for the female condition, expressive of women’s lack of confidence, dependency on external, often masculine, definitions of the self, split between the body as sexual object and the mind as subject, and vulnerability to conflicting social messages about femininity and maturity.

Within this framework it is society’s patriarchal structures that are to blame when a woman becomes schizophrenic. Similar to the early Freudian analyses of hysteria, it is the limited roles available to women that cause the disease. In many of the literary works from the early 1960s that deal with schizophrenia, the act of institutionalizing women on the grounds of their diagnosis is represented as patriarchy’s way of attempting to control women who do not conform.
One of the most known and lauded literary heroines associated with schizophrenia is Sylvia Plath. Her fictional work *The Bell Jar* (1963) inspired many feminist readings of the protagonist as breaking down under the pressures of patriarchal society. With Plath’s real life following a very similar trajectory, and ending in suicide at age 30, she was established as an icon of contemporary female madness. Part of a larger movement of female literature critical of contemporary psychiatric institutions, she also became an important figure in the early women’s liberation movement of the 1960s. For the American feminist movement at the time, Plath “grew into a saint of female victimization, her madness and suicide themselves signals of what patriarchy did to talented women who dared to aspire.”

During the 1950s and 60s, schizophrenia became the most common diagnosis in America, and shortened in everyday speech to “schizzy” it became a synonym for crazy, odd, weird, or peculiar. Many of the behaviors that were diagnosed as pathological at the time would most likely be understood as defiance or teenage unruliness today, and this over-diagnostication fueled feminist interpretations of schizophrenia as something used to limit women with aspirations beyond contemporary gender conventions.

**Feminism and Psychoanalysis**

While Freud himself most likely had no moralizing intentions behind his work, when psychoanalysis was taken up as a profession, especially in the US, his theories were largely transformed into norms with which women had to comply. This meant that new neurotic conditions flourished, which stigmatized “women with psychological diagnoses that had their basis as much in the needs of medical and social conformity as in sexual difficulties.” In post-Second World War America, tropes such as “the frigid woman” and “the nymphomaniac” became popular labels of psychic imbalance as “psychoanalysis flourished as a far more normative profession than Freud had ever imagined.”

The Freudian “theory of the girl’s anatomical deficiency” was one such essentialist view. This thesis included a view of woman as castrated, “leading to the female version of the Oedipus complex, which comprised penis envy, feelings of inferiority or self-hatred, and contempt for the mother.”

Feminist thinkers such as Simone de Beauvoir in her classic *The Second Sex* showed that woman had always been defined in relation to man, and challenged Freud’s idea of gender relations. Betty Friedan and Kate Millett
in America, Germaine Greer and Juliet Mitchell in Britain, among many others, pointed out the part Freud’s psychoanalysis had played in women’s oppression in the West. For Millett, one of the main problems of Freud’s theories was that it individualized the family dynamics and “undercut an engagement in sexual politics, the very possibility of women acting as the collectivity they in fact were.” Within the conservative iteration of psychoanalysis, resistance to stereotypes of motherhood or wifeliness was classified as neurosis and women who refused to conform were deemed crazy.

Phyllis Chesler published her seminal book *Women and Madness* in 1972, where she argued that definitions of mental illness were directly linked to conventional understandings of femininity and masculinity, and that any norm violation tended to be understood as madness. But as the 1970s progressed, the field of women’s studies began to be established and there was a move by many feminist scholars to themselves train as psychoanalysts and psychologists. This meant that an increasing number of women populated the psychoanalytic field, and the profession gradually became less male-dominated.

One of the feminist analysts was Juliet Mitchell, whose 1974 book *Psychoanalysis and Feminism* began to salvage psychoanalysis and highlight Freud’s importance for the feminist project. In Europe Jacques Lacan’s development of psychoanalysis was highly influential among feminists. In Lacan’s interpretation, the phallus did not correspond to the literal penis, but to the symbolic order of civilization where the phallus was most valued. For the feminists following in his footsteps, “psychoanalytic thinking, which posited a dynamic psychic reality and no gendered essentials, was women’s best hope of escaping a reduction to essentialist terms.”

**Antipsychiatry and the Radical Schizophrenic**

In conjunction with the feminist critique and redefinition of psychoanalysis grew a wider antipsychiatry movement, spearheaded by R.D. Laing in the UK. Together with Aaron Esterson, Laing conducted a study of women who had been hospitalized as chronic schizophrenics, which concluded that the cause of their illness was in their family situation and not in their biological makeup. Laing’s theories blossomed around the height of 1960s counterculture, and his stance on schizophrenia was that it was not a mental illness but “a mode of insight and prophecy.” In this framework psychosis was glorified as the route to spiritual and religious wisdom, much like the LSD trips popular at the time.
In 1965, to test their theories about schizophrenia, Laing and a group of antipsychiatrists started an experimental clinic at Kingsley Hall in East London. Showalter points out that Laing’s theories generally held that women were being unfairly institutionalized and that schizophrenia was partly caused by the role women had been given in a patriarchal society. When the clinic at Kingsley Hall opened, however, all of the doctors were men, and “the model patient was a woman.” In practice, women never obtained the status of doctor, which, no matter how much antipsychiatrists critiqued it, remained a position of great authority. Laing even had a “star schizophrenic,” just like Charcot had his star hysterics. Mary Barnes, a 40-year-old catholic nurse, became, as Showalter puts it, Laing’s Augustine.

Barnes had a long history of mental illness and had been hospitalized in other institutions for years before coming to Kingsley Hall. What set her apart from the institutionalized hysterics of the previous century was that she herself sought out Laing’s treatment. She had read his influential book *The Divided Self* and concluded that his experimental methods were going to cure her. She also wrote her own narrative about her experiences at Kingsley Hall, in addition to establishing herself as a painter, with her artwork being displayed to the public on multiple occasions. Barnes became the face of the English antipsychiatry movement, even having a play written about her time at Laing’s clinic.

**THE RISE OF PSYCHOPHARMACEUTICALS**

As the cultural fascination with schizophrenia faded, the consumption of psychopharmaceuticals outside of the institution increased and became the new venue through which feminine coded madness expressed itself. This coincided with the gradual process of closing asylums in Europe and the United States, which was partly influenced by government cutbacks and anti-psychiatry movements, but whose primary instigator was the development of said psychopharmaceutical drugs. In the US, this move began in 1955 with the widespread introduction of the antipsychotic drug chlorpromazine, commonly known as Thorazine, and was further enacted 10 years later with the introduction of the federal health care programs Medicare and Medicaid.

The history of American psychiatry is often told as that of a professional field that in its early years was heavily influenced by psychoanalysis (and dominated by its restrictive gender roles), but sometime in the 1970s was
taken over by neuroscience and an “objective” prescription of pills. An important part of this was the development, and transformation of, the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The first edition was published in 1952 and was largely made up of psychoanalytical disorders that “assumed presenting symptoms, and, indeed, personality itself, to be the result of early life conflicts that were mapped onto the unconscious psychical apparatus for the remainder of life.” In the 1970s, however, a series of randomized clinical research studies revealed the benefits of biological psychiatry and psychopharmacology. In this new framework, “scientific findings laid bare neural pathways that exposed the inner workings of the mind.” The result was the creation of an “‘objectifiable, biological’ psychiatry that eschewed the role of early-life experience to identity formation and instead looked beneath these constructs to the level of the anatomic substrate.” And most importantly, the primary treatment for the biological mental disorders was psychopharmaceutical rather than psychoanalytical or psychodynamic.

This change was reflected in the third edition of the DSM, published in 1980 and significantly reworked under the leadership of Robert Spitzer. Previous to this edition psychiatrists often had different understandings of the same diagnosis and the aim was to create a reliable system with stable definitions of mental disorders. 25 committees, made up of scientifically inclined, anti-psychoanalytic, psychiatrists, were created to come up with detailed definitions of diagnoses. Each diagnosis included in the DSM-III came with a checklist of symptoms, and specific criteria for how many of these symptoms needed to be present for a diagnosis to be made. With the new criteria, the American Psychiatric Association had created “a manual with a biomedical ‘viability’.” The DSM-III and its subsequent editions have had an enormous impact on psychiatry worldwide, as it is the most widely used diagnostic manual globally, employed by psychiatrists almost everywhere to determine diagnoses.

As Appignanesi critically points out, two important driving forces behind the remaking of the DSM and the turn towards a biological psychiatry were pharmaceutical and insurance companies. “Big Pharma” requested standardization of disorders so as to be able to show medication’s efficiency with particular demographics, and insurers wanted measurable symptoms/illnesses so as to regulate their payments. When the DSM was imported to Europe and countries with public health care, the text was used by governments to decide which treatments to cover.
The DSM made psychiatry a quantifiable science, like other medicine, and removed the fuzziness of psychoanalysis and other psychotherapies. This was especially important for insurance companies and governments, where the set diagnoses of the DSM alongside its quantifiable talk therapy colleague—cognitive behavioral therapy (CBT)—gave those in charge of paying for treatments a range of measurable evidence of efficiency. A cynical reading of this kind of treatment is that a prescription and ten sessions of CBT makes the patient ready for the labor market again.

Jonathan Michel Metzl has also critiqued the idea that the shift from psychotherapy to bio-psychiatry in mainstream treatments of mental illness left the biased psychoanalytical assumptions about gender and the family behind, letting the tangible “truth” of biology take its place. Metzl argues that the psychiatric discourse that claims to have displaced the gender roles of psychoanalysis via its reliance on an “objective” biology, in fact, maintains and reproduces these very roles. Through a detailed analysis of pop cultural representations of psychotropic drugs, he shows how medications and their cultural representations have worked in dynamic ways to influence the development of psychopharmacology itself. His study ranges from the release of the first “miracle cure for anxiety,” Miltown, in the 1950s, via the tranquilizer craze of the 1960s and 70s with Valium at its center, to the ubiquitousness of Prozac in the 1990s.

Throughout the development of psychopharmacology, the connection between femininity and mental dis-ease remained strong, despite the biopsychatrical promises of “objective” approaches that went beyond gender. The “’emotional’ problems [that] could be cured simply by visiting a doctor, obtaining a prescription, and taking a pill” were primarily marketed as cures against female ailments, such as “a woman’s frigidity, to a bride’s uncertainty, to a wife’s infidelity.” Metzl suggests that the anxieties surrounding mothers, and the accompanying framing of psychotropic drugs as the “saviors” of women who risked to reject traditional gender roles, was in reality a worry about the destabilization of traditional family norms. As the worries about traditions changed, so did the model patient for psychopharmaceuticals. In the 1950s it was the frigid or cheating wife who needed to be medicated, in the 1960s and 1970s it was the feminist who dared to question patriarchal institutions like marriage and essentialist male-female roles. In the 1990s and early 2000s, the workplace became the primary site for gender “struggles.” Drugs like Prozac promised to keep the working woman upbeat and optimistic so that she could perform the tasks required by her particular line of work.
Anorexia and Eating Disorders

Metzl’s argument speaks, again, to the relation between the specific pathologizations of women and contemporary gender relations. Another set of diagnoses that have been highly feminized is anorexia and accompanying eating disorders. Susan Bordo has written significantly about their role in Western culture as diseases that primarily affect women and that arose as particularly prominent in the 1980s and 1990s. Eating disorders might take their most visible form on the physical body, but they are firmly rooted in the mind, and thus belong to the “family” of psychopathologies. Bordo’s analysis is rooted in Foucauldian theories of how power/knowledge structures come to discipline the body and psyche down to the level of influencing the process of subjectivation. In that vein she argues that “the escalation of eating disorders into a significant social phenomenon arises at the intersection of patriarchal culture and post-industrial capitalism.”

Eating disorders, then, are strongly connected to the social and cultural context in which they are found. Bordo further argues that anorexia is not an individual expression of a pathology, but “a remarkably overdetermined symptom of some of the multifaceted and heterogeneous distresses of our age.”

Psychotherapist Susie Orbach argued in a similar vein, based on her own experience treating women with eating disorders, that anorexia is “a hunger strike, a protest against times which hold out the promise of independence and a life lived beyond the home while simultaneously demanding that women, as lovers, wives, mothers or carers, service the needs of others.” Orbach’s book, Hunger Strike: The Anorectic’s Struggle as a Metaphor for Our Age, was first published in 1986 and has since become a classic printed in multiple editions. In both Bordo’s and Orbach’s arguments, we see again how larger anxieties in society and culture are expressed in the pathologization of female mental health. They both also make the case for a feminist interpretation of self-starving as an act of protest, and thus they echo earlier feminist readings of mental dis-ease as a refusal of feminine conventions, such as those of fictional portrayals of Victorian madwomen and the rebellious schizophrenic. But crucially, the connections between eating disorders and feminist rebellion are not presented as conscious choices by the suffering individuals. Bordo directly states that “anorexia is not a philosophical attitude; it is a debilitating affliction,” and remarks that “these pathologies of female protest … actually function as if in collusion with the cultural conditions that produced them.”

This
opens up for an understanding of mental illness diagnoses as affected and influenced by contemporary social mores without seeing the sociocultural connection as “proving” that the affliction is “made up” or only socially constructed. In other words, the fact that social structures are reflected in the popularity of a particular diagnosis does not take away from the suffering experienced by those who have received it.

**Feminist Approaches to Psychopharmaceuticals**

Feminist interpretations of medical diagnoses and treatments were prominent also in relation to the introduction of Prozac on the mainstream cultural and medical scene in the early 1990s, when narratives of women taking the drug were abundant. Judith Kegan Gardiner addresses feminist approaches to these narratives and to psychopharmacology in general in her influential essay “Can Ms. Prozac Talk Back? Feminism, Drugs, and Social Constructionism” from 1995. In it she reviews three of the most prominent contemporary books about Prozac, the first two written by medical professionals: Peter D. Kramer’s *Listening to Prozac: A Psychiatrist Explores Antidepressant Drugs and the Remaking of the Self* (1993); Peter R. Breggin and Ginger Ross Breggin’s *What Doctors Won’t Tell You About Today’s Most Controversial Drug* (1994); and writer Elizabeth Wurtzel’s autobiography *Prozac Nation: Young and Depressed in America* (1994).

Writing at a time when feminist scholarship still held on firmly and unequivocally to the idea that women’s depression was a result of patriarchy, Kegan Gardiner addresses the contradictory behavior she had encountered in personal meetings with other feminist scholars. The theoretical consensus seemed to be that there were no biological components to depression, only negative social circumstances. But Kegan Gardiner describes how she repeatedly met feminist scholars who held this critical position while simultaneously taking Prozac themselves to alleviate depressive symptoms. This led her to ask “what drugs like Prozac mean for women today and what the discourses about them say to and about American feminism.”

Kegan Gardiner’s reading of the two physicians’ texts shows how they exemplify contesting opinions of Prozac at the time. For Kramer, the drug works miracles in freeing women from traditional female roles, and he even calls it outright feminist and empowering. Breggin and Breggin hold the almost opposite view, which Kegan Gardiner describes as similar to cultural feminism, extolling “women’s traditional virtues, including
maternal nurturance and empathy, and view[ing] women as endangered by the patriarchal violence of doctors and the drug industry.”

Wurtzel’s autobiographical narrative, which Kegan Gardiner also reviews, instead recounts a firsthand experience of taking Prozac. Wurtzel is a professional woman—a Harvard student and successful journalist who “portrays herself as the daughter of an abandoning father and an overinvolved mother.” She has a long history of depression and has had multiple therapists without results. Relief comes when she meets her first psychiatrist who prescribes her Prozac. The drug alleviates her symptoms and helps her recover from depression. Importantly, Wurtzel does not portray Prozac as a wonder drug that immediately cures, but sees it as a necessary tool in addition to therapy. Autobiographical and fictional narratives like Wurtzel’s were plentiful in the 1990s, all following similar trajectories of finding relief from the drug, then having it wear off and result in disappointment and regression, to finally end in a more or less balanced mental state.

Are the “Ms Prozacs” in these narratives equivalent to the hysteric Augustine or the schizophrenic Mary Barnes? The fact that Wurtzel’s book became a best seller and was turned into a feature film in 2001 suggests that “Ms Prozac”-narratives took hold in American culture. As such the young woman on anti-depressants can be seen as the embodiment of female madness in the late twentieth and early twenty-first century. Narratives like Wurtzel’s, which assign positive attributes to anti-depressants, might seem to propagate a view that always deems drugs necessary in the treatment of depression. But paying attention to details, these stories also portray ambivalence about taking psychopharmaceuticals.

Here again then is the question that keeps resurfacing in the various analyses of femininely coded mental illness regarding its cause. Is female madness socially constructed or rooted in a biological and incontestable “truth”? If it is the former, is madness available as a radical tool to oppose power structures, as many feminist scholars of literary madness narratives have argued? And if it is the latter, do we have to give up on any attempt at viewing mental health as anything other than what the current biopsychiatric episteme holds to be true? What scholars like Bordo, Kegan Gardiner, Metzl, and Wilson suggest, is that there is an in-between where the complex entanglements of psyche and soma can be explored. And as Appignanesi points out, “in a rampantly medicalized age, the classification of depression or borderline carries not stigma but the hope of cure.” Whereas in previous eras a diagnosis might have meant confinement,
significant limitations to one’s life, and rampant stigma, in the early
twenty-first century, a diagnosis is in many places what will guarantee sup-
port and relief.

The discourses around diagnoses like depression, anxiety, bipolar disor-
der, and more that I examine in the rest of the book are in indirect dia-
logue with the history of female pathologizations of mental health explored
in this chapter. I hope to have shown that there are clear connections
between contemporary sociocultural discourses and popular mental illness
diagnoses in that understanding of what is wrong with suffering women
always takes shape in a larger cultural context that inevitably informs the
articulation of dis-ease.

While women’s sad experiences historically have been classified as
pathologies leading to institutionalization and confinement, in the early
twenty-first century, they tend to be medicalized within a biochemical
discourse that reverts to (deinstitutionalized) psychotropic drugs and psy-
chotherapy as solutions. In this way, the current pathologization of wom-
men’s sad experiences takes place within a neoliberal framework that does
not position them as abject and (completely) other, but instead renders
them intelligible within a larger culture of self-help in which the individual
is responsible for her own wellbeing. In this framework, all ties between
health and structures of inequality are severed, and any attempts at politi-
cizing widespread ill health are thwarted. In the chapters to come I argue
that this mode of thinking about mental health is dominant, but not all-
encompassing in contemporary popular culture. Alongside the profitable
vulnerability of the most mainstream representations of mental illness,
there are several sites where ties between mental wellbeing and larger
power structures are being made, most explicitly in Teen Vogue and among
the sad girls on Instagram. In these spaces of sad girl culture, more radical
understandings of feeling bad can be found, where both the suffering of
those who struggle is acknowledged and critical analyses of the structural
causes of diagnoses are spoken.

Notes

1. Appignanesi, Sad, mad and bad; Chesler, Women’s madness; Showalter,
The female malady.
2. Chesler, Women’s madness.
3. Wilson, Psychosomatic: Feminism and the neurological body.
4. Appignanesi, Sad, mad and bad; Showalter, The female malady.
5. Foucault, *Discipline and punish*.
6. Ibid; Foucault, *History of madness*.
7. Foucault, *The Birth of the Clinic*.
10. Ibid, 8.
11. Ibid, 8.
12. Ibid, 8.
19. Ibid, 126.
22. Ibid, 14.
24. Ibid, ix.
26. Ibid.
27. Ibid, 132.
31. Free and Brown, “Freeing the insane.”
35. Ibid, 68, emphasis in original.
36. Ibid, 67, 68, emphasis in original.
37. Ibid, 69, emphasis in original.
40. Ibid, 115.
43. Ibid, 32.
44. Ibid, 88-89.
45. Bourneville and Régnard, *Iconographie photographique de la Salpêtrière*.
49. Wilson, *Psychosomatic: Feminism and the neurological body*.
50. Ibid, 5.
53. Bourneville and Régnard, *Iconographie photographique de la Salpêtrière*, plate XIV.
55. Ibid, 155; Showalter, *The female malady*, 156.
57. Ibid, 158.
59. Foucault, *The history of sexuality*.
60. Appignanesi, *Sad, mad and bad*, 222.
61. Ibid, 223.
64. Showalter, *The female malady*, 204.
65. Ibid, 213.
66. Ibid, 213.
68. Ibid, 285.
69. Ibid, 401.
70. Ibid, 227.
71. Ibid, 227.
74. Ibid, 419.
75. Ibid, 422.
76. Ibid, 423.
77. Laing and Esterson, *Sanity, madness, and the family*.
80. Ibid, 232.
82. Appignanesi, *Sad, mad and bad*, 413.
85. Ibid, 1.
86. Ibid, 1.
87. Ibid, 2.
89. Ibid, 528.
90. Ibid, 528-529.
91. Ibid, 529.
93. Ibid, 72.
94. Ibid, 15.
95. Bordo, *Unbearable Weight*.
96. Ibid, 32.
97. Ibid, 141, italicization in original.
103. Wurtzel, *Prozac nation*.
105. Ibid, 509.
106. Metzl, “Prozac and the pharmacokinetics of narrative form.”

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