

**RESISTING RATIONALITY: THE TRANSFORMATIVE CAPACITY OF
ANXIETY AND ITS IMPLICATIONS FOR POLITICAL THEORY**

by

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Abstract

Large-scale national epidemiological surveys consistently find that women are more likely to be diagnosed with emotional disorders,¹ specifically anxiety and depression, than men. Although the cause(s) for this phenomenon are difficult to determine, research increasingly shows that environmental factors play a greater role than genetics/biology in producing this anomaly (D. Freeman and J. Freeman 2013). Current psychological models of mental illness, however, tend to negate social and political aspects of experience by depicting anxiety as a naturally occurring pathology within women (Ussher 2010).

This thesis seeks to critically interrogate and re-create constructions of mental illness by examining how our conceptions of female anxiety have been shaped by negative images in psychiatric discourse and liberal political theory. I analyze hysteria as a precursor to anxiety to show how the age-old association between femininity and madness continues to influence prevailing attitudes around gender. To challenge these negative depictions, I reconceptualize anxiety as a natural response to power, in particular, patriarchal relationships. Further, I contend that while anxiety can be debilitating, it is also the source of a significant contribution to diverse and oftentimes empathetic voices. Thus while psychological therapy may be a useful tool for some people who experience mental illness, it should not be the overarching paradigm through which we view anxiety, nor should it define the identities of anxious individuals.

Bringing anxiety into communication with contemporary social theories of disability, I conclude that liberal theory is an inadequate political ideology in that it is unconsciously gendered and thus excludes women (and men) who experience emotional illness from its

¹ When discussing anxiety from a psychological viewpoint, I have opted to use standard scientific terminology. However, I wish to be critically reflexive in my word choice, as common medical terms such as ‘disorder’ and ‘illness’ often have pathological connotations/depict anxiety as a defect, as opposed to a form of difference. I will discuss this in greater detail in Chapter Three.

theoretical criteria for citizenship. Consequently, it is necessary to reject wholly negative images of anxiety at the crux of liberal theory. Instead, expanding on the work of care ethicists, I advocate viewing anxiety as a different, relational voice rooted in an ethic of interdependence.

Lay Summary

This thesis traces the history of hysteria to explore how psychiatry and political theory have negatively associated emotional illness, specifically anxiety, with femininity. Although hysteria is no longer a recognized illness, I argue that the concept of the ‘emotionally unstable woman’ still influences prevailing attitudes around gender. To help change perspectives around female mental illness, and hence re-frame anxiety, I argue the following: first, that anxiety is a natural response to living in a patriarchal world, and secondly, that although anxiety can be disabling, it can, paradoxically, also be positive. Anxious people are often highly intuitive, excel at critical insight, and have been scientifically shown to demonstrate greater empathy. Thus while psychological therapy is a useful tool, we must not let it define the identity of the individual. Instead, I view anxiety as a different voice that may be effectively expressed if embedded in a relational system of interdependence.

Preface

This thesis is an original, unpublished, independent work by the author, Katriona Vera Stewart.

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Dedication

This thesis is dedicated to my wonderful, insightful and courageous Mum, who first and foremost expresses her anxiety through care. You have given so much to this work - I could not have done it without you.

Chapter 1: Introduction

1.1 Overview:

Madness is a female malady because it is experienced by more women than men...But how should we interpret this statistical fact? There have always been those who argued that women's high rate of mental disorder is a product of their social situation, both their confining roles as daughters, wives and mothers and their mistreatment by a male-dominated and possibly misogynistic profession...By far the more prevalent view, however, sees an equation between femininity and insanity that goes beyond statistical evidence or the social condition of women...women, within our dualistic systems of language and representation, are typically situated on the side of irrationality, silence, nature and body, while men are situated on the side of reason, discourse, culture, and mind..[Feminist philosophers, literary critics, and social theorists] have analyzed and illuminated a cultural tradition that represents "women" *as* madness, and that uses images of the female body...to stand for irrationality in general.

- Showalter, E. 1985. *The Female Malady*. London: Virago, 3-4.

On Monday, the 11th of July, 2016, an audience member on the Australian news show, ABC Q&A, asks panelists a heart wrenching, yet critical question: “[Football presenter] Sam Newman has courted controversy yet again for defending [broadcaster] Eddie McGuire for making a joke about drowning [sports writer] Caroline Wilson...My sister Nakita was stabbed to death by her partner in January last year with a meat cleaver. She was twenty-three. Male violence is a leading cause of death and disability of women under forty-five in Australia. How will politicians and the media play a better role in bringing about long overdue cultural shifts so tragedies like what happened to my family are not normalized?”²

The questioner, Tarang Chawla, is an ambassador for domestic violence groups Our Watch, White Ribbon, and the Safe Steps Family Violence Response Centre. Still reeling from his sister's murder, his intent was to draw attention to the casual manner in which Australian media

² The full exchange can be viewed at <http://www.huffingtonpost.com.au/2016/07/11/qanda-steve-price-accuses-female-panelist-of-getting-hysterical/>. Date accessed: February 6, 2017.

handles violence toward women. In his question, he refers to controversial remarks broadcaster Eddie McGuire had made on a popular radio show a month earlier. McGuire had quipped that he would pay \$20,000 to force AFL writer Wilson into a bath of iced water, and \$50,000 to make her “stay under;” to which the other men on air had snidely laughed, saying that they too were “straight in”, and “amongst it.”

The first to respond to Chawla’s Q&A question is another well-known radio broadcaster, Steve Price. Price does not acknowledge Chawla’s horrific loss, nor does he recognize the need to critically evaluate the media’s casual approach to domestic violence. Instead, he dismisses the McGuire controversy as a “bunch of blokes laughing about things they shouldn’t laugh about,” before lamenting that “far too much” was made of what was “originally a joke on a football show.”

Guardian columnist and novelist Vanessa Van Badham then responds. First, she offers her heartfelt condolences to the victim’s family, before pointing out how explanations like Price’s further cultural attitudes condoning domestic violence: “First can I say it’s absolutely heartbreaking to hear about your sister. I am terribly sad for your family and everyone left behind...it’s one of the reasons why we have to take this so seriously.” She then emphasizes the need to end the cultural attitudes around the “different treatment around women,” attitudes that present domestic violence against women as “jokes made by a bunch of blokes.”

Meanwhile, Price, quick to take offence, speaks over her, saying “I don’t want you to twist stories when you shouldn’t.” Van Badham tries to respond, but Price interrupts, declaring: “just because you’re a woman doesn’t mean you’re the only person who can get upset about this.” To this Van Badham declares that Price is proving her point “excellently.” The challenges, she observes, are “multifaceted.” The fact is, we can “make jokes and apologize, and it’s all fine,”

but then on receiving end are the “ludicrous proportion of women who do endure violence.” At this point Price interrupts for the umpteenth time, proclaiming that Van Badham is “just being hysterical.”

Van Badham gets the final word, exclaiming: “It’s probably my ovaries making me do it, Steve.” The crowd cheers. However, her victory is short lived. The following week Price appears on several radio stations, each time refusing to apologize, and instead branding Van Badham as an “aggressive woman” who has engineered the whole encounter. Meanwhile, the Guardian columnist receives a tirade of online abuse, with comments such as: “she needs a hole drilled in her arse so she can be carried around like a bowling ball.” “I’d smack the b*tch in the mouth - I’d do it to a guy and equal rights mean I can do it to a girl;” “with a mouth like that I’m surprised she hasn’t become a victim of DV herself;” “maybe if Van BagHag got something up hers she wouldn’t be such a cranky twat waffle;” “now if her husband beat her up, I’d honestly have to say good on him;” and “I honestly pray for your death every day, I’d do anything to stop this, people like you are disgusting, entitled, and of course, hysterical. You deserve a good slap.”³

• • •

In the saga just described, a well-known male broadcaster used a specific, loaded word to jointly end an important discussion and undermine his fellow panelist’s credibility. The word was ‘hysteria,’ a profoundly gendered term that became widespread in the nineteenth century when it was used as a medical diagnosis for women. As the above example demonstrates, this world still infuses our language to this day. As the exchange between Van Badham and Price

³ See Van Badham read the negative comments she received out loud at <http://www.smh.com.au/entertainment/tv-and-radio/van-badham-says-clash-with-steve-price-on-qa-inspired-week-of-abuse-20160713-gq59su.html>. Date accessed: February 6, 2017.

demonstrates, when a woman tries to calmly reason with an enraged man, ultimately it is she who bears the label, ‘hysterical.’ Men may be considered passionate, angry, or distraught, but the term ‘hysterical’ remains almost exclusively reserved for women. Why is this?

In attempt to answer this question, I will trace the age-old association between femininity and madness, examining how prevailing ideas concerning gender which reach back to a previous epoch still influence cultural attitudes today. The purpose of this work is to extend the feminist critique of liberal political theory by focusing specifically on anxiety, and the way that pathologies of anxiety typically associate this emotion with women. By bringing feminist critiques of hysteria into communication with contemporary disability theory, I hope to make an original contribution to the existing literature in terms of the meaning of anxiety, and how our understandings of mental illness can be conceived in relation to gender and patriarchy.

My argument is two-fold: first, I make the case that anxiety is a natural response to living in a powerful, patriarchal world, and secondly, I contend that when viewed as a different, relational voice, anxiety can, paradoxically, be positive.

While first and foremost a piece of political theory scholarship, it bears noting that this thesis is a cross-disciplinary piece, which is best described as a synthesis of feminist, political, psychological, medical and sociological research.

1.2 Introduction

Why should political theorists care about mental illness, specifically anxiety? On a purely demographic level, anxiety is a widespread mental illness that affects people of all ethnicities, nationalities, religions, sexes and classes. Anxiety disorders are the most common mental illness in the United States (U.S), affecting over forty million Americans aged over eighteen, or roughly

18% of the population (Kessler et al, 2005).⁴ According to the World Health Organization, anxiety and depression disorders cost the global economy approximately U.S. one trillion every year.⁵ In the U.S. alone, the Anxiety and Depression Association of America (ADAA) estimates that anxiety disorders cost around 42 billion annually (Greenberg 1999, 427-435). However, it bears noting that this statistic is nearly twenty years out of date, and comes from a study that does not account for long-term opportunity costs (i.e. the financial losses caused by excess unemployment and underemployment): thus the true cost of anxiety in the U.S. is undoubtedly much higher.

The ADAA also makes another interesting observation: that women are twice as likely as men to develop anxiety disorders over the course of their lifetime.⁶ Although this statistic is also outdated, it has since been affirmed by multiple epidemiological surveys, all strongly suggesting that women are more likely to be diagnosed with emotional disorders than men. In their book *The Stressed Sex: Uncovering the Truth About Men, Women, and Mental Health* (2013), Oxford Clinical Psychology Professor Daniel Freeman, and his brother, psychology writer Jason Freeman analyze the best research available at the time: twelve wide-scale, randomized and weighted, national epidemiological surveys from the U.S., U.K., Europe, Australia and New Zealand, and South Africa and Chile assessing the prevalence of a range of psychological disorders.⁷

⁴ The statistic is over ten years out of date, so based on upwards trends, current numbers are presumably much higher.

⁵ For more information, see: <http://www.who.int/mediacentre/news/releases/2016/depression-anxiety-treatment/en/>. Date accessed: February 2, 2017.

⁶ Over the course of a lifespan, women are twice as likely as men to have a generalized anxiety disorder (6.6% versus 3.6%), panic disorder (5.0% versus 3.5%), post-traumatic stress disorder (10.4% versus 5.0%), or agoraphobia (7.0% versus 3.5%) (Kessler et al, 1994).

⁷ The surveys selected focus on the prevalence of psychological problems more generally, as opposed to records of hospital admissions/doctor visits. The rationale for this selection is that women have been found to seek treatment more frequently than men (D. Freeman and J. Freeman 2013, 9).

The results proved to be remarkably consistent - every one of the twelve studies show that women are considerably more likely than men to experience emotional disorders such as anxiety and depression: two conditions which are closely linked.⁸ For example, the U.S Comorbidity Survey Replication (NCS-R) found that over the previous twelve months, 23% of women had experienced an anxiety disorder, and 9% had had depression. The figures for men were 14% and 5% respectively (D. Freeman and J. Freeman 2013, 36). Conversely, men were found to have a greater propensity for substance disorders (i.e. alcohol and drug dependence). However, despite this, and while factoring in the likelihood that men are less likely to come forward about their struggles with mental illness, the authors still contend that women appear to be more vulnerable to psychological problems on the whole (D. Freeman and J. Freeman 2013).

At this point I must make explicit that I am very wary of trivializing male mental illness: to categorize mental illness as an exclusively female problem would be grossly inaccurate. In a paradoxical way, I fear that if I do not say more about men and their anxieties, and how we need to understand more, my research might be misconstrued. So let me say now, emphatically, that it is far from my intention to further sustain ancient male/female, rational/irrational, and civic/home-bound dichotomies. Ultimately, rates of mental illness are dangerous across the board, irrespective of gender. In fact, while more women than men report having suicidal thoughts, men in the U.S. are 3.5 times more likely to actually commit suicide than women, and are more likely to suffer in silence.⁹ The professional and personal silence with respect to male anxiety is dangerous, however, it remains undisputed that women are more likely to be diagnosed with anxiety as a ‘medical condition.’ In this thesis I shall seek to explore why this is

⁸ Close to 50% of people diagnosed with an anxiety disorder also meet the diagnostic criteria for depression (Batelaan et al 2012).

⁹ Statistic provided by the American Foundation for Suicide Prevention. For more information see <http://afsp.org/about-suicide/suicide-statistics/>. Date accessed: November 11, 2016.

the case, and, assuming that anxiety is a gendered phenomenon, the implications of this for political theory.

But firstly, what exactly do I mean by anxiety? Some anxiety is normal – it helps us to function because we care, we prepare, we pay attention. To a certain extent, anxiety is an appropriate evolutionary response to danger, dating back to a time when people had to be on constant alert to survive – ready for flight or flight. Thomas Hobbes viewed anxiety as a basic cognitive ability that if used ‘rationally,’ can be a vital, life-affirming problem-solving skill. In chapter eleven of *Leviathan*, he declares that “Anxiety for the future time, disposeth men to enquire into the causes of things: because the knowledge of them, maketh men the better able to order the present to their better advantage” [1651] (2010). Words of course change across time, place and situation, but it is clear that here Hobbes is using ‘anxiety’ in the modern sense of worry, or the anticipation of a future threat. In this context, anxiety makes one more aware of his/her situation: as a result of this awareness, s/he is prepared, and thus able to respond to events to his/her advantage.

However, I can attest from personal experience that for some, anxiety can be debilitating. It can strike at the most unexpected times, and can make us imagine things to be far worse than they actually are – to the extent we convince ourselves that we are losing our minds and that we will never be able to function normally again. It can manifest itself in circular, racing thoughts that are almost impossible to switch off, a sinking feeling of doom and depression, as well as a series of miserable physical symptoms such as insomnia, fatigue, acid reflux, nausea, vomiting, diarrhea and dizziness.

The *American Heritage Medical Dictionary* defines anxiety as a “state of intense apprehension, uncertainty, and fear resulting from the anticipation of a threatening event or

situation, often to a degree that normal physical and psychological functioning is disrupted” (2007, 38). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which is the standard authority medical professionals use to classify and diagnose mental illness, charts a range of anxiety disorders including generalized anxiety disorder (GAD), social anxiety disorder (SAD), panic disorder, agoraphobia, specific phobias, and post-traumatic stress disorder (PTSD) (American Psychiatric Foundation (APA), 2013). These disorders have a high co-morbidity rate, meaning that people will commonly experience more than one of them at the same time. They also share several key features, including excessive fear, which is defined as the “emotional response to real or perceived threat,” and anxiety: the “anticipation of future threat” (APA 2013, 189). Although these two feelings overlap, DSM-5 distinguishes fear on the basis that it tends to be more associated with “surges of autonomic arousal necessary for fight or flight, thoughts of immediate danger, and escape behaviours,” whereas anxiety is more commonly associated with “muscle tension and vigilance in preparation for future danger and cautious or avoidant behaviours” (APA 2013, 189).

Based on recent trends, it would not be far-fetched to say that we are experiencing an anxiety ‘epidemic.’¹⁰ The World Health Organisation states that between 1990 and 2013 the number of people with depression and/or anxiety nearly doubled, increasing from 416 to 615 million.¹¹ Approximately 9.0% of people will develop Generalized Anxiety Disorder (GAD), one of the most common anxiety disorders, over the course of their lifespan (Kessler et al 2012). Women, yet again, are twice as likely to be affected (Seedat et al. 2009). The features of GAD,

¹⁰ This is a view shared by theorists and physicians alike, see for example: Maria Angell. 2011. “The Epidemic of Mental Illness: Why?” *The New York Review of Books* 58:11, 2-4. However, as stated earlier, I am critical of using words like ‘epidemic’ due to their pathologizing connotations.

¹¹ Statistic provided by the World Health Organization. For more information see <http://www.who.int/mediacentre/news/releases/2016/depression-anxiety-treatment/en/>. Date accessed: February 2, 2017.

as stated in DSM-5 are prolonged anxiety and worry (for at least six months) about a number of events, whereby the anxiety is disproportionate to the actual or expected event, causes considerable distress, and can significantly interfere with social, psychological, and occupational functioning (APA 2013). In addition to the anxiety experienced, individuals are said to have GAD when the anxiety is accompanied by at least three of the following symptoms: restlessness or feeling on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, and sleep disturbance (APA 2013). As well as these mental challenges, people with GAD and other anxiety disorders often also have incapacitating somatic symptoms such as muscle aches, nausea, sweating, headaches, and irritable bowel syndrome (APA 2013).

Complaints will vary considerably based on the individual, which leads to one of the main criticisms leveled at current psychiatric practices: that they do not factor into account the severity of symptoms. Daniel and Jason Freeman, among others, have criticized the DSM for its essentially binary approach to diagnosis: you either meet the criteria or you do not; an approach which they argue does not align with people's real-life psychological experiences (2013, 61). In agreement with D. and J. Freemans' critique, I propose that anxiety is best viewed as part of a continuum, ranging from relatively unproblematic to incapacitating. Regardless of whether anxiety has been clinically diagnosed, it may or may not be disabling, depending on the social context and the specific individual in question. Thus when I speak of 'anxiety,' I am referring to a generalized state of anguish that may or may not satisfy clinical requirements.

So now that I have outlined the medical perspective, how might one approach anxiety as a political theorist? My understanding of anxiety aligns with current social understandings of disability, as articulated in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which focus on the interaction between individuals and their health

conditions, and the contextual barriers that these individuals navigate in their daily lives.¹² Rather than focus on an individual's physiological impairment, the UNCRPD definition recognizes that often it is the social environment that needs fixing, not simply the individuals themselves. This definition has evolved in response to criticisms of the 'medical model' of disability, which locates the source of disability, in this case, mental illness, within the individual.¹³ Theorists such as Peter Handley have criticized the individual-deficit model, implicit in most political theory, on the basis that it casts responsibility solely on the affected individual. Instead, they advocate a 'social model' of disability that takes into account the "marginalizing impact of social and economic structures upon disabled people" (2001, 112).

While the social model is definitely a step toward removing the stigma and blame associated with 'individual deficits,' if we view mental illness as entirely environmental, we risk erasing individual difference and the real embodied challenges that people with anxiety may face (Ussher 2010). We thus need to find a middle ground that is sensitive to personal experience and individual particularities (Wendell 1996). Following philosopher Eva Kittay's approach to disability, I do not discount that anxiety is in part physiological, rather, I view anxiety both as a product of one social's environment, and as an element of embodied experience (2001, 565-6).

In Chapter Two of this thesis I explore how anxiety, both as a medical and theoretical term, came to be distinctly gendered. This chapter's focus is to provide a synthesis of a wide-ranging literature to show the emergence of liberal discourses on 'irrationality' and their long

¹² The preamble of the UNCRPD states "Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others," <http://www.un.org/disabilities/convention/conventionfull.shtml>, preamble, paragraph e. Date accessed: February 12, 2017.

See also Arneil and Hirschmann 2016, 11 (unpublished manuscript).

¹³ See Anita Silvers, David Wasserman, and Mary Mahowald. 1998. *Disability, Difference, Discrimination*. Lanham, Md.: Rowman and Littlefield.

association with medical thought. First, I trace how our conceptions of female anxiety have evolved from hysteria: a mental and physical ‘disease,’ which links ‘female irrationality’ to female anatomy, encapsulated in the notion of the ‘wandering womb’ (Veith 1965). I argue that historical portrayals of hysteria not only overtly objectify and sexualize female patients: they also typecast anxiety as a distinctly ‘female malady,’ depicting women as overtly emotional, ‘hysterical,’ and thereby incapable of self-control and rational decision-making.

Secondly, I examine current psychiatric practices through a gendered lens, looking at how psychiatry continues to pathologize femininity by locating anxiety as a naturally occurring disorder within the woman, as opposed to a condition that is in part, socially constructed (Ussher 2010). Then, drawing on the work of Barbara Arneil, Eva Kittay, and Licia Carlson, and others, I explore how the theme of female irrationality, as espoused in historical psychiatric discourse, is endemic to political theory scholarship. These, and other thinkers argue that a problematic binary exists in Western liberal thought between the ‘rational’ citizen and the ‘irrational other.’ Liberal thinkers who associate citizenship, and even personhood, on the basis of ‘reason’ and ‘capacity,’ will, by definition exclude those whose mental facilities do not meet this standard (Arneil 2016, 6-7). This includes the ‘irrational’ anxious female, who is ‘incapable’ of making levelheaded decisions.

This outcome is significant as it demonstrates that despite its intentions, liberalism has failed to create a universal, inclusive theory of citizenship (Arneil 2016, 6-7). Employing Arneil’s critique of Kant, Taylor, Locke and Rawls, in the second half of Chapter Two I will argue that negative images of mental disability are endemic to modern political thought: liberal political theory has a well-established history of constructing the ‘irrational,’ mentally unstable ‘other’ in opposition to the ‘rational’ citizen (Arneil 2009). Ironically, the predisposition of men

- oft associated with testosterone, namely anger/violence (which is also a form of instability) - is way more dis-abling to society than anxiety. And yet, for so many centuries, ‘citizens’ were - by definition – males.

At base, these negative images perpetuated by psychiatric discourse and liberal theory continue to influence our conceptions of female anxiety. The centuries old idea that women are constrained by their physicality and emotional instability in ways that limit their contribution to society (compared to men) may seem grossly outdated; however, cultural world worldviews of the past still influence current thought, even when they have been rejected in many domains. Sexism can be public, as the Price/Van Badham ABC Q&A saga demonstrates, however, most of the time these attitudes have impacts in ways that are not necessarily seen or acknowledged. Admittedly, at least in the Western world, we have made significant headway in legislating against sexism and discrimination. However, in practice, there are still fundamental, deep-rooted cultural attitudes that need to change, as well as gendered psychological assumptions that ‘anxiety’ is a ‘disorder’ entirely contained within the individual, as opposed to in some part a product of her environment.

To this day, the word ‘hysterical’ remains reserved almost exclusively for women. Furthermore, society continues to associate ‘masculine’ traits such as reason, individuality and assertiveness with success, while the feminine virtues of caring and connectivity remain undervalued, and oftentimes seen as a barrier to a woman’s career progression. Anxiety, I argue, is in many ways a natural response to having to navigate a patriarchal world. Problematically, anxiety is self-perpetuating, and often affects people with low self-esteem (Freeman and Freeman 2013), paradoxically oftentimes arising because the person has high expectations of self, or of the self’s obligations with respect to others; hence, when society teaches women that

they are innately more inclined to ‘hysteria’ than men, they are more likely to experience anxiety that typifies them to be that way.

So what can be done about this? While not wishing to deny that anxiety can be debilitating, if not tragic, for sufferers and their families, I argue that it is important to focus on anxiety’s positive dimensions,¹⁴ the reasons for which are twofold. First, this is a necessary step toward acknowledging the agency, voices, and identity of those who experience anxiety beyond what society may regard as normative; and secondly, as I shall expand in Chapter Three, this thesis argues a focus on the transformative capacity of anxiety supports the call by prominent feminist scholars to break down and redraft the current bounds of conventional liberal political theory. Because anxiety can also be ultimately empowering, and a form of difference and diversity, I conclude that while psychological therapy may be a useful tool for many, its use must not become the prism through which an individual’s identity is defined.

By reconceiving political theory through care ethics, I hope to build a case for inclusion and citizenship of those who have previously been marginalized as a result of their perceived irrationality. A key component of my argument is that although some forms of anxiety can be rationally experienced or explained, the ‘irrational’ or ‘hysterical’ forms of anxiety also have the capacity to be enabling once heeded and understood. To view anxiety through a parochial, rational lens ignores the inner meanings and positive traits – empathy, care, critical and interpretive insight, creativity, self-knowledge and awareness – that, not all, of course, but many ‘excessively’ anxious people may possess. In order to reconceptualize anxiety, I propose that we replace conventional liberal theory with Arneil’s concept of interdependence: a theoretical

¹⁴ In a similar vein, ‘crip’ theorists such as Robert McRuer (2006) have focused on reclaiming the positive aspects of disability. McRuer rejects rehabilitation as a form of silencing, instead encouraging the disabled to “come out” and embrace their difference as a key part of their identity.

solution for breaking down the classical liberal binaries created by the overly rigid juxtapositions of autonomy/independence/justice and disability/dependency/charity (Arneil 2009, 234).

Interdependence is an important concept for anxiety in that it facilitates both dependence and independence: while anxiety sufferers will inevitably at some point rely on the care of others, they are often also self-reliant, industrious, and the foremost amongst caregivers themselves. The notion of interdependence therefore recognizes that people with anxiety can enter into mutually supportive, symbiotic relationships with those around them.

Chapter 2: Female anxiety: a history

2.1 Hysteria as a precursor to anxiety

To properly understand anxiety as a distinctly female condition, it is first necessary to trace its history. For several millennia, mental health victims have been branded with a pathological, chameleon-like condition broadly labeled as *hysteria*. Although no longer recognized as a condition today, “conversion hysteria” was listed as an identifiable and specific clinical disorder in both the first and second editions of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, and was not excluded from the APA’s diagnostic and statistical manual until 1980 (Devereux 2014, 19). The American Heritage Dictionary of the English Language (2016) defines the condition as:

n.

1. Behaviour exhibiting excessive or uncontrollable emotion, such as fear or panic.
2. A group of psychiatric symptoms, including heightened emotionality, attention-seeking behaviour, and preoccupation with physical symptoms that may not be explainable by a medical condition. The term hysteria is no longer in clinical use, and such symptoms are currently attributed to any of several psychiatric conditions, including somatic symptom disorder, conversion disorder, and histrionic personality disorder.

The earliest records of this ‘disease’ date back to Ancient Egypt: the Eber Papyrus (1600 BC), which is the oldest medical document detailing depressive syndromes, charts a range of hysterical disorders, with symptoms including tonic-clonic seizures (a type of generalized seizure, today commonly associated with epilepsy) and a feeling of suffocation¹⁵ (Tasca et al 2012, 110). By definition, this ‘disease’ was almost exclusively attributed to women.¹⁶ Ancient

¹⁵ Aka Freud’s globus hystericus.

¹⁶ It is however, important not to overlook (the albeit significantly smaller) cases of male hysteria, notably in the wake of the two World Wars (see Showalter 1985). The diagnosis of male hysteria was made possible in the late eighteenth century, when the causes of the disease were expanded to include issues of the nervous system

practitioners believed that disordered emotional behaviour resulted from spontaneous uterine movement, and was best treated by using therapeutic measures to force the uterus back to its natural position (Sigerist, 1951). The term *hysteria* is usually attributed to Hippocrates, and derives from the Greek *hystera*, or “uterus” (Veith 1965, 1).¹⁷ In *Sicknesses of Women*, he describes the uterus as an uncontrollable organ that moves around the body, causing hysterical symptoms such as anxiety, tremors, breathing difficulties, and even paralysis (Phillips 2006, 64).

For Hippocrates and other canonical thinkers including Plato and Aristotle, female madness could be attributed to a lack of sexual fulfillment (Tasca et al 2012, 110). Plato writes in *Timaeus* that the uterus is disturbed and incomplete when it does not join with the male to create offspring (Sigerist, 1951). This idea stems from the Greek myth of the Argonaut Melampus, considered the ‘founder’ of psychiatry (Tasca et al 2012, 110). The story goes that Melampus, a physician, is able to cure hysterical virgins of their “uterine melancholy” by giving them hellebore and encouraging them to engage in carnal activity with young, strong men (Sigerist, 1951).

Associating hysteria with the female reproductive organs was in essence an acknowledgment of the malign effect society perceived ‘disordered’ sexual activity to have on a woman’s emotional stability (Veith 1965, 2). Although no longer recognized as a disease by contemporary psychiatrists, the image of a ‘wandering womb’ causing physical and emotional symptoms has been used for centuries “as a dramatic medical metaphor for everything that men

(Showalter 1997, 15). It has, however, always been considered a ‘female malady’ that is inseparable from the traits of femininity (Ussher 2013).

¹⁷ English classicist Helen King has since questioned traditional accounts of “Hippocratic hysteria” in her essay “Once upon a Text: Hysteria from Hippocrates” in *Hysteria Beyond Freud* (1993). King finds that the term *hysteria* never actually appears in pertinent classical texts; instead she only finds statements referring to the *hystera* (uterus). King discovers that the term itself was actually coined by mid-nineteenth century Frenchman Emile Littré who, after producing an influential translation of the Hippocratic corpus, assembled an array of symptoms under the diagnostic term hysteria.

found mysterious or unmanageable” in women (Micale 1989, 320). Even as late as the nineteenth century, the dominant viewpoint still associated female instability with female reproductive organs. Victorian women were encouraged to control their menstruation¹⁸ to ward off insanity (Phillips 2006), and it was common also for women to carry toxic smelling salts in their handbags to alleviate hysterical symptoms, namely fainting.¹⁹ The belief, again postulated by Hippocrates, was that the pungent odour would repel the wandering uterus, forcing it to return to its proper place so that the woman would regain consciousness (Leff 1981). Nineteenth century practitioners counted faintness as one of many hysterical symptoms: other common traits include nervousness, sexual desire, insomnia, muscle spasms, irritability, irrationality, and a ‘tendency to cause trouble’ (Maines, 1998).²⁰ On the whole, Victorian physicians were highly critical of the female ‘malady,’ describing hysterical women as difficult, narcissistic, labile, craving sympathy, and possessing an ‘unnatural’ desire for privacy and independence (Smith-Rosenberg 1986, 202; Donkin 1892).

Although the image of the ‘hysterical woman’ dates back millennia, it was not until the end of the eighteenth century that madness came to be seen as inherently female (Showalter 1985, 8). This change can arguably be attributed to changing societal attitudes toward madness brought about by the Enlightenment. According to Foucault, this “new age of positivism” was the first to “separate the innocence of unreason from the guilt of crime”: leading people to

¹⁸ Showalter (1985) argues that efforts to control the female reproductive cycle indicated male psychiatrist’s fear of female sexuality.

¹⁹ Attributed by some commentators to overly tight corsets, which possibly did cause a ‘wandering womb’, in that it resulted in an unhealthy constriction of female organs.

²⁰ The list is non-exhaustive, as hysteria has never been definitely diagnosed. In fact, American neurologist and inventor of the infamous “rest cure”, Silas Weir Mitchell, was so baffled by patient fits, paralyses and unexplained emotional instability, that he dubbed the disease “mysteria”: the “nosological limbo of all un-named female maladies” (quoted in Sicherman 1977, 41).

perceive the mad as no longer akin to animals, but as deserving of sympathy (Foucault [1973] 1988, 221-2). Foucault remarks how psychologists and historians began protesting against the imprisonment of mad “unfortunates” next to criminals, which resulted in tide-turning events such as French physician Phillippe Pinel’s liberation of the insane. Pinel, who in 1774 famously freed the ‘madmen’ from the Bicetre prison and relocated them in asylums, was instrumental in developing a conscience-based moral therapy approach to dealing with the mentally ill (Foucault [1973] 1988, xii; 241-2).

Although hailed as a pivotal step toward a more enlightened society, Foucault questions the ‘humanitarian’ motives behind this so-called liberation, as in many ways asylums were as oppressive as prisons. For all the talk of liberation, mad people were really more like prisoners: patients remained confined; both literally, through being detained within an asylum, and figuratively, in being designated ‘mad.’ Madness was still silenced, and in many ways what was worse, was that it was now observed and controlled through a process of surveillance and judgment. Foucault writes that:

[Pinel’s asylum is a] juridical space where one is accused, judged, and condemned, and from which one is never released except by the version of this trial in psychological death – that is, by remorse. Madness will be punished in the asylum, even if it is innocent outside of it. For a long time to come, and until our own day at least, it is imprisoned in a moral world.

(Foucault [1973] 1988, 269).

An important point that Foucault does not speak to in *Madness and Civilization* is that the irrationality and ab-normality silenced and confined by the asylum, was disproportionately female (Showalter 1985, 6). It was around this time that “the appealing madwoman gradually

displaced the repulsive madman, both as the prototype of the confined lunatic and as cultural icon” (1985, 8). This resulted in plentitude of representations of female insanity in art and literature, with works such as George Dyer’s sonnet *Written in Bedlam: On Seeing a Beautiful Young Female Maniac* (1801) profoundly influencing cultural perceptions linking femininity to madness (Phillips 2006, 54). Hysteria, once attributed to female biology, came to be associated with ‘feminine’ personality traits more generally: the diagnosis was in essence a caricature of the attributes that would otherwise be considered ‘attractively feminine’ (Showalter 1993, 286). French physician August Fabre claimed in 1883 that as a “general rule...all women are hysterical and...every women carried with her the seeds of hysteria,” (1883, 3). These cultural attitudes in turn influenced asylum admission numbers: prior to the mid-nineteenth century, the majority of asylum inmates were men; however, by 1872, 31,822 out of 58,640 ‘certified lunatics’ in England and Wales were women (Showalter 1985, 52).

Perhaps the most significant change marked by the creation of the asylum was the birth of psychiatry, and the newfound role of the physician. Foucault describes how the move to more ‘enlightened’ treatment gave the physician moral, as well as medical authority. Wearing the “mask of father and of judge,” his role was to use his “distinguished education” to act as a “mediating element between reason and madness”: a position that enabled him to exert extraordinary power over his inferior patient (Foucault [1973] 1988, 272-3; 251).

This power was, and in many ways still is, profoundly patriarchal. The ‘moral management’ approach was common practice: female patients were encouraged to assume domestic tasks performed by ‘ordinary’ women, and they were punished for not being lady-like/not caring about their appearance. Elaine Showalter describes how in Friern Hospital in Colney Hatch, London women were “sedated, given cold baths, and secluded in padded cells, up

to five times as frequently as male patients (1985, 81). “It is worth remembering,” Foucault remarks in *The History of Sexuality*, “that the first figure to be 'sexualized' was the 'idle' woman. She inhabited the outer edge of the 'world,' in which she always had to appear as a value, and of the family, where she was assigned a new destiny charged with conjugal and parental obligations. Thus there emerged the 'nervous' woman...In this figure the hysterization of woman found its anchorage point” ([1976] 1978, 104).

Asylum doctors were perhaps the most oppressive when they sought to control and restrict female sexuality. Prominent nineteenth century gynecologist and obstetrical surgeon, Dr. Isaac Baker Brown devised an extremely invasive procedure, clitoridectomy (the removal of female external genitalia) on the basis that masturbation caused female insanity. Many of Brown’s female patients were considered mad because of disobedient non-submissive behaviour: he made a point of selecting women for surgery who had expressed their desire to utilize the newly introduced 1857 Divorce Act (Phillips 2006). Brown’s career ultimately ended when he was accused of performing procedures without consent, leading to his expulsion from the Obstetrical Society of London (Phillips 2006, 55).

Although Brown lost his position for ‘misusing male authority’ (Phillips 2006, 55), his dismissal did not mark the end of invasive ‘treatment’ for female mental illness. Several feminist theorists including Showalter (1985) have described psychiatry as an inherently patriarchal system that seeks to control the female body and sexual autonomy. Returning our focus to hysteria more specifically, a popular Victorian method for treating the condition was to massage the patient’s vulva, a procedure that dates back to classical antiquity. The rationale was that through reaching climax, the womb would be brought back into a ‘neutral’ condition. Because such an act does not involve phallic penetration, it was not believed to be sexual, an incredibly

male-centric view of sexuality. Such treatment was so popular that the procedure became mechanized with Joseph Granville's invention of the vibrator in the 1880s (Parker 2013). The fact that the vibrator originated as a psychiatric tool speaks to Foucault's observation that the woman was not only 'othered' through psychiatry, but also profoundly sexualized. The idea of Victorian physicians routinely committing what we would nowadays consider sexual assault is remarkable in itself, but the fact they devised a tool to facilitate this abuse – is even more so.

Although hysteria had been recognized and treated for centuries, it was only properly conceptualized as a medical condition, whose symptoms would later be included in the first DSM (1952), in the late nineteenth century (Devereux 2014, 23). Up until this time, medical conceptions of hysteria hovered somewhere between the psychological and biological. French neurologist Jean-Martin Charcot was one of the first people to reconceive the female 'malady' as a neurodegenerative syndrome. Through a series of publications and lecture demonstrations at the Salpêtrière Hospital in the 1880s Charcot successfully disentangled hysteria from its superstitious associations, reframing the condition as just another subject of neuropathology (ibid, 23). However, it was Charcot's student, Sigmund Freud who in the following decade brought newfound attention to the 'disease.' Foucault argues that "all nineteenth century [psychiatric history] really converges on Freud," as he was the first person to recognize the significance of the doctor-patient relationship ([1973] 1988, 277). Although Foucault commends Freud for helping demystify asylum structures, he also observes that Freud amplified the magical powers of the medical personage, paving the way for its "omnipotence as a quasi-divine status" (ibid, 277).

Inspired by Charcot and French neuropsychiatrist Pierre Janet,²¹ Freud theorized that neurotic patients generally suffer emotional tension arising from an unconscious source of repression/trauma, and that this tension may manifest itself in physical symptoms (Phillips 2006, 68). His studies mark a crucial turning point, as previously hysteria was believed to stem from a lack of conception/motherhood. Freud, however, posits the reverse: hysteria results from the suppressed trauma caused by a stunted libidinal process (pre-empting the Oedipal conflict). Hence, a failure to conceive is a symptom, not the cause, of the disease (Pérez-Rincón, 2011). In 1895 Freud published *Studies on Hysteria* with Joseph Breuer, where he proposed that an original trauma could be made to resurface through hypnosis, causing hysterical symptoms to disappear (Phillips 2006, 68). Although the core concepts of his psychoanalytic theory (the impact of childhood sexual fantasies/experiences, and the workings/motives of the unconscious mind) had yet to be formulated, they are implicit in this work (Tasca et al 2012, 115).

Studies in Hysteria traces Breuer's discoveries treating Anna O. Anna was an intelligent young woman who wished to attend university, but her family compelled her to stay home and care for her father who had tuberculosis. When her father passed away, Anna began to experience hysterical symptoms including headaches, a severe cough, muscular rigidity, speech difficulties, insomnia and hallucinations (Phillips 2006, 68). Breuer developed a method of treatment where he asked her to recount her thoughts and fantasies, which Anna named the "talking cure." When hypnotized, Anna was able to recall events that had occurred while she was caring for her sick father, an emotionally fraught time. According to Breuer, Anna's physical symptoms were a manifestation of these repressed traumatic events. Remarkably, after recalling

²¹ Pierre Janet (1859-1947) was one of the first psychiatrists to explore using hypnosis as a model for treating hysterical symptoms, primarily dissociation. See Haule 1986.

and verbalizing her original trauma, Anna's hysterical symptoms, at least temporarily, disappeared (Phillips 2006, 68).

The case of Anna O has prompted vigorous debate among feminist scholars. Foucault views psychoanalysis as a progressive step in psychiatry in that it advocates a dialogue with madness, whereas previously the mad were silenced (1973, 278). However, he concludes that while psychoanalysis can decipher some of the forms of madness, ultimately it is unable to hear the validity of voices that lie behind what manifests as unreason, thus cannot truly be a source of liberation (1973, 278).

On the other hand, one may argue Breuer's study demonstrates how women's so-called symptoms, which are in fact non-verbal means of communication, can be recognized and valued. Through uncovering Anna's lived experience, Breuer saw how being denied a university education and forced to live a life of domesticity stifled his patient's intellectual and creative potential (Phillips 2006, 70). Showalter posits that by actively experiencing/listening to Anna's repressed psychical tension, Breuer was able to enter "a female world of consciousness repressed by patriarchal structure, the world of the unconscious" (1985, 157).

In a similar vein, some feminists have sought to reclaim hysteria, claiming that hysterical symptoms echo a feminine protolanguage that can be used as a form of resistance against patriarchal oppression (Showalter 1993, 286). As Hunter posits, hysteria can be viewed as "feminine discourse in which the body signifies what social conditions make it impossible to say linguistically" (Hunter 1983, 474).

Showalter, however, is against romanticizing the female malady. "Hysteria has taken many strange turnings in its long career," she writes, "but one of the most surprising is the modern marriage of hysteria and feminism" (1993, 286). She has several reasons to be wary.

After all, up until the time she was writing, stories about hysteria were predominately told by men: women's perspectives, if not silenced, were at the least, retold from a male perspective. Ultimately, she questions whether hysteria can truly be an effective form of subversion. After all, the hysteric's form of communication is usually indiscernible because it is outside the realms of reality and culture: you could argue in Lacanian terminology that it is outside the Symbolic, thus remains in the Imaginary (Cixous and Clement [1975] 1986, 154). "Hysterics," Showalter claims, actually "reinforce the social structure by their preordained place on the margin" (1993, 332). They do not "break through [their] private language and act" unless they pursue another form of feminist social engagement (333).

Although Showalter's critiques have historical validity, most are now out-dated: I argue that women today largely do have the agency, resources and outreach to 'reclaim' hysteria in the name of feminism. However, Showalter's most important point still stands: that we must not overlook the extent to which psychiatric and psychoanalytic treatments have been used to exploit and further marginalize 'hysterical' women (1993, 286). The fundamental problem with Freud's psychoanalysis is that rather than seek to uncover women's status as oppressed within society; it instead focuses on attaching sexual meanings to hysterical symptoms (Phillips 2006, 70). By suggesting that women's repressed traumas were in fact fantasies of being seduced by their fathers, Freud's theory shifts the blame from an external perpetrator to the 'sexually repressed' hysterical women themselves.

Feminists such as H el ene Cixous have taken issue with Freud's study of eighteen-year old "Dora" (Ida Bauer) in 1905, arguing that his conclusions here reinforce sexist and patriarchal attitudes (see Cixous 1976). Dora came to Freud with an accusation that her father's friend, Herr K., had made unwanted sexual advances toward her beside a lake. Herr K. denied these

accusations and Dora's father told Freud that his daughter had fabricated the incident, mentioning that his daughter had become overexcited after reading books on the physiology of love (Freud [1905] 1977, 26). From this Freud concluded that Dora's physical symptoms of choking and nausea were a result of her feelings of disgust: a disgust that was in fact pleasure in disguise. He suggested that Dora's hysterical symptoms stemmed from repressed sexual desires for both her father and for Herr K., intensified by her jealousy associated with her father's relationship with Frau K. (Herr K.'s wife). Dora broke off her therapy as a result of this interpretation (Phillips 2006, 74). Although Freud was sympathetic to Dora, her case undoubtedly highlights the sexist foundations of his theory. Problematically, it signifies the coercion of a young female patient by a person who reposes trust and confidence. Instead of being perceived as a potentially vulnerable victim, Dora is cast as a deceitful and sexualized perpetrator, in turn absolving the men involved of any guilt. Although Dora demonstrated agency by removing herself from the treatment, she was still silenced, and her body fetishized.

In the *History of Sexuality* (1976), Foucault describes the "hysterization of women's bodies" as a paradigm example of psychiatric power. Hysterization, he claims, was a "a three-fold process whereby the feminine body was analyzed . . . as being thoroughly saturated with sexuality; whereby it was integrated into the sphere of medical practices, by means of a pathology intrinsic to it; whereby, finally, it was placed in organic communication with the social body . . . the family space . . . and the life of children; the Mother, with her negative image of 'nervous woman,' constituted the most visible form of this hysterization" ([1976] 1978, 104).

Similarly, ex-psychiatric nurse turned academic, Louise Phillips observes that British psychiatry in relation to women has "consistently focused upon the body and its observation". She remarks that: "interventions for depression and schizophrenia prevalent in the 1950s and

60s, such as insulin therapy, epileptic shocks and ECT (electroconvulsive therapy)” were “all treatments aimed at affecting the body in order to treat the mind” (Phillips 2006, 5). Some of the cruelest and most invasive (and ineffective) procedures included ovariectomies, the removal of the ovaries to treat ‘deviancy’ ‘madness’ or ‘hysteria,’ and pre-frontal lobotomies, which left patients zombie-like, completely devoid of character (Parker 2013).

One woman to narrowly avoid being lobotomized was celebrated New Zealand author, Janet Frame, ONZ CBE. Frame was admitted to Seacliff Hospital Dunedin, New Zealand in 1945 following a mental breakdown, and was subsequently diagnosed with schizophrenia. After attempting suicide she spent eight years in and out of psychiatric institutions, receiving 200 electroshock treatments (Douglas 2004). She was scheduled to have a leucotomy only to be taken off the list at the eleventh hour upon notice that she had won a literary prize. In 1957, her diagnosis of schizophrenia was reversed: it was believed her mental struggles were the result of years of invasive ‘treatment’ in New Zealand psychiatric hospitals (ibid).

Provocative theorist and member of the anti-psychiatry movement, Bonnie Burstow describes the practice of psychiatry as a “regime of ruling” (to use Dorothy Smith’s Foucauldian-inspired terminology) (1987, 2005). As the “only profession allowed to incarcerate people who have committed no crime,” Burstow argues that psychiatry and its discourse exercise hegemonic control over its subjects. She laments how a person is labeled “schizophrenic,” or “of danger to self or others,” purely because a medical official has made a diagnostic “performative utterance” (Burstow 2013, 80). Janet Frame’s voice might have been silenced, and yet she went on to write award-winning novels such as *Owls Do Cry* and *Faces in the Water*. These compelling works poignantly explore the plight of the mentally ill, offering a radical critique of society and its institutions. Showalter may argue that Frame is only a feminist heroine because she subsequently

engaged in subversive actions through her writing; however, I argue that it was the combination of Frame's hysteria, her dual struggles with oppression and the inner workings of her mind, and her eventual success, that make her actions so powerful. Although Frame viewed mental illness as an integral part of her identity, the medical profession sought to silence this unique part of her through acts of diagnosis and categorization. However, in the end, Frame's anxiety was transformative, not only of herself, but through her novels and experience, of many others.

To summarize, this section has traced the turbulent history of anxiety's precursor, hysteria, a female 'malady' that dates back to classical times, yet gained newfound attention in nineteenth century Britain. I have demonstrated how physicians used this catchall condition to contain and control 'unmanageable' women, inflicting many forms of invasive, if not harmful, treatment, which would nowadays be considered sexual abuse. In this next section I will trace how hysteria evolved to become anxiety, examining how the idea that women are constricted by their emotional instability continues to influence psychiatric practices, although perhaps in more subtle and unconscious ways.

2.1.1 The shift to anxiety

Most twentieth century women who are psychiatrically labeled, privately treated and publically hospitalized are not mad...they may be deeply unhappy, self-destructive economically powerless, and sexually impotent – but as women they're supposed to be.

- Phyllis Chesler, 1972. *Women and Madness*. New York: Doubleday, 25.

At what point did hysteria become anxiety? As stated earlier, the term hysteria was removed from the DSM-III in 1980,²² and has now been completely abandoned by medical professionals

²² The DSM-III replaced 'hysterical personality disorder' with 'histrionic personality disorder', however even then, a typical patient was depicted as a feminine caricature: aka someone who is "typically attractive and

(Devereux 2014, 19). Hysteria diagnoses (and their corresponding Victorian attitudes) were, however, common well up into the twentieth century (Tasca et al, 2012). Even as late as 1968, the DSM-II entry for ‘hysterical personality disorder’ listed a series of traits that were essentially a “caricature of exaggerated femininity” (Jimenez 1997, 158). According to the DSM-II, hysterics are “attention seeking, seductive, immature, self-centred, vain ... and dependent on others,” and experience ‘symptoms’ including emotional instability, over-reactivity, and self-dramatization (APA 1968, 251). Freudian psychoanalysis also dominated psychiatric theory right up until the 1960s, as physicians continued to associate female-dominant ‘neurotic disorders’ with Oedipal notions of gender development. The DSM-1 (1954), for example, holds that ‘mental disorders’ result from early parent-child experiences that become internalized through unconscious processes (Metzl 2003, 39).

Although women continued to be disproportionately treated, diagnostic approaches changed slightly in the wake of the two World Wars, as, for the first time, a significant number of men came to be diagnosed with this ‘feminine’ complaint. A soldier facing the prospect of either death or the shame of being considered a coward, might become overcome with emotion, and develop hysterical symptoms as a means of escaping the conflict (Leff 1981). Although there have been far fewer cases of male hysteria, it is important to remember that men too, have been the victims of oppressive gender norms: to this day, male anxiety is still largely culturally repressed. As Showalter (1985; 1993) emphasizes, many wartime physicians treated soldiers suffering from shellshock with “great brutality” for failing to exhibit male stoicism.

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” (APA 1980: 348, cited in Ussher 2013, 65).

By the second half of the twentieth century, however, the number of hysteria cases dropped significantly (Tasca 2012). For example, between 1949 to 1978 in England and Wales, annual psychiatric admissions for hysteria dropped by nearly two-thirds, with a marked decrease from 1971 onwards (Leff 1981). Hysteria's decline has ultimately been attributed to growing feminist backlash, as well as advancements in diagnostic techniques, as the condition came to be replaced by a series of now common depressive, anxiety and dissociative disorders (Micale 2000, 4-6).²³ Many cases of the disease, which was once used as a catchall diagnosis for a range of ambiguous cases, have since been re-labelled as other conditions such as schizophrenia, borderline personality disorder, conversion disorder, and anxiety attacks (Costa and Lang 2016).

So if women are no longer diagnosed with hysteria, and no longer subjected to cruel and invasive treatments such as ovariectomies and lobotomies, can we really claim psychiatry still pathologizes femininity? It cannot be denied that societal changes in the 1960s and 1970s have changed the way we perceive gender roles, in turn giving women more freedom and opportunities in terms of work, sexual, and family relations. Women, at least in the Western world, are more liberated than ever before, which has undoubtedly contributed to hysteria's decline as a diagnostic category (Ussher 2013, 65). This is not to mention the change resulting from feminists' insistent critique of 'hysteria' as a legitimate medical diagnosis, as opposed to a socially constructed and sexist stereotype.

However, there is ample evidence to suggest that women continue to be pathologized by psychiatric practices. The World Health Organization recognizes the gender bias present in the treatment of psychological disorders, noting that doctors are more likely to diagnose women with

²³ Hysteria's decline was marked by an inverse relationship whereby rates of depression and anxiety (in Western society) increased (Tasca et al, 2012).

depression than men, even when their symptoms are identical.²⁴ Similarly, in their research on male and female emotions, Lisa Feldman Barret and Eliza Bliss-Moreau find that men's misery and anger tended to be associated with related factors – such as 'having a bad day' – whereas women who are angry/sad are more likely to be labelled 'emotional,' that is, their experience is more likely attributable to internal factors (Barrett and Bliss-Moreau, 2009).

One such example of the medicalization of women's misery is the controversial inclusion of premenstrual dysphoric disorder (PMDD) in the DSM-5. Women who experience psychological premenstrual changes, notably anxiety, heightened emotions, anger, irritability and depression, can be diagnosed with PMDD. However, the fact that premenstrual distress is often strongly associated with a women's relational context, and that such 'symptoms' are often experienced as a reaction to over-responsibility, communication problems, and the absence of partner support, is unaccounted for in bio-medical accounts of this condition (Ussher and Perz, 2012). Feminists have opposed the pathologization of menstrual distress on the basis that there is no biological validity for including PMDD as a distinct 'mental illness' (Cosgrove and Caplan 2014). Rather, they argue that premenstrual change is an expected part of the female experience, which is only constructed as PMDD because in Western society we associate this phase of the cycle as a period of emotional disturbance (Ussher 2013, 65), that is possibly unsettling for men/others. By contrast, in Eastern cultures such as China, where such biological change is normalized, women may claim to experience premenstrual pain and fatigue, but rarely report premenstrual misery (Yu et al., 1996).

This relates to the wider psychiatric trend of medicalizing normative variation by increasing the number of medical 'disorders' with which people can be diagnosed (Welch et al,

²⁴ See: http://www.who.int/mental_health/prevention/genderwomen/en/. Date accessed: February 5, 2017.

2013). With each new edition of the DSM, the overall number of disorders increases, expanding from 106 in the DSM-1 (1952) to over 300 diagnostic categories in the DSM-5 (APA 2013). The inflation of diagnostic categories serves to benefit pharmaceutical companies,²⁵ who, acting in conjunction with psychiatry, seek to legitimize medical treatment for “common personal and social problems” (Double 2002, 900). It also relates to the insurance industry, as those seeking support from therapists in the U.S can claim medical insurance only in those instances where an expert attributes them with a diagnosable condition. Critics argue the pharmaceutical industry engages in a process of ‘disease mongering,’ actively encouraging consumers to self-diagnose, and consume medicine to treat ‘ordinary ailments’ (Moynihan et al., 2002: 324).

Contributing to this pattern of self-pathologizing is the DSM’s essentially binary approach to diagnosis, whereby you either met the criteria for mental illness or you not: there is no such thing as ‘slight anxiety.’ Freeman and Freeman, who instead advocate a dimensional approach to psychiatric nosology, argue that this “all-or-nothing attitude,” with “hundreds of separate conditions,” does not align with “people’s real life experience of psychological problems (Freeman and Freeman 2013, 62). Indeed, as I have stated earlier, anxiety is much better viewed as a spectrum ranging from the fairly un-troublesome to the severely debilitating. However, because the DSM fails to acknowledge any degree of variation, many women feel the need to go to the medical extreme in order to have their experiences recognized.

Feminist theorists are wary of this trend, arguing that psychological and biomedical theories of depression/anxiety place too much emphasis on using expert intervention to cure, or at least medicate, what they perceive to be essentially ‘biological’ (i.e., non pathological) or

²⁵ Several workgroup members involved in the formation of the DSM-5 were said to have had conflicting interests with the project, notably, ties to pharmaceutical companies. See Welch et al, 2013.

environmental-sociological conditions: insufficient attention is paid to the economic, political and discursive aspects of female experience (Ussher 2011; Lafrance 2009; Stoppard 2000).

In her book *The Madness of Women*, critical health psychologist Jane Ussher writes:

Women outnumber men in diagnoses of madness, from the ‘hysteria’ of the eighteenth and nineteenth centuries, to ‘neurotic’ and mood disorders in the twentieth and twenty-first. Women are also more likely to receive psychiatric ‘treatment’, ranging from hospitalization in an asylum accompanied by restraint electro-convulsive therapy (ECT) and psychosurgery, to psychological therapy and psychotropic drug treatments today. Why is this so? Some would say that women are more mad than men, with psychiatric treatment a beneficent force that sets out to cure the disordered female mind. I proffer an alternative explanation – that women are subject to misdiagnosis and mistreatment by experts whose pecuniary interests can be questioned, as can their use (or abuse of power).

- Jane Ussher, *The Madness of Women*. 2011. Hove: Routledge, 1.

Ussher doesn’t deny that many women suffer real psychological distress, and does not wish to erase women’s individual experience. However, she argues that it is more accurate to interpret this misery as a “reasonable response” to “restricted and repressive” lives, than as a sign of a medical ‘disorder’ (2011, 1-2). Indeed, sociologists such as Walter Gove and Jeanette Tudor have identified the expectation and experience of gendered roles as a key factor in the development of female anxiety and depression, claiming that “in modern Western industrial nations, women, because of stress associated with their sex roles, [have] higher rates of mental illness than men” (1977, 1327). Women today are expected to juggle work, raising a family, and running a household, with housework and child raising often consisting of repetitive, solitary, tiring and undervalued tasks - the kind of activity that is likely to have a dampening effect on one’s mood (Freeman and Freeman 2013, 12).

In addition to the pressures of gender roles, researchers have found that women who experience regular sexism or discrimination report higher levels of depression and anxiety than those who do not frequently experience sexism/are not often the subjects of discrimination (Belle and Doucet, 2003). Furthermore, the World Health Organization has acknowledged that there are

a range of gender-specific risk factors that make women disproportionately likely to experience mental illness, including socioeconomic disadvantage, gender-based violence, low or subordinate social status, and a continuing responsibility for the care of others.²⁶ Something I do not explore in this work, but is of vital importance (and worthy of further research), is how gender intersects with other identities such as race/ethnicity, and how these confounding factors might lead to even greater marginalization/discrimination: a Black woman is more likely to be othered and discredited than her White counterpart, thus arguably magnifying the chance of her developing feelings of isolation, anxiety and depression.²⁷

In sum, psychologists, feminists, political theorists and sociologists alike have identified a range of environmental factors that make women more susceptible to anxiety and depression than men. However, the leading medical authority, the American Psychiatric Association, continues to depict mental illness as a biological pathology situated within women themselves, advocating medical intervention over and above societal change.

2.2 Madness, ir-rationality and the age of reason: a legacy

I have so far made a case for the historical origins of hysteria as a gendered term, which far more recently gave way to gendered meanings imbuing of anxiety and its treatment, demonstrating something of the extent to which female anxiety sufferers have been discriminated against, if not abused, by psychiatric practices. This leaves the question, to what extent is political theory complicit in this repression?

²⁶ For more information, see http://www.who.int/mental_health/prevention/genderwomen/en/, Accessed February 5, 2017.

²⁷ While it is almost axiomatic that Black women will have a more challenging time navigating patriarchal power structures, recent research has showed that significant life events have a lower effect on depression among Blacks than Whites. See Assari and Lankarani, 2016.

Throughout Western political thought, liberal theorists have defined the *rational* autonomous citizen in opposition to the *irrational*, mentally ill ‘other’ (who is excluded from the social contract, and hence denied citizenship). This problematic distinction is a key focus of Barbara Arneil and Nancy J. Hirschmann’s recent volume, *Politics and Disability* (2016); a collection of essays from some of the leading scholars in the fields of political theory and disability. Drawing on the works of Locke, Hume and Rawls, Arneil (2016; 2009) makes the case that the key founders of Western political theory have explicitly excluded people with both mental and physical disabilities in their principles of citizenship. These exclusions have created a binary between the rational, physical-bodied, autonomous citizen who has rights under the principles of freedom, equality and justice, and the dependent, mentally and/or physically disabled ‘other,’ whose needs are governed under the principle of charity. The binaries of autonomy/justice and dependency/charity are premised on the belief that mental/physical disability is a negative defect caused by nature, precluding the possibility of a social model that views mental illness/disability as the product of one’s physical and emotional environment (Arneil 2009; 2016).

Arneil (2009) begins by tracing the two traditions in Western modern philosophy. First is the Anglo-American ‘liberal’ thread, as demonstrated by the works of Locke, Hume, and later Rawls. These thinkers have been strongly informed by the ideas of rational consent, rights, and ‘rough equality.’ Secondly, there is the Continental/republican tradition, encompassing theorists such as Rousseau, Kant, and later Taylor. This thread is informed by the ideas of general will, personhood (rooted in autonomy), humanity dignity, and self-rule. Although these two threads have subtle differences, they overlap in their emphasis on the centrality of the rational citizen, defined in opposition to the ‘lunatic,’ ‘mentally handicapped’ other (Arneil 2009, 221).

Underpinning the Anglo-American ‘liberal’ tradition is the idea that the ‘citizen’ must possess reason in order to consent to political authority. The problem with basing citizenship on an individual’s capacity to reason, however, is that it has concerning implications for the cognitively impaired (people with ‘irrational’ anxiety risk falling under this category). Locke, who was the first modern theorist to root his political theory in reason, is explicit that people with mental disabilities will never truly be ‘freemen,’ and thus like slaves, must be subject to a permanent form of patriarchal rule:

If through defects that may happen out of the ordinary course of Nature, anyone comes not to such a degree of Reason, wherein he might be supposed incapable to know the Law . . . he is never capable of being a Free Man, he is never let loose to the dispose of his own Will . . . And so Lunaticks and Ideots are never set free from the Government of their Parents (II: 60)
(As cited in Arneil and Hirschmann, unpublished manuscript (published 2016), 34)

Similarly, in the Continental/republican tradition, Kant holds that because autonomy is the basis of human dignity, those who are not rational and not ‘autonomous,’ and thus are not accorded the ‘dignity’ awarded to ‘rational beings’ (Arneil 2009, 225). Alarming, Charles Taylor, who is one of the leading thinkers of the politics of difference, develops this idea to form his own basis of humanity dignity. For Taylor, persons are separated from the handicapped on the basis that the latter only have the ‘potential’ for reason (Arneil 2009). By adopting Kantian theory that defines personhood on the basis of capacity for reason, Taylor, despite acting on the best intentions, is “forced to define those incapable of ‘rationality’ as outside the ‘normal’ meaning of personhood” (Arneil 2009, 225). This notion of ‘normal’ is highly problematic in that it is the implicit moniker of ‘abnormal’: suggesting that the mentally disabled or ‘irrational’ and somehow ‘deviants’ from the norm (Arneil 2009, 225). As I have demonstrated, both political theory and psychiatry have latched onto this concept of normalcy to construct mental illness as something ‘abnormal,’ whereas in reality, mental illness is both natural and

widespread: we are all likely to be affected by anxiety to varying degrees in our lifetimes. Thus, as disability theorist Lennard Davis rightly argues, we should redirect our focus to deconstruction the concept of ‘normalcy.’ Normalcy is an artificial and alienating concept that simply reflects the perceptions and ideals of the powerful. The ‘problem’ is not the person with mental illness/disabilities, it is “the way that normalcy is constructed by to create the ‘problem’ of the disabled (and/or mentally ill) person” (Davis 1995).

Returning our focus to the liberal canon, Rawls combines the major tenets of the liberal and republican threads to explicitly exclude the mentally and physically disabled from his original position. His grounds are that the disabled lack reason, are not ‘normal’, and are unable to fully participate in society:

For our purposes here I leave aside permanent physical disabilities and mental disorders so severe as to prevent persons from being normal and fully cooperating members of society in the usual sense.

(As cited in Arneil 2009, 227)

Upon an analysis of these foundational liberal texts it becomes apparent that the mentally and physically disabled (the latter who are often automatically also excluded without theoretical justification) have been explicitly denied citizenship rights. Excluded from the principle of justice, the disabled are thus rendered objects of pity to be governed by the principle of charity (Arneil 2009, 233).

These ideas perpetuated by liberal theory are still implicit, and have impacts in ways that are not necessarily seen or acknowledged. To this day, we associate authority and success with rational, self-serving individuals, whereas relational activities such as caregiving are usually poorly paid, and seen as inferior, subsidiary fields of work. Unlike their male counterparts, stressed women are often perceived as irrational and incompetent if they do not act calm and levelheaded - traits championed by liberal theory.

So what can we do about this? In the next chapter I will delve into greater detail about some of the shortcomings of liberal theory, ultimately proposing an alternative, inclusive theory of citizenship rooted in the concept of universal interdependence. An extension of care ethics, interdependence enables us to resist rationality, and instead embrace the parts of us that may be deemed hysterical/ir-rational.

Chapter 3: Reconceptualizing anxiety

3.1 Anxiety's transformative potential

I have so far discussed how liberal theory and psychiatry has helped perpetuate a negative view of female anxiety, reinforcing the age-old stereotype of the hysterical, 'irrational' woman. The prevailing medical approach is to view anxiety as something that needs to be 'fixed' through a process of medical intervention. In recent years, cognitive-behavioural therapy (CBT) has gained prominence as an alternative approach to medical intervention for dealing with depression and anxiety,²⁸ however, because of the powerful influence of pharmaceutical industries, and limited resources available for behavioural therapies, more times than not, it is easier for doctors to simply prescribe medicine, rather than tackle the problem at its root. Which brings me to my next point: even if CBT and other psychological treatments were more readily available, such approaches continue to situate the solution to anxiety/depression within the individual, as opposed to considering mental illness as a wider social problem. Consequently, the social and political inequalities that contribute to anxiety in the first instance remain unchallenged (Ussher 2010, 15).

I, personally, am skeptical as to whether you can ever truly 'cure' mental health issues. I talked about this with my friend Luke,²⁹ who has struggled with anxiety, depression, drug and alcohol dependence, and depersonalization on and off for many years. He, like me, was of the opinion that anxiety, like other mental health challenges, is more cyclical: it comes in waves, and can never be eradicated completely, however, it can be managed so that one may still live a fulfilling and meaningful life. I asked Luke if he could cure his anxiety and depression

²⁸ Many governments now recommend cognitive behavioural therapy, including those of the UK and Australia, as a first point of call for addressing depression (Holmes 2009).

²⁹ Name changed to maintain confidentiality.

completely, would he? Some may find this surprising, but he said he would not. Although there are times where Luke's anxiety causes him anguish and suffering, it is also an integral part of who he is: his anxiety is what enables him to empathize – to think and feel so deeply, and without it, he would feel as if he had lost a core part of his identity.

Nancy J. Hirschmann and Rogers M. Smith explore what they term the “politics of curing” in an essay in *Politics and Disability*. The authors contend that there is a key tension in disability studies (or in my case, mental health scholarship) over how we ought to respond to ‘impairment.’ Ought we be seeking to modify/cure a condition altogether? Or should we accept people the way they are, and instead look for ways to accommodate difference? (2016, 365). Hirschmann and Smith rightly point out that it is an over-simplification to present ‘accommodation’ and ‘cure’ as two starkly opposed options; however, they do make a compelling case for critically interrogating the meanings and ramifications behind the concept of ‘curing.’

The very notion of ‘illness,’ they argue, is intrinsically negative, and contains within it the desirability of a cure (Hirschmann and Smith 2016, 367). The dominant understanding of curing has its roots in restoring the body and mind to the Platonic ideal – a physically strong, rational, and productive state. This ideal, which Rosemarie Garland Thompson (1997) terms the ‘normate,’ stems from the presumption that disability, whether mental or physical, is a distortion of the norm, and if possible, ought to be eradicated. As Cathy Kudlick points out, the quest for a cure legitimates erasing disability without questioning established definitions of normality (Kudlick 2014). If 18% of Americans will develop an anxiety disorder in their lifetime (Kessler et al, 2005), can we really deem such a significant number of people ‘abnormal’?

Echoing my friend Luke, Harlan Hahn and Todd Belt (2004) found that many disabled people are reluctant to receive a 'cure' for their condition because it could threaten their affirming, self-constructed identities, of which disability is often at the core. In such instances, the costs of curing could outweigh the benefits (Hirschmann and Smith 2016, 394). As a reaction to the problems underpinning the notion of 'curing,' several disability scholars including Eva Kittay (who is also the mother of a severely cognitively disabled child, Sesha) have shunned the concept of entirely, instead arguing that our differences, whether physical or mental, add valuable diversity to society. Instead of seeking to be 'fixed,' many people who experience mental illness and disability simply wish for their differences to be accommodated, and to not have to fear exclusion from belonging. For example, many Deaf people do not wish to hear, they simply want to be able to have Deaf children and to be able to live in Deaf communities where being Deaf is not viewed as a disability, but as something to be embraced, much like cultural minorities (Hirschmann and Smith 2016, 394). While Deaf people might not consider themselves disabled, even those who do, still often see a lot of value in their diversity. In her book *Too Late to Die Young*, Harriet McBryde Johnson (2006) reflects on how her disability has given her greater insight and empathy into the human condition, and has helped her grow as a person.

The danger of solely focusing on anxiety as difference is that we risk discounting its potentially tragic consequences: we must not forget that mental illness can be debilitating for who experience it, and heartbreaking for loved ones. Therefore, I think it is helpful to think about 'treating' anxiety through the lens of 'rehabilitation' - whereby therapy is conceived as a tool that can be used to alleviate suffering, but not the paradigm that defines the individual (Arneil 2016, 46). If we are to understand disability or anxiety as something produced through an interaction between individual genetic predisposition and the wider environment, then it is

important to acknowledge that such conditions can be *both* a part of someone's identity, and *also* something which can interfere with one's life vis a vis community expectations and personal aspirations, and/or be very painful/debilitating. Thus, like Arneil, I view rehabilitation, treatment and educative therapy as possible tools that individuals may wish to access so to respond to their health condition(s) in order to enable full participating in society in diverse ways. Ultimately, it comes down to what the individual believes is best to improve his/her quality of life, while holding on to whatever it is that makes him/her unique.

Hirschmann and Smith similarly claim that it is possible to understand treatment/cure in a way that does not repudiate one's pre-cure identity (2016, 394). In fact, they argue that we need to remove the association of cure and eradicating an illness/disability entirely: a 'cure' "must be conceived as a transformation to a new state of being that will carry within it elements that result from both the condition and the cure" (Hirschmann and Smith 2016, 392). In sum, 'curing' anxiety and depression in the traditional sense, may be neither feasible, nor desirable. Instead, we should endeavour to support the management and accommodation of these conditions in a way that recognizes and embraces diversity.

So what is it about anxiety that is worth embracing? Several political theorists have sought to reconceptualize mental disability in a more positive light,³⁰ however Eileen Hunt Botting is one of the few political theorists to explore how anxiety, specifically, can be transformative. In Arneil and Hirschmann's edited volume, *Disability and Political Theory*, Botting seeks to challenge the perception of a rising 'epidemic' of female anxiety by proposing a social model of anxiety based on the works of Thomas Hobbes and Mary Wollstonecraft: two members of the canon of liberal thinkers who were progressive for their time in that they

³⁰ See Eva Kittay, Licia Carlson, Rosemarie Garland Thomson, and Lennard Davis, among others.

believed women's unequal social condition in relation to men is first and foremost a product of society, not a result of biological sexual difference (Botting 2016, 294).

Botting's social model seeks to re-cognize anxiety by re-framing it as a rational, as opposed to irrational, endeavour. While acknowledging that anxiety can be a harmful, disabling embodied experience (and that too strong a positive evaluation might result in further marginalization and lack of accommodation), Botting argues that women's anxiety has the potential to be empowering when understood as both a rational and emotional response to the challenges women face in a patriarchal society. According to Botting, Hobbes and Wollstonecraft are important resources for reconceptualizing women's anxiety in that they seek to reconcile the false binary between reason and emotion (ibid, 302-8). For both Hobbes and Wollstonecraft, anxiety is not antonymous with rationality, but rather is a fearful emotion that can be rationally felt: anxious people can use their rational faculties to predict danger and solve problems, and thus are experts at self-preservation (ibid, 308).

To properly understand how anxiety has been conceived in Western political thought, Botting firstly turns to Hobbes, who is the possibly the most influential philosopher of anxiety in that he argues that fear is a driving motivator of human behaviour (ibid, 293). Hobbes views anxiety as a central human cognitive capacity that can combine reason and fear into a forward-thinking problem solving skill. In chapter eleven of *Leviathan* he explains that:

Anxiety for the future time, disposeth men to enquire into the causes of things: because the knowledge of them, maketh men the better able to order the present to their better advantage.
(As cited in Botting 2016, 308).

As the political theorist Philip Pettit claims, this capacity for anxiety, combined with speech and reason, allows people "to take precautionary action against various dangers. It primes them to worry about the range of future possibilities" (Botting 2016, 308). Inspired by Hobbes'

political thought, Wollstonecraft proposes a similar understanding of anxiety to explore how women use their rational feelings of fear to navigate the challenges of patriarchy. Wollstonecraft contends that since women are not raised with freedom, they must rise above their sub-optimal social conditions. In her first book, *Thoughts on the Education of Daughters* (1787), she cautions that if anxiety of any sort is ‘concealed’ rather than revealed, it may ‘impair’ the constitution of girls (Botting 2016, 313). Women’s anxious awareness of socially constructed gender inequality is thus the first step toward their rational formulation of adaptive solutions for dealing with patriarchal oppression. The next step is to pool their “care and anxiety” for strategic advantage by channeling their problem-solving efforts for the benefit of their ‘sisters’ (ibid, 317).

However, it is important to note that Wollstonecraft is explicit that only *rational* anxiety has the power to be transformative. She views *irrational* anxiety as self-destructive because it does not seek to solve actual problems, but merely allows such problems to fester in the mind (ibid, 313). In sum, both Hobbes and Wollstonecraft argue that anxiety, when rationally felt, can be skillfully exercised to navigate social obstacles. Anxiety is beneficial if it contributes to an individual’s capacity for rational assessment of potentially harmful external circumstances.

Botting is to be commended for locating disability as partly a product of one’s social environment, and for seeking the ways in which anxiety can be used to fight patriarchal oppression. She makes some excellent remarks via Wollstonecraft about the power of pooling “care and anxiety” which align with my own insights on interdependence, as will be discussed later in this chapter. However, her social model is problematic in that it reinforces rationality’s hegemony. By situating anxiety within the masculine framework of rationality, she further

marginalizes women who experience non-rational anxiety.³¹ Under Botting's model, women only have legitimate agency when they use their anxiety for rational pursuits. Thus, like the many classical liberal thinkers before her, she elevates rationality at the expense of the non-rational. As Arneil asks, "why should 'rationality' be the defining feature of 'personhood'?" (Arneil 2009, 233). Although Botting's intentions are undoubtedly sound, she is effectively cherry picking the most competent of anxious women, women who can still be molded to conform to the Platonic ideal. Consequently, her social model encompasses only a small selection of people with anxiety: other forms of neurodiversity are implicitly deemed unworthy.

I take the stance that non-rational anxiety *also* has the power to be transformative. As theorist Juliet Mitchell asserts, women ought to "demand the right to be hysterical" (cited in Showalter 1993, 334). I would argue that what women really ought to demand is the right to be heard: the right to express suppressed pain, grief, frustration, and to have those emotions acknowledged. Anxiety, I thus contend, is an appropriate response to a world that is both irrational and patriarchal. Like the non-verbal utterances made by the hysterical women interviewed by Breuer, anxiety is, in many ways, a reaction against the discrimination women face in all aspects of their everyday experience.

This begs the question: can non-rational anxiety be reconciled with liberalism? As Kittay (2003) has argued, neurodiversity presents a major challenge to the liberal 'rational' ideal. If liberal thought repeatedly constitutes the 'rational' person in opposition to the 'irrational' other, then it is not simply a case of 'including' the disabled/mentally ill within existing paradigms. Instead, following the insights of disability scholars such as Eva Kittay, Carlos Ball, Peter

³¹ I.e. those women who are viewed by medical practitioners, family members, employers or others as de-stabilized by their anxiety, i.e., falling into the parts of the spectrum where the 'anxious person' is deemed by her or his 'rational' other to be mentally unwell.

Handley, Susan Wendell, and Barbara Arneil, I argue that we need a radically new framework: one that consists of languages and images that mentally unwell people and scholars use to define themselves (Arneil 2009, 228). In the next segment I explore care ethics as an alternative to the dominant liberal paradigm, making the case that when embedded in this new framework, anxiety can be reconceptualized as a different, relational voice.

3.1.1 From curing to caring: exploring the nexus between anxiety and empathy

As previously discussed, although treatment may be a useful avenue for some, it ought not be the definitive paradigm that governs our understanding of disability and anxiety. Instead, like disability philosopher Eva Kittay (2003), I wish to renounce the notion of ‘curing’ in favour of an ethic of ‘caring.’ As I shall elaborate in Chapter 3.2, I advocate a theory of care ethics rooted in a universal principle of interdependence. But first, what do we mean by ‘care’? As Kittay remarks, “it is not in the human capacity of rational practical reasoning that we find the ultimate source of our dignity but in a distinctly moral capacity to care...Our dignity I want to argue is bound both to our capacity to care for one another and in our being cared for by another who is herself worthy of care” (2005, 111).

The concept of care ethics, often attributed to psychologist Carol Gilligan, is an alternative approach to the masculine ethic of justice; one that views the individual not as an independent rational being, but as a relational creature. Because we will all at some times in our lives be dependent on others, dependency, rather than autonomy is the key principle. In her seminal book, *In a Different Voice* [1982] (1993), Gilligan challenges the theories of her supervisor Lawrence Kohlberg, who had produced what was considered to be a definitive work on the stages of adolescent moral development. Kohlberg had proposed that as children develop,

they become better at principled thinking, ultimately reaching the highest stage of moral reasoning, which is universal, impartial, perspective. Boys, he claimed, are more adept at this process than girls.

Gilligan responded by arguing that it is not that girls are less developed in their moral reasoning, but rather, that they have a different voice that emphasizes relationship and care, over impartiality.

As Gilligan observes:

The moral imperative that emerges repeatedly in interviews with women is an injunction to care, a responsibility to discern and alleviate the “real and recognizable trouble” of this world. For men, the moral imperative appears rather as an injunction to respect the rights of others and thus to protect from interference the rights to life and self-fulfillment.

- Gilligan [1982] 1993, *In a Different Voice*, 100

Expanding on the work of Gilligan and other care ethicists, I argue that female anxiety is not only a natural response to patriarchal domination, but that it also potentially embodies a different, relational voice that is worth celebrating. While wary of being essentialist, I posit that most women who experience anxiety also feel deeply, are highly sensitive, and often have a heightened capacity for empathy that makes them particularly attune to other people’s emotions. This ability renders them excellent listeners who are able to think intuitively and consider situations from multiple perspectives. However, just as the girls Gilligan interviewed shut down when their voices were discredited, women with anxiety will also retreat into their shells when they feel like their perspective is being ridiculed as ‘irrational.’

The idea of anxious empaths goes beyond base intuition. In fact, empaths have been scientifically proven to be more susceptible to anxiety and depression. Several psychological/psychiatric studies have drawn a link between anxiety and empathy, for example, in their study published in the *Israel Journal of Psychiatry*, scientists Y. Tibi-Elhanany and S.G.

Shamay-Tsoory found that individuals with high levels of social anxiety have elevated tendencies for affective empathy: in other words, they are more sensitive, discerning and sympathetic to other people's states of mind (2011, 98-106). Similarly, Karen Auyeung and Lynn Alden (2016) have recently published their findings that socially anxious individuals have a greater capacity for empathizing with others' social pain. Admittedly this is still a new field of research: scientists must conduct additional studies with larger samples before they can draw affirmed conclusions; however, at base, this confirms what many sociologists and psychologists have sensed for some time.

In sum, a re-occurring theme in this thesis is that liberalism is an inadequate theoretical framework as it is gendered and exclusionary. In this last section, I have continued the work of care ethicists by questioning the moral supremacy of reason. I have argued that women with anxiety are far from morally inferior; they simply have a different, relational voice – one that is worth celebrating. Even if irrational, anxiety can still be valuable: as demonstrated, anxious people often have heightened capacity for empathy, nurturance and care. For this reason, we should be wary of discourses that place too much emphasis on 'treating' mental illness: while psychiatric therapy may be beneficial for some, if we focus solely on treatment, we risk devaluing, if not erasing, individual difference. The key contribution I wish to make by re-framing anxiety is to re-direct our focus from a politics of reason, to a study of neurodiversity grounded in care ethics. The ethic of care, however, is not immune to criticism. In the concluding section I will address some of the shortcomings of care ethics, before outlining my alternative theoretical paradigm: interdependence.

3.2 Interdependence as an alternative to the liberal ethic of justice

Whilst I am a firm believer in the importance of care, there have been some valid criticisms laid against care ethics as a subset of political theory that need to be addressed. Firstly, several critics have argued that some subsets of care ethics essentialize the female experience, in turn reinforcing gender stereotypes and failing to take into account the ways in which women differ from one another (Tronto 1994). In a similar vein, one could argue care ethics embodies an “us versus them mentality,” which also excludes men.

However, I propose that the ethic of care is more universal in its application than critics suggest. After all, as Alasdair MacIntyre contends, from the outset we – women and men alike – are all “intrinsically vulnerable.” There is a “scale of disability on which we all find ourselves...and at different periods of our lives we find ourselves, often un- predictably, at very different points on that scale” (1999, 73). Whether it is in infancy, old age, or otherwise, there will undoubtedly be a time in our lives that we will be in need of care; thus I believe care truly is, a universal ethic.

In addition, one of the earliest objections against care ethics is that it is a “slave morality” that valorizes female oppression by affirming subservient ‘feminine’ traits (Puka 1990; Davion 1993). As previously discussed, caregiving can be a tiring, solitary, and thankless task, and many women who assume caregiving roles are economically and politically disadvantaged. Thus, if caregiving does not serve the women who perform such roles, ought we be seeking to elevate its moral status?

These criticisms raise important questions, however, I believe that they only hold weight if the care in question is one-sided and not reciprocal. The problem with Kittay’s care ethic, for example, is that she emphasizes dependency, as opposed to mutually reinforcing processes of

care and support. In recognizing that personhood is best rooted in “our common connection to others in our need for care,” Kittay addresses some of the problems with liberal theory (2005, 117-118), however, by depicting care as asymmetrical, she risks denying the care receiver’s agency/autonomy (Arneil 2009, 233).

In an effort to address these critiques, while still keeping with the essence of care ethics, this thesis proposes a political theory inclusive of mental (and physical) illness (and disability) based on Arneil’s notion of interdependence (2009; 2016). Arneil’s interdependence model begins by critically interrogating the liberal binary between freedom/autonomy and dependence/needs. The concept of interdependence does not seek to disregard the value of autonomy or ‘independent living’ (as some care theorists risk doing). Rather, it challenges the liberal depiction of dependency as the antonym to autonomy, instead suggesting that these two concepts correlate. As Michael Davidson points out, “A number of disability activists...see dependence not as a relinquishing of agency to the care of others but as a constellation of interrelations, whose ultimate trajectory is independence” (cited in Arneil 2016, 63). Dependence and independence are therefore inextricably linked. We are all in varying ways both independent and dependent on others, depending on the particular stage we have reached in our life cycle, and our surrounding physical environment (Arneil 2009, 234).

This is particularly true of anxiety sufferers, who may depend on the care of others, whilst simultaneously acting as caregivers themselves. As previously stated, people who experience anxiety tend to internalize their relationships with others, which in turn makes them more empathetic. Therefore, paradoxically, women with anxiety often make excellent caregivers, despite often requiring additional accommodation themselves. Arneil’s interdependence model thus strikes the ideal balance between structure and agency: it recognizes that although anxiety

sufferers have the ability to make incredibly worthwhile contributions to society, their social environments must be constructed in such a way as to support their needs.

The interdependence principle also complements Kymlica's liberal rights model (a newer form of liberal scholarship which although not without fault, is more communitarian in outlook than its canonical predecessors). Kymlica holds that the right to membership in society ought not be grounded in individual capacity to reason, but rather on the basis that all individuals in a given community, including people with physical and mental disabilities, coexist within webs of trust, interaction and communication with others (Kymlica 1995). After all, when we think of humanity, we think not of reason, but of compassion and connection. It therefore makes sense for us to embrace an alternative theory of citizenship/personhood grounded in an image of interdependence.

So how might people act/interact within systems of interdependence to help shape attitudes toward mental health? Taylor, in spite of his problematic notion of 'potentiality,'³² offers a useful tool for re-framing and replacing negative images perpetuated by psychiatry and political theory. He argues in the "Politics of Recognition" that the "crucial feature" of human life is its "fundamentally dialogical character" (1992, 32). We define our identity, and hence become full human agents, he argues, through our acquisition of human modes of expression. Here Taylor is referring to communication in a broad sense, including the "languages" of art, love, and gestures. The key requirement is that we cannot learn these languages through self-reflection alone - we do so through our interactions with others (1992, 32).

Thus through engaging in inter-subjective dialogue within systems of interdependence, we can replace negative images perpetuated by the powerful with positive images of our own

³² Taylor contends that the physically and cognitively disabled are only citizens in that they have the 'potential' for reason (1992). I discuss this in greater detail in Chapter 2.2.

making. For example, autism theorists such as Ian Hacking (2010) and Victoria McGeer (2010) have traced how an emerging genre of autistic self-narrative has had a profound impact on how we think and talk about autism. Autistic self-narratives help challenge autistic stereotypes, many of which are negative, such as the image of socially awkward, uncommunicative human beings with limited capacity for empathy (McGeer 2010, 280). Hacking and McGeer ask the question: “to what extent is this public image being augmented – or even transformed – by paying attention to what individuals with autism say about themselves?” (McGeer 2010, 280). Autistic autobiographies, Hacking argues, help contribute to “the ongoing social and cultural evolution of the autistic spectrum”, in turn having a considerable transformative impact on the lived experiences of autistic individuals (Hacking 2009, 1467).

Anxiety autobiographies could have a similar effect, helping to create the inter-subjective dialogue necessary to replace the misrecognition of anxiety with re-cognition. New Zealand author Janet Frame’s semi-autobiographical novels come to mind as an example of how people might replace the negative portrayals perpetuated by society with images of their own making. Through autobiography, women can take on their own agency and narrate some of the positive aspects of their condition, such as their heightened capacity for empathy and critical insight. Or perhaps these self-narratives will focus more on exploring how anxiety is an appropriate response to patriarchal oppression. For some women, embracing their anxiety might be a means of critically interrogating the societal attitudes that give greater weight to traditionally ‘male’ qualities such as reason, power, and levelheadedness. Through recounting their own personal experiences, women with anxiety can demonstrate that traditionally ‘female’ qualities such as emotional expressiveness, care and compassion are not necessarily subordinate values, but represent a different voice that is of crucial importance to community wellbeing.

Chapter 4: Conclusion

Beginning with the centuries-old gendered diagnosis of ‘hysteria,’ this thesis traces an historical association between femininity and madness that still influences prevailing ideas around gendered capabilities and tendencies, although perhaps in more subtle and nuanced ways by the mid twenty-first century than in earlier cultures and societies. These continuing attitudes ground current psychiatric practices in ways that still depict anxiety as a distinctly gendered ‘defect’ that ought to be ‘fixed’ through medical intervention.

In addition to the negative depictions of female mental illness perpetuated by psychiatric discourse, I have proposed that the canonical theorists of Western liberal political thought have consistently portrayed the mentally unwell as the ‘irrational’ other, as deviant degenerates, who are deemed undeserving of citizenship due to their lack of rationality. Unlike the citizen who is guaranteed justice, freedom and equality under the social contract, the mentally disabled ‘other’ must be attended to under the principles of charity.

Rejecting these negative images perpetuated by psychiatric discourse, this thesis intends to challenge our understandings of mental illness by reconceptualizing anxiety as an appropriate response to power, in particular with reference to patriarchal relationships. While not wishing to deny that anxiety and depression can be extremely distressing, and in worst cases, fatal, this thesis is arguing for the potentially transformative power of anxiety, a human emotion proven to be associated with qualities such as empathy, nurturance and care (in addition to productivity and accuracy – traits that are already positively associated with anxiety in Western culture). Qualities associated with care are so often undermined and underpaid because of the ways they have been feminized throughout history. This needs to change, because ultimately, at some time of our lives, precariousness defines all of our existence. In making this argument I am not suggesting

that anxiety is without pain, or that individuals who wish to access treatment or other tools to allow them to either relieve that pain or be able to fully participate in society should not access them. But ‘treatment’ should not become a paradigm that governs our understanding of anxiety as pathological and expressive of individual deficit, as it is currently understood through a medical lens. Rather, treatment can be reconceived as a tool which individuals can access as needed, depending on their particular experiences, and/or in relation to a specific environment.

Bringing anxiety into communication with contemporary social theories of disability, I conclude that we must reject liberal theory as a complete political ideology, as it is gendered – sometimes unconsciously so - and thus excludes women (and men) who experience emotional illness from its theoretical criteria for citizenship. Instead, I seek to break down the rational/irrational binary endemic to liberal theory by advocating a social model of anxiety based on Arneil’s universal principle of interdependence. By reconceptualizing anxiety as a condition that lends to both dependence and independence, I believe anxiety, along with other forms of neurodiversity, can be reconceived as a form of personal and communal empowerment for all. Unfortunately due to word constraints, this thesis has not discussed how anxiety intersects with other forms of social and cultural stratification such as race, class, and sexuality. What makes Arneil’s interdependence model so powerful, however, is that it offers a theory of citizenship that is inclusive of people of all genders, races/ethnicities, sexualities, and physical and cognitive abilities. The ethic of care is an innate human morality that forms the core of multiple cultures, religions and societies. This is an exciting and evolving field of political theory that calls for further research.

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