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ATTAQUE DE SOMMEIL HYSTÉRIQUE

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In 1851, the prominent American surgeon and psychologist Dr. Samuel A. Cartwright published an alarming report in the *New Orleans Medical and Surgical Journal*: a disease had become increasingly prevalent among the South's Black population and was causing slaves to run away from their white masters.^[1] Cartwright coined this disease "drapetomania." While the condition was concerning to the South's wealthy slave owners, Cartwright suggested a solution— to make running impossible by removing the big toes of potential runaways.^[2] Such diagnoses and "treatments" among slaves were not unusual for the time period. According to Jonathan Metzl, medical journals of this era were also concerned with a condition called "*dysaesthesia aethiopsis*, a form of madness manifest by 'rascality' and 'disrespect for the master's property' that was believed to be 'cured' by extensive whipping" (ix).^[3]

Since slavery was the norm in the South, physicians believed that slaves who rebelled or escaped were unwell and required treatment. The remedy was a return to enslavement. And yet, despite the abolition of slavery, Metzl notes how "Even at the turn of the twentieth century, leading academic psychiatrists shamefully claimed that 'Negros' were 'psychologically unfit' for freedom" (ix).^[5] The mass incarceration of African Americans in prisons and psychiatric institutions—which continues to this day— reflects such discriminatory beliefs. But oppression was not limited to African Americans. Among the many disenfranchised, women were also deemed unfit for the freedoms middle-class white men could enjoy.

In 1892, Charlotte Perkins Gilman published “The Yellow Wallpaper,” a semi-autobiographical account of her struggle with post-partum depression—then diagnosed as “hysteria.” The doctor’s “rest cure” for the condition was confinement: to remain housebound with little mental stimulation and excessive sleep. “The Yellow Wallpaper” follows its protagonist over the course of her captivity; at first a woman of sound mind, she is driven to madness by the monotony of the room to which she is confined. As Gilman notes in a later publication, “It is not that women are really smaller-minded, weaker-minded, more timid and vacillating, but that whosoever, man or woman, lives always in a small, dark place, is always guarded, protected, directed and restrained, will become inevitably narrowed and weakened by it” (277).^[6] In other words, the “rest cure” functioned to keep women in their place.

Although we have moved past conjectural conditions like “drapetomania” and “hysteria,” socially constructed illnesses persist in the disproportionate attribution of certain diseases to marginalized individuals. Diseases are biological, but they are also products of their social environments. How gendered and racialized diseases are produced and treated thus reflect shifting social orientations toward these populations over time.

Speculative causes and definitions of disease have powerful implications for what constitutes treatment, and we need to be wary of the motivations that drive current diagnostics. Whereas African Americans and women were largely excluded from mainstream society in the nineteenth century, as individuals endowed with voting rights and consumer agency in the twenty-first century, these populations are now being targeted as both problem patients and niche consumers.

For example, in 2005, BiDil became the first race-specific drug to be approved by the FDA for the treatment of heart failure in Black populations.^[7] Although the drug was initially conceived of as a treatment for anyone with heart failure, in order to extend the product’s patent and to cater to a niche market, the drug became uniquely designed for and targeted to African American patients.^[8] The advertising for BiDil presented the drug as a unique product for underserved populations who were reportedly twice as likely as white people to die of heart failure. While this statistic has since been debunked, there is truth behind the assertion that Black people are generally more vulnerable to health inequalities—most often as a result of racism and structural oppression.

In addition to these uniquely racialized conditions, women continue to be scrutinized for their sexual practices. A recent case of another pharmaceutical campaign is that of Flibanserin, a drug designed to ameliorate what has been diagnosed as “Hypoactive Sexual Desire Disorder,” one of four conditions associated with “Female Sexual Dysfunction.”^[9] As Judy Segal notes, “disappointing sex lives and the figure of the ‘frigid’ woman have been around for a long time. But the turn of this century marked a very public moment in the medicalization of sex and pathologization of low desire... many women who experience low sexual desire have been persuaded that they may well have a medical condition (916).”^[10] While women may wish to increase their sex drive, they should not be convinced that a problem of desire is exclusively

biological—or exclusively theirs. Nonetheless, Flibanserin’s rhetorical strategy was to convince its target audience that this drug was a step forward in gender equality: a “pink Viagra.”^[11]

The marketing of these targeted drugs falsely identifies patient populations, while negating the social factors that may be causing these individuals harm. While BiDil perpetuates the racialization of biomedicine, Flibanserin preserves heteropatriarchy’s hold over women’s bodies. Despite the fact that these drugs are designed to help their customers, by racializing and gendering conditions and treatments, pharmaceutical companies are needlessly pathologizing patients based on the same differences for which they have been subjugated for centuries.

Works Cited

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[3] Metz, Jonathan. *The Protest Psychosis: How Schizophrenia Became a Black Disease*. Boston: Beacon Press, 2010. Print.

[5] Ibid.

[6] Perkins Gilman, Charlotte. *The Home: Its Work and Influence*. New York: The Co-Operative Press, 1910. Print.

[7] Kahn, Jonathan. *Race in a Bottle: The Story of BiDil and Racialized Medicine in a Post-Genomic Age*. New York: Columbia University Press, 2014. Print.

[8] Ibid.

[9] Segal, Judy. “Sex, drugs, and rhetoric: The case of flibanserin for ‘female sexual dysfunction’” *Social Studies of Science* 48.4 (2018): 459-482.

[10] Segal, Judy. “The rhetoric of female sexual dysfunction: faux feminism and the FDA.” *Canadian Medical Association Journal* 187.12 (2015): 915-916.

[11] Ibid.

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