Praise for *No Such Thing as Normal*

'Bigg meticulously documents how pervasive and harmful psychiatry's biomedical vision continues to be, while guiding us toward more compassionate responses to human suffering' **Professor Justin Garson, author of *Madness* and *The Madness Pill***

'Written with sharp insight and unflinching clarity, this book is more than a critique – it is a call to action for a more honest and compassionate response to mental distress, one that is both possible and urgently needed' **Dr Samara Linton, co-editor of *The Colour of Madness***

'A really much-needed contribution' **Nick Dearden, author of *Pharmanomics***

'This book made me revaluate everything I thought I knew about psychiatric care, challenging some of the most fundamental assumptions about mental health, and showing how a radically new approach to "normality" is needed' **Emma Szewczak, author of *The Stich Up***

'Amazingly well done and an insightful read – a must-have if you want to look past what is defined as "normal"' **Dr Nighat Arif, author of *The Knowledge***

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'A stimulating and timely primer on the social model of mental health' **Daniel Tammet, author of *Nine Minds***

'A shocking and powerful critique, this is essential reading for everyone interested in mental health, how the mind works, and how psychiatry could become a force for social change' **Dr Helen King, author of *Immaculate Forms***

'Bigg has the entire discipline of psychiatry in her sights as she turns our attention to the violence at its heart: the human costs borne by the most vulnerable that modern psychiatry is built on' **Dr Rianna Walcott, co-editor of *The Colour of Madness***

'A timely, incisive and rigorous critique of modern psychiatry that never loses sight of the individual person at the centre of it all. I hope all students, and practitioners, of pharmacology will read this' **Dr Andrzej Harris, associate professor of pharmacology at the University of Cambridge**

NO SUCH THING AS NORMAL

Disorders, Diagnoses and the Limits of Psychiatry

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To the parts of ourselves we learn to love.

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Introduction

Psychiatry and Society: A Mental Health Tragedy

Most of us today have either had our own experience with, or know someone with, a mental health problem. More so than any other time, mental health is a topic on our tongues and on our minds. There is talk of a crisis. Opinions are divided about whether mental disorder is actually on the rise.[1] Whatever your view, around a billion people are living with a mental, neurological or substance-use disorder today.[2] People are diagnosed more than ever before; once psychiatric disease was a marginal matter, today it affects us all.

The crisis is often discussed in epidemiological terms, as a population problem, not an individual problem. People explain the rising rates by pointing to pandemics, social isolation and austerity. They talk about mental disease, or disorder, as linked to the world that causes us to suffer.

We intuitively understand that people don't suffer in a vacuum. That things happen to people to make them feel a certain way. And yet, somehow, we continue to think about the appropriate solutions for mental distress in individual medical terms. Rather than turning to the structural problems that we have all seen as somehow connected with the state of our minds, we continue to think of mental health as personal responsibility. We are told to care for our minds the way we care for our bodies.

We are told to see a doctor, get a prescription, and find a way to cope.

At the heart of the medical view of mental suffering is the field of psychiatry. Spokespeople for psychiatry have made some bold promises over the past decades, to cure mental illness with its medical solutions. Despite the scientific breakthroughs reported in the media, about genes found, brain patterns identified, or new cutting-edge drugs, these don't seem to be making much of a difference to the amassing new cases.[3] As much as the field has undoubtedly offered a lifeline to many, there are so many others it hasn't helped, and there is no way that we could possibly claim to have eradicated mental suffering with drugs or other medical technology. If its aim has been to cure mental disorder, psychiatry hasn't exactly achieved its objective. And yet we keep turning to its methods.

All this stems from an inconvenient truth at the foundation of our understanding of mental health: the mental disorders we today make sense of as illnesses akin to diabetes or arthritis still have no proven biological cause. There is no catch-all explanation rooted in genetics or the brain for any of the psychiatric diseases that have been defined by modern psychiatry. While we can use drugs to mitigate symptoms, it is doubtful that we will ever use them to cure psychosis or depression in any straightforward way.

There *is*, on the other hand, a proven link between the world we live in and the state of our minds. And yet, this view is often discredited by the profession with the means and influence to push for social changes that will help.

Both the United Nations (UN) and the World Health Organisation (WHO) have now recognised that the biomedical model for mental health is falling short and, importantly, that the social determinants of mental health

need urgent attention.[4] WHO have even called for a total overhaul of the medical model in mental health.[5] This medical model in its current form isn't meeting the needs of people who are suffering mentally across the globe. And yet we continue to prescribe drugs and treat mental distress as exclusively biological conditions. Antidepressant drug prescriptions are only on the rise.[6] Psychiatric drug sales overall have increased internationally, at an average of 4 per cent annually between 2008 and 2019.[7]

Psychiatry is failing us, yet it is a growing, steadily powerful force shaping our economy, our society, and our very sense of self.

With numerous pronouncements in recent years, even from within the psychiatric community itself, that the discipline is based on a discredited and defunct set of beliefs, it is surprising that money and demand continue to flow. The profession has achieved what some psychiatrists have called a 'cult-like' status, in that it has insisted on untruths, has found ways to exercise control over psychiatrist-dissenters who have spoken out or pulled away, and continues to proselytise aggressively against the tide of scientific findings that contradict its approach. All this, while also manipulating its messaging to the outside world through the mechanisms of a powerful authority vested in a bible under the title of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association.[8] While this bunker-like mentality was noted as far back as sixty years ago,[9] the profession has clung to its methods, and has continued to find financial and political support, far beyond what is justifiable in terms of human benefit.

By delineating a narrow field of vision in which it could claim sole authority, psychiatry has grown in influence

and scope. Endorsed by governments, it has shaped public understanding of mental disease as individual and biologically rooted, garnering support while detracting from the conditions that we know perpetuate mental distress, and entrench inequality.

Because as well as an inconvenient truth, there is also an injustice at the heart of the mental health crisis: it is worse among groups of people who are marginalised or discriminated against. This has a lot to do with the conditions they live in. Women in the UK are 10 times as likely as men to have experienced extensive physical and sexual abuse during their lives; in the US, 9 out of 10 victims of rape are female.[10] UK statistics show that 26 per cent of victims of sexual abuse have tried to take their life, and 22 per cent have self-harmed.[11] Research from across the world shows that these predominantly female victims are very likely to experience post-traumatic stress disorder, or suicidal ideation, as well as other mental health conditions like schizophrenia or depression as a result of their abuse.[12] This likelihood increases for women of colour. When women do find themselves diagnosed, mental health support is generally lacking. In the UK, only 1 in 3 people who experience mental health problems are able to access the support they need[13]; in the US, the figure is as high as 4 in 10,[14] yet groups facing particularly high levels of poor mental health – those who are also already disadvantaged in other aspects of their lives – also often experience the greatest difficulty in accessing services. In both the UK and the US, minoritised groups are the least likely to access the help they need – whether medication for mental health, counselling or therapy.[15]

Looking at gender disparities in mental health in particular brings the inequality in mental health into high

relief. Globally, women and girls are nearly twice as likely as boys and men to suffer from mental ill health.[16] This disparity is echoed, to a greater or lesser degree, across almost every mental condition. UK and US studies show that women are twice as likely to be diagnosed with anxiety or depression as men. Women are 3 times as likely to be diagnosed with an eating disorder. 25.7 per cent of women as opposed to 9.7 per cent of men aged 16 to 24 report having self-harmed at some point in their life.[17] In the cases where women are diagnosed less often, this doesn't mean they aren't suffering, only often that they are underdiagnosed because male criteria are being applied with no regard for how these might manifest differently in women. US research suggests that men are 4 times more likely than women to be diagnosed with autism.[18] Some research suggests that as many as 80 per cent of autistic women are missed.[19] Often, they are initially misdiagnosed with more 'typically female' conditions like anxiety disorders, depression and mood disorders, borderline personality disorder, obsessive compulsive disorder and eating disorders.

Other disorders still, like post-traumatic stress disorder, that have always been studied and understood with a male patient in mind, are now increasingly being diagnosed in women, but with little understanding of the specific social conditions in which they arise. These are conditions that exist outside of psychiatry's gendered caricatures, like ghosts haunting them with the limitations of the profession.

And yet, psychiatry continues to thrive.

Where there is contradiction there is often power holding incommensurate opposites in place. When we zoom out on the state of psychiatry, those power dynamics become clear. We see why, in the context of global

capitalism, a profession vested in marketable solutions was preferable over social changes that would compromise the profits of the wealthy few.

In the context of a history of patriarchy, colonialism and other forms of oppression, too, we see how countless minds of the already disenfranchised could be easily sacrificed to maintaining the status quo. Psychiatry has long provided an authoritative explanation for people's suffering that has nothing to do with the system that fails them, and placed the deficiency in the bodies of implicitly inferior individuals. In doing so, it has isolated us with our suffering, and exacerbated the self-blame and shame that conveniently prevents us from sharing, and so possibly exposing the systematic scope of our distress.

It seems absurd to think that a mind can exist independently, in complete disconnect from the physical world around it, but that is what modern psychiatry makes us believe. To rectify the problem of our sad, stressed and isolated minds we need to reconfigure our image of mental disorder, to put it back in the world, and to bring to light the problem where it truly lives. We may not be facing a mental health crisis after all, but a crisis in our social and mental healthcare systems that needs an urgent remedy.

In this book I want to chart the cost that we pay to uphold a solely psychiatric, medicalised view of mental distress and experience. I want to show who suffers as a result of this view's shortcomings, how they suffer, and what it would take for psychiatry to help.

We will explore how psychiatry diagnoses and treats human experience, and how psychiatric thinking has created a system that prioritises policing gendered and racial stereotypes over answering the questions that would help its patients the most. We see how this has allowed

some of psychiatry's nineteenth-century, most pejorative constructs to survive. Take hysteria, which, in its modern guises, is often used to discredit the impact of the traumas women face by placing the cause and deficiency in their bodies and minds, rather than the violence they experience. This stands in contrast to the story of post-traumatic stress disorder (PTSD) that validates the violence experienced by men in warfare.

Many of psychiatry's faulty concepts have survived due to financial backing. In modern times, financial imperative helps explain how a pharmaceutical industry and extensive government marketing efforts have secured a narrow, brain-based, biochemical view of mental suffering that may not be offering us the answers we need.

Financial imperative, political incentive and historic prejudice combine to shape many of the common understandings in psychiatry today. Borderline personality disorder (BPD) is one of psychiatry's most contested diagnoses. BPD today is diagnosed predominantly in women deemed angry or resistant to treatment. We'll unpick how prejudice has trumped science with these labels, and what it would take to instead help people to cope with the traumatising realities of their lives.

Biological psychiatry does not tell the full story of mental distress. We follow one of the most gendered diagnoses, postpartum depression (PPD), to show that it isn't as exclusive to women as the DSM makes us think and masks the inordinate social expectations placed on mothers. The side effects of all these conditions are not only social disadvantage in material terms, but also internalised stigma and shame that undermine the sense of agency that is so essential to healing. Cases like PPD point to places where cultural assumptions, rather than human benefit, can

easily drive research and care when psychiatrists cling too tightly to the power and legitimacy vested in their biological approach. This leads those working in the field to miss opportunities to help that might fall outside their purview. We'll see this in the most explicit form in the case of psychopathy; especially female psychopathy, which has reinforced ideas about inherent biological difference that is of little help to the individuals and their families. Psychopathy shows us the extreme consequences of asserting an uninterrogated biological view; here asserting and reinforcing social power structures through incarceration, precluding the possibility of rehabilitation, choosing instead to control.

We'll open up to a broader perspective, drawing on the case of schizophrenia, and begin to expose the social determinants of mental distress, especially among minoritised groups, and how medical diagnoses obscure the need for social reform, as well as more humane and more helpful forms of support. We'll also look to psychedelics, long seen as a countercultural alternative to pharmaceuticals, that today are being embraced by mainstream psychiatry. There is an opportunity, here, to learn from these previously marginalised practices, and use them to meet the needs of people who have also been sidelined. There is a risk, though, that financial incentive, once again, will pave the way. This likelihood is evident in the ways that these alternatives to western medicine have been periodically invented, rejected, and now greedily embraced by an industry wary of losing control of its medically sanctioned, highly profitable sector. We explore what it would mean to learn from excluded perspectives. We'll turn to autism, too, now more often diagnosed in women than it has previously been (though still highly under-diagnosed),

to ask what we can learn from autistic people about adequate support. The research currently focused on deficits, the ways in which autistic people fall short of a norm, for example, may not be the most pressing. Perhaps research on how they process and experience the world will be more interesting. Maybe we need to augment treatment currently emphasising the behavioural adjustment of people with autism, with social changes to better facilitate a range of cognitive processing styles. When we listen to these voices, we find that the goals of psychiatric research shift; that they might be less about 'curing' difference, and more about supporting individuals with their unique and equally valid experience.

This leads us to a vision of a different psychiatry; of psychiatry embedded in a mental healthcare system rather than reigning over it. This system is premised on connection over oppression, on supportive relationships over prescriptions, on people's experiences over diagnoses, on collaboration between services over fragmentation. We imagine a profession that, rather than conspiring with a social order that atomises, takes responsibility for social neglect, and offers a systemic, individualised approach to supporting people to live meaningful and connected lives. And in doing so, psychiatry, too, could become a powerful engine for social change.

Mental health crisis or not, mental illnesses are specific inflections of human suffering. Neuroscientific research continues to confirm what Freud already knew – that we all have the propensity for madness. Given the right triggers – a sufficiently hostile environment – we can all slide along that slippery spectrum of human coping strategies in an attempt to meet the challenges of our lives. And

so it makes sense that these coping strategies will differ depending on the environment in which we find ourselves, and it makes sense that those who find themselves in a particularly hostile environment will likely need to adapt more starkly. We need to understand how the world shapes minds, to treat mental distress as a social disease. We also need to understand how individuals can work with the world to heal their minds from distress, and we need to understand how we can shape the world to alleviate mental suffering.

Above all, what drives recovery is the taste of something better. This book is about the madness that connects us, and how, in a world that creates the conditions of our experience, we can find answers that might lead to personal and social change.

1

Hysteria, PTSD and the Birth of Psychiatry

While hysteria has existed through the ages, it wasn't always a psychiatric diagnosis. It began as a gynaecological disease, with early uses of the term in ancient Egypt referring to the havoc wreaked by a wandering womb, causing women to behave erratically. Over time, modifications of this gynaecological explanation were used to explain other gender-defying symptoms, like a refusal to have children or marry. Hysteria emerged again in the late nineteenth century, this time as a neurological disease. The symptoms of hysteria, by this point, were well known: emotional lability, mental fits, paralysis, loss of sensation and convulsions, an affliction that seemed to affect predominantly White, affluent women, and had a sexual overtone. And the symptoms look fairly similar in the modern psychiatric manuals of mental disorders. The Diagnostic and Statistical Manual of Mental Disorders (DSM), the psychiatric manual used largely in the US to guide clinicians with diagnosis, still lists symptoms that closely resemble those long associated with hysteria under a new term, histrionic personality disorder (HPD). A person with HPD might present with attention-seeking and seductive behaviour, emotional instability, a dramatic way of expression and emotional neediness.[1]

While hysteria has existed as a female disease from the

earliest days of western civilisation, the roots for modern-day hysteria were really consolidated in the nineteenth century. At a time when psychiatry was still nascent, psychiatrists sought to assert their profession as on par with medicine. In the era of Enlightenment science, an era of objective truths and empirical evidence, this meant finding a biological basis to classified conditions in the same way medicine had.

One doctor in particular, Jean-Martin Charcot, who took up his post as the chair of pathology at the Salpêtrière hospital in 1872, laid the groundwork for systematic investigations into the root of the disease. He didn't consider hysteria to be a gynaecological disease like many of his colleagues and predecessors; he and his followers were convinced that the cause was located in the brain. Charcot was a neurologist, which meant that he had a very particular method. He called his approach 'clinico-anatomic': he would deduce patterns of symptoms across various patients, and once those patients died, he would dissect their brains. These dissections would, in theory, show associations or commonalities between patients presenting the same symptoms, potentially offering insight into the cause of the disease itself. If he could connect the symptom to a common physical abnormality, he would have a generalisable scheme for diagnosis.

This approach had proved successful for Charcot in deducing many neurological conditions, not least multiple sclerosis. But when he turned his attention to hysteria, it didn't yield the results he expected. He wanted to understand this disorder. He wanted to investigate, given its symptomatic similarity to the epilepsy of patients who coinhabited the hospital, whether this was a discrete condition from epilepsy. And he was convinced that this was

a biological, physical condition with a root that could be found in the brains of the patients he diagnosed.

As it turned out, the post-mortem brains of hysterical patients were structurally completely normal.[2]

Not to be dissuaded, Charcot doubled down. He believed that better microscopes and new techniques would eventually reveal the defects of hysterical brains; it was just a matter of time and technology. In the meantime, he focused his efforts on the patients' presenting symptoms, which were available for all to see. Charcot classified these symptoms into two broad categories of permanent physical defects like loss of sensation, impaired vision, or paralysis, and periodic fits, or 'convulsions', that arose spontaneously or when a patient was somehow distressed. He also identified clear stages to these fits, attempting to make sense of the disease in lieu of the biological evidence he anticipated.

Charcot documented his patients, employing the latest cutting-edge scientific equipment available to him – the camera – to photograph and categorise the postures the women took into patterns. The female body fainting listlessly backwards and the *arc-en-cercle* in which the hysterical patient sharply arches her back, leaving only the head and feet resting on the floor or bed, are two of the most famous postures defined by Charcot and his colleagues.[3] This technology elevated their findings, pandered to the new empiricism of the time that prized observable, objective evidence above all other forms of knowledge. The camera recorded what was there, and so provided 'objective' evidence for Charcot's patterns, reflecting a brain disease that would, he was certain, soon be discovered.

The Salpêtrière where Charcot worked wasn't just a living museum of pathology either, it was a theatre too.[4]

And Charcot had other tools in his scientific toolkit – like hypnosis, which he used to elicit the hysterical symptoms he wanted to categorise. Researchers reassured themselves that they weren't *evoking* performed behaviours from vulnerable patients, they were simply drawing out hysterical symptoms for long enough to allow for proper observation.

Charcot had many research subjects, some better known than others, and mainly women, and as he studied them, he began to see patterns in their postures and categorised them into types.

There was, however, something else his patients, and the many 'hysterics' to come, had in common, something that went overlooked by Charcot: a history of sexual abuse. It seems incredible now that a scientist – a neurologist, no less – would place such a premium on the shared symptoms displayed by his patients, but not the shared history. Then again, even today, trauma is frequently overlooked as a root of disorders. Even today, many psychiatrists still vastly prefer a biological, rather than experiential, explanation.

Louise Augustine Gleizes is the patient who skyrocketed Charcot to fame. What we know about Augustine was recorded by the doctor D.M. Bourneville who, alongside Charcot's photographer P. Regnard, recorded anything deemed 'noteworthy' about her case. She was fourteen when she first started seeing Charcot, and hadn't started her period yet, defying the belief at the time that hysteria could only come after menstruation.[5] Bourneville's notes describe Augustine as 'active, intelligent, affectionate, impressionable, temperamental', adding that she 'likes drawing attention to herself.'[6]

Augustine was tested with all the existing indicators of neurological conditions to see the difference in movement

between the right and left side of her body. Charcot's methods included poking, prodding and administering drugs[7] – he was, after all, a neurologist, and every patient was simultaneously an experimental subject.[8] Traditional indicators were meticulously described, including temperature of various body parts, patterns of excretion, and of course, the ever-important marker of femininity, menstruation, once it started.[9]

A lack of mobility and sensation with no easily apparent underlying cause was one of the determining features for a diagnosis of hysteria. For Augustine, it was her right-hand side that was affected. She was numb in some parts and hypersensitive in others. She had also lost thought, vision and sense of colour[10] – all marks of hysteria. She also displayed the characteristic fainting fits common to so many of his patients, and so Charcot arrived at a diagnosis.

This is all documented in the official narrative. But if we scratch beneath the surface of this scientific case report, we get a different story. It is difficult to discern which details of Augustine's story were omitted, given that doctors were well convinced of the hysteric's tendencies to exaggerate and lie. From the notes, however, one salient theme is not difficult to believe: sexual harassment and assault.

Augustine grew up for the most part in a convent. While there, Augustine occasionally visited the wife of a decorator. The decorator was violent and on one occasion he hit his wife, tied her up by her hair, and then tried to rape Augustine.[11]

That summer, Augustine's mother took her to the house where she and her husband worked as servants. Augustine was told to call the man of the house 'Daddy' and to kiss him. At thirteen, she was removed from the convent and brought back to live with them. While there, 'Daddy' tried

to have sex with her. She resisted and he failed the first few times. The third time he tried to seduce her, promised her gifts, then threatened her with a razor, forced her to drink alcohol, threw her on the bed and raped her. She bumped into 'Daddy' on the street sometime later and he grabbed her by the hair. She had a 'fit' after that.[12]

Shortly before her arrival at the hospital, Augustine was arguing a lot with her parents, who would scold her for her 'unladylike' behaviour. In one of these fights, she learned that her mother had been sleeping with her assaulter. She learned that her brother may even be his, and not her father's son. She realised that her mother may have brought her to the house as a proxy, or a gift.[13] She had discovered that she had been subjected to sexual assault and coercion as a pawn in adults' games.

These snippets give a sense of the texture of Augustine's life. The horrifying scenes of her rape would revisit her during hypnosis at the Salpêtrière – that's what made her such an 'alluring' star patient. And yet, as she rose to fame, with whole audiences gawking at her, no one thought to ask what the woman or girl with the body was trying to say.

Charcot and his followers built the basis for the science of hysteria by making a show of their patients. Charcot's lecture theatres became stages for performances beheld by students as well as an increasingly influential and international audience. Stage-lighting, iconographic art, enlarged photographs and costumes elevated the drama of his demonstrations. Women like Augustine who had been exposed to sexual assault were paraded around as part of an evasive taxonomy, bodies distilled into silent 'evidence' before trainee doctors or a public audience. Photographs were taken and displayed to taunt the public imagination with the threat

of feral femininity. In Charcot's public lectures, hypnosis was often induced by ringing large gongs or tuning forks, or by applying electrical shock and pressure to 'hysterogenic' points on the body (typically the ovaries).[14] Augustine's memories and those of the numerous patients before and after her, became the evidence Charcot used to deduce his symptomology for a theory of a biological disease.

But when we take stock of Augustine's biography riddled with sexual threat and assault, the hysteric fits and visions start to seem less like symptoms of a problem situated within her, than an entirely proportionate response to physical and emotional violation. They seem more like embodied responses to traumatic events. And yet, Augustine's real experiences became irrelevant, were entirely erased, in the process of turning her body into evidence for the dysfunction of her mind.

The hysterical women did not just testify to the power of a new science. They also mirrored very particular gender roles. For Charcot, hysteria wasn't exclusive to women, but his patients were mainly women, and he made his name through his work with some legendary female patients. These women, their bodies and their postures, provided fertile ground for policing the bounds of what a woman should be. Female hysterics embodied many of the traits that had been conventionally associated with femininity – lability, fragility, susceptibility. At the same time, they enacted scenes of an often-sexual nature; unladylike behaviour that served as testament to their illness. Hysterical performances exemplified the fragility of women in general, while also pathologising these women in particular by drawing light to their gender transgressions. Audiences could gawk from a safe distance at the freakshow of feral femininity.

As well as being something of a spectator sport, hysterics in the nineteenth century proved useful models for oppression. During a time of social upheaval in France, against the backdrop of a fierce struggle between monarchy and secular republicans, the feminist movement was on the rise, sparking conservative anxieties about consolidating gender roles in a rapidly industrialising, strange, new, modern world. It is no coincidence that many of the traits Charcot used to describe hysterics, mirrored the language used to describe the feminists of the time, drawing a parallel that would serve to frame feminists as hysterics too. The feminist, like the hysteric, was either hyper-feminine – vain, malleable, suggestible, seductive – or not feminine enough – troublemaking, assertive, aggressive.

The science of hysteria presented the aims of women to leave the home and abandon their roles as babymakers, as unnatural and pathological, serving as 'a dramatic medical metaphor for everything that men found mysterious or unmanageable' in women, in the words of the medical historian Mark S. Micale.[15]

Charcot did not go unchallenged and was met with some criticism at the time, not least by feminists, for his condescension towards women; how he turned them into experimental subjects under the pretext of studying a disease for which he knew neither the cause nor the treatment,[16] guided only by the belief that the root cause had to be in their brains. Some scientists, too, questioned whether he was more of a showman than a scientist. The supposedly objective evidence Charcot was gathering by means of hypnosis, some claimed, was highly contrived, and did not represent discoveries but tricks. He had created the symptoms he purported to discover, they argued.

Eventually, Charcot's performance lost its audience.

The neurological evidence that was needed to support his supposedly scientific classifications, and to justify his method, did not come. Researchers were beginning to doubt whether hysteria had anything to do with the brain and nervous system at all.[17] And, slowly, a new interpretation of 'hysterical' behaviour emerged through the work of a neurologist from Vienna who had spent a few months studying at the hospital to learn from Charcot: Sigmund Freud.

Touching trauma

Freud's theory of hysteria came tantalisingly close to acknowledging the role that sexual violence continued to play in causing women's mental suffering – indeed, for a while it did – only in the end to fall short. Freud had been initially impressed by Charcot's approach, but he was also intrigued by the criticisms that suggested that Charcot had brought on the symptoms he purported to discover, and that there may be some other, non-biological basis to the disease to explore. In his early studies on the topic, he diverged from Charcot's neurological approach to make his mark on the debate and propose a different explanation.

In one study published in 1893, Freud showed hysterical symptoms, such as the 'paralysis' displayed by hysterical patients, to be entirely different to 'organic', physical paralysis caused by stroke or injury. Hysterical patients, he observed, did not move their paralysed limbs in ways that made anatomical sense[18]: a hysterical patient would drag her leg behind her, while someone organically paralysed would make a circumduction with the hip. Moreover, paralysis resulting from brain damage usually spared the hip area. Patients, he noted, seemed to move in a way that

reflected a popular understanding of anatomy, rather than a medical one. These findings eventually led Charcot himself to abandon the physiological approach for one based on emotional trauma.[19] Charcot's findings suggested that there was more than simply something neurological going on, and Freud's observations raised the radical possibility that women were not suffering from neurological deficiencies, nor responding to the suggestions of their physicians, but perhaps had some other reason to behave this way.

One common thread that Freud noticed was that many hysterical women had experienced sexual trauma. Perhaps this was key to the cause of the disease.

But Freud soon hit the limits of his capacity to confront the violence of rape. The social implications were simply too great, and Freud became increasingly troubled by the prevalence of sexual assault among his female patients. Hysteria was so common among women that if his patients' stories were true, and if his theory was correct, he would be forced to conclude that 'perverted acts against children' were endemic, both among the proletariat in Paris, where he had first studied hysteria, and among the respectable bourgeois families of Vienna, where he had established his practice.[20] This was more than Freud's professional credibility could withstand, leaving only one solution – to stop listening to his female patients.[21] And so, Freud's theory, based on sexual trauma, gave way to another pathological version of femininity: that of sexual repression.

By 1987, Freud had fully replaced sexual exploitation with sexual repression as the 'locus' of hysteria.[22] He no longer believed that women's reports of sexual coercion and violence were memories of real events. They were, he asserted, actually remembered *fantasies* of sexual

encounters from childhood. Memories of forbidden erotic feelings that we all shared, but that for some reason resurfaced in hysterical patients. Whatever had or hadn't happened to women was, to Freud, almost irrelevant, as the unconscious mind couldn't distinguish between fantasy and reality. The real problem, in any case, wasn't any sexual encounter, but femininity itself. Hysteria, he argued, was 'characteristically feminine',[23] the result of woman's inevitable lack.

'In a whole series of cases', he wrote in 1909, 'the hysterical neurosis is nothing but an excessive overaccentuation of the typical wave of repression through which the masculine type of sexuality is removed and the woman emerges.'[24] Freud now saw hysteria in relation to his all-important Oedipal theory. He posited that when young women find they lack a penis, they believe themselves to be castrated, leading to an inferiority complex, a form of internalised resentment towards other women, displayed as exaggerated emotional response. The concept of a 'castrated female' and their associated anxieties were what caused the nervous disposition of women, behaviour that enacts a lack, a void.[25] Women were always already physically scarred by the recognition of their own 'castration'[26] – in other words, by simply being women. For Freud, the scar that caused hysteria was still physical, but in a different sense to the belief that motivated Charcot. For Freud, hysteria was rooted in the lack of male genitalia, and *all* women suffered from this same lack.

Hysterical men

Between 1914 and 1915, as Freud was shoring up his theory of psychoanalysis that placed the roots of hysteria in