

# Diagnosing difficult women and pathologising femininity: Gender bias in psychiatric nosology

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## The genealogy of women's madness

The pathologisation of femininity and regulation of 'difficult' women through psychiatric nosology has a long history. If we look to accounts of hysteria, the most commonly diagnosed 'female malady' of the 18th and 19th century, we can trace the genealogy of the 'regimes of truth' reified in the *Diagnostic and Statistical Manual of the American Psychiatric Association* (DSM) (American Psychiatric Association, 2000), which define and regulate women's madness today. Whilst hysteria was first described by the ancient Greeks, appearing in the writings of Plato and Hippocrates, it was in the 17th century that it emerged as one of the most common diseases treated by medics. Thus Thomas Sydenham commented that 'the frequency of hysteria is no less remarkable than the multiformity of the shapes which it puts on. Few of the maladies of miserable mortality are not imitated by it' (Sydenham, 1679: 85). Although the causes of this nebulous disorder were widened to include the nervous system in the late 18th century, allowing men to receive a diagnosis of hysteria (Showalter, 1997:15), it was always considered to be 'woman's disease', a disorder linked to the essence of femininity itself. Indeed, Laycock (1840), described hysteria as a woman's 'natural state', whereas it was deemed a 'morbid state' in a man (Smith-Rosenberg, 1986: 206), and in 1903 Otto Weininger asserted that 'hysteria is the organic crisis of the organic mendacity of woman' (Bronfen, 1998:115).

The 19th-century physicians were highly critical of this feminine 'state' describing hysterical women as difficult, narcissistic, impressionable, suggestible, egocentric and labile (Smith-Rosenberg, 1986: 202). The affluent hysteric was characterised as an idle, self-indulgent and deceitful woman, 'craving for sympathy', who had an 'unnatural' desire for privacy and independence (Donkin, 1892) and was 'personally and morally repulsive, idle, intractable, and manipulative' (Showalter, 1987: 133). Some

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went as far as to describe such women as 'evil', with the physician Silas Weir Mitchell, declaring that 'a hysterical girl is a vampire who sucks the blood of the healthy people around her' (Mitchell, 1885: 266). In contrast, women suffering from the 'nervous disorder' of neurasthenia, which shared many of the symptoms of hysteria, yet was characterised by an 'ill defined set of symptoms – a form of nervous exhaustion' (Busfield, 1996: 130), were described as having a 'refined and unselfish nature', and as being 'just the kind of woman one likes to meet' (Showalter, 1987: 134). Neurasthenic women were 'sensible, not over sensitive or emotional, exhibiting a proper amount of illness... (with) a willingness to perform their share of work quietly and to the best of their ability', in the words of one 19th-century physician (Playfair, 1892: 851). Politeness and compliance on the part of the patient was clearly of the essence, as is still the case today, when 'difficult' women are at risk of being diagnosed with borderline personality disorder or premenstrual dysphoric disorder (PMDD).

By the late 19th-century, as Rosenberg has argued (1986: 202), 'every known human ill' was attributed to hysteria, meaning that the diagnosis ceased to mean anything at all (Micale, 1995: 220). Women diagnosed with hysteria could exhibit symptoms of depression, rage, nervousness, the tendency to tears and chronic tiredness, eating disorders, speech disturbances, paralysis, palsies and limps, or complain of disabling pain. Many women also exhibited a hysterical 'fit', which could either come on gradually or could occur suddenly, mimicking an epileptic seizure (Smith-Rosenberg, 1986: 201). Indeed, hysteria has been described as a 'veritable joker in the taxonomic pack' (Porter, 1993: 226), and as the 'wastebasket of medicine' (Bronfen, 1998: xi) largely because of its nebulous and multifarious nature. Hysteria has also been described as a 'mimetic disorder' because it mimics culturally permissible expressions of distress – hysterical limps, paralysees and palsies were accepted symptoms of illness in the 19th century, but have virtually disappeared today, as they no longer stand as a 'sickness stylistics for expressing inner pain' (Porter, 1993: 229).

At the beginning of the 21st century the 'legitimate' symptoms of madness are laid out for all to see in the DSM. As new diagnoses are added with each edition (and others, such as hysteria or homosexuality, removed), details of the necessary symptoms for diagnosis are circulated through interactions with the psy-professions, or through pharmaceutical company advertising, media discussion of madness, and 'self-help' diagnostic websites. Is it surprising that so many women self-diagnose with these disorders and then come forward for professional confirmation of their pathological state? Their distress is no less real than that of the women diagnosed as hysterics in the 19th century. However, the myriad disorders with which we are now diagnosed are no less mimetic than hysteria was then – we signal our psychic pain, our deep distress, through culturally sanctioned 'symptoms', which allows our distress to be positioned as 'real'. Or we are told by others that we have a problem, and are then effectively positioned within the realm of psychiatric diagnosis and treatment, with all the regulation and subjugation that this entails (Ussher, 2011). Femininity is still central to this process, as is evidenced by the diagnosis of the modern 'female maladies', hysterical and borderline personality disorders, and PMDD.

## Exaggerated femininity: Hysterical and borderline personality disorders

Hysterical personality disorder's depiction in the DSM-II, published in 1968, has been described as 'essentially a caricature of exaggerated femininity' (Jimenez, 1997: 158), as the 'symptoms' included excitability, emotional instability, over-reactivity and self-dramatisation. Indeed the description in DSM-II of hysterics as 'attention seeking, seductive, immature, self-centred, vain... and dependent on others' (American Psychiatric Association, 1968: 251) is almost identical to the 19th-century description of hysteria. In DSM-III (American Psychiatric Association, 1980), published in 1980, hysterical personality disorder was renamed 'histrionic personality disorder', to avoid the negative connotations that were associated with 'hysteria' (Jimenez, 1997). However, the descriptors of the typical patient outlined in DSM-III still depict an exaggerated femininity, someone who is 'typically attractive and seductive... overly concerned with physical attractiveness' as well as interested in 'control(ling) the opposite sex or enter(ing) into a dependent relationship (and continuously demanding) reassurance, approval or praise' (American Psychiatric Association, 1980: 348). Isn't this how we are taught to 'do girl' through teenage magazines, romantic fiction, and 'chick flicks?' (Ussher, 1997). But we should be careful. Enacting this particular version of 'seductive' femininity may attract more than a man – it can also clearly attract a psychiatric diagnosis. This was evidenced in a study where psychiatrists were asked to judge a range of case descriptions, wherein a diagnosis of histrionic personality disorder was given to women, even though the case studies gave little indication of the 'disorder' (Loring and Powell, 1988).

Changes in gender roles after the 1960s and 1970s, which saw Western women enter the workforce in unprecedented numbers, and reshaped sexual and family relations, resulted in the marginalisation of hysteria as a diagnostic category. However, as Jimenez (1997: 161) has argued, this did not mean that exaggerated femininity was no longer pathologised, as borderline personality disorder simply took the place of hysteria, capturing 'contemporary values about the behaviour of women'. Borderline Personality Disorder is described as a 'feminised' psychiatric diagnosis (Becker, 1997), because it is applied more often to women than men, at a rate of 3:1–7:1 (Becker, 2000). The criteria for diagnosis consists of symptoms that characterise 'feminine qualities' (Jimenez 1997: 163). These include depression and emotional lability, as well as 'impulsiveness in areas such as shoplifting, substance abuse, sex, reckless driving, and binge eating', and 'identity disturbance', evidenced by 'uncertainty about self-image, sexual orientation, long term goals or career choice' (American Psychiatric Association, 1987: 347). However, where borderline personality disorder differs from hysteria (or histrionic personality disorder) is the inclusion of the more masculine characteristic of 'inappropriate intense anger' as a criterion for diagnosis (Jimenez, 1997). So whilst both diagnostic categories adopt gender stereotypes in positioning particular women as 'mad', Jimenez comments, 'if the hysteric was a damaged woman, the borderline woman is a dangerous one' (p. 163). As almost half of the women who qualify for a histrionic or a borderline

diagnosis meet the criteria for both disorders (Becker, 2000), many women are clearly seen as both damaged and dangerous.

The typical borderline patient has been described as a 'demanding, angry, aggressive woman', who is labelled as 'mentally disordered' (Jimenez, 1997: 162, 163) for behaving in a way that is perfectly acceptable in a man. Evidence that there is a clear gender difference in the pathologisation of emotions, in particular anger, is supported by recent research by Lisa Feldman Barrett and Eliza Bliss-Moreau, who examined judgements made about emotions expressed by men and women. They found that men's sadness and anger was considered to be related to situational factors – such as 'having a bad day' – whereas sad or angry women were judged as 'emotional' (Barrett and Bliss-Moreau, 2009). Thus women's emotions are deemed a sign of pathology, whereas men's are understandable. Dana Becker has described borderline personality disorder as 'the most pejorative of personality labels' which is 'little more than a shorthand for a difficult, angry, female client certain to give the therapist countertransference headaches' (Becker, 2000: 423). As many women diagnosed as 'borderline' have been sexually abused in childhood (Ussher, 2011), their anger is understandable, as is their 'difficulty' with men in positions of power over them – the therapists who give out diagnoses. These women are pathologised, occupying the space of the abject, that which is 'other' to all that is desired in the feminine subject (Wirth-Cauchon, 2001).

### **Menstrual madness: Premenstrual dysphoric disorder**

The same could be said of premenstrual dysphoric disorder (PMDD), another example of the positioning of 'difficult women' as mad (Chrisler and Caplan, 2002; Ussher, 2006). Women who report a range of feminised psychological changes premenstrually, primarily anxiety, tearfulness, and depression, can be diagnosed as having PMDD – as can women who contravene idealised femininity through 'symptoms' of anger and irritability. The fact that these 'symptoms' are often experienced in a relational context, as a reaction to over-responsibility and absence of partner support (Ussher and Perz, 2012), and take the form of a rupture in the self-silencing, which is practiced for 3 weeks of the month (Ussher and Perz, 2010), is completely absent in bio-medical accounts of PMDD.

Whilst a 'mood disorders work group' is 'accumulating evidence' as to whether PMDD should be included in DSM-5 (Fawcett, 2010), its inclusion in the DSM-IV met with widespread feminist opposition, on the basis that there is no validity to PMDD as a distinct 'mental illness' (Cosgrove and Caplan, 2004). Feminist critics have dismissed this process of pathologisation, arguing that premenstrual change is a normal part of women's experience, which is only positioned as 'PMDD' because of Western cultural constructions of the premenstrual phase of the cycle as a time of psychological disturbance and debilitation (e.g. Chrisler and Levy, 1990; Rodin, 1992). In Eastern cultures, such as Hong Kong or China, where change is accepted as a normal part of daily existence (Epstein, 1995), women report premenstrual water retention, pain, fatigue, and increased sensitivity to cold, but rarely report negative premenstrual moods (Chang et al., 1995; Yu et al., 1996). This has led to

the conclusion that PMS is a culture-bound syndrome (Chrisler and Johnston-Robledo, 2002) that follows unprecedented changes in the status and roles of women in the West, with the belief that women are erratic and unreliable premenstrually serving to restrict women's access to equal opportunities (Chrisler and Caplan, 2002). Indeed, belief in the negative influence of premenstrual 'raging hormones' has been used to prevent women being employed as pilots (Parlee, 1973), physicians, and presidents (Figert, 2005), which by extension casts doubt on the reliability of *all* women occupying positions of responsibility.

## Conclusion

As the outspoken, difficult woman of the 16th century was castigated as a witch, and the same woman in the 19th century a hysteric, in the late 20th and 21st century, she is described as 'borderline' or as having PMDD. All are potentially stigmatising labels. All are irrevocably tied to what it means to be 'woman' at a particular point in history. And whilst the 19th-century hysteric was deemed labile and irresponsible, as a justification for subjecting her to the bed rest cure or incarceration in an asylum (Ussher, 2011), women diagnosed as borderline today are often considered to be mentally disabled, subjected to involuntary institutionalisation or medication, as well as being stripped of child custody or parental rights (Becker, 2000: 429), and women diagnosed with PMDD are medicated with SSRIs (Steiner and Born, 2000). At the same time, a diagnosis of borderline can be used as a justification for denying women access to mental health care, because of supposed 'resistance' to treatment (Morrow, 2008). However, if we examine the negative consequences of contemporary bio-psychiatric 'treatment' for many women (Currie, 2005; Ussher, 2011), this may not be such a bad thing.

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