Desire and Nothingness: Hysteria, Medicine, and Spirits of Exchange in Contemporary France

An Honors Thesis for the Department of Anthropology

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Introduction

From Fall 2016 to Summer of 2017 I found myself in Paris, living with a host family in the 16th arrondissement, taking classes at a French university and interning in a not-for-profit psychiatric outpatient unit. One of my classes delivered a surprise so unexpected, that I couldn't help but follow its trail for the remainder of my time in France. After its premiere in Paris, the American film *Split*, became a popular discussion topic in my psychopathology class at Paris Diderot. Engaging the student interest, my professor incorporated a lecture on 'American' Dissociative Identity Disorder, otherwise known as Multiple Personality Disorder. Over the course of the lecture she expressed her fascination and her skepticism with this exclusively American phenomenon. From my own clinical training, I knew Dissociative Identity Disorder (DID) to be a controversial diagnosis, however I was unaware that part of this controversy was due to the absence of cases outside the US. However, I was further taken aback by the critical stance of the lecture.

My professor's skepticism was not simply a disbelief in the 'reality' of the presentation, rather it was a critique of multiple personality disorder as a category of the DSM. In her opinion, which was emphatically shared by all of my classmates, DID was simply a renaming of hysteria. Even as she read the list of symptoms from her copy of the manual, a classmate raised his hand and said, "but that's just a manifestation of hysteria". She went on to delineate the history of the disorder's apparition in the American psychiatric setting. She recalled that the

DSM III was specifically created to dismantle psychoanalytic logics from the American psychiatric cannon. She pointed out that exactly at the moment that hysteria was erased from the manual, a new diagnosis was introduced that shared all of its defining elements. This was my first witnessing of hysteria's apparition. This lecture startled me, I was shocked to hear my classmates engage with the concept of hysteria not as some relic of the past, but as a live, active force.

Following this incident, hysteria returned over and over again. It took the form of small disruptions of daily life: it was being casually thrown around by practitioners at my internship; a fellow exchange student relayed a dinner table debate with her host family over its continued existence; at the base of Sacre Coeur, I stumbled across modernist paintings of Charcot's iconic images. The matter of fact tones, the banality of its appearance, sparked my curiosity. The only frame of reference I had for hysteria was as an outdated, meaningless, catch all category used as a tool of oppression. It was something to be shoved away in a dusty attic, a sordid moment of psychiatric history best forgotten. And yet here it was, being employed casually by practicing clinicians, classmates, and families. So I began to seek it out. The more I learned, the more I felt hysteria's presence everywhere. However, despite this nagging sentiment, I couldn't quite manage to gain access to it.

No matter how hard I tried to unravel hysteria, I couldn't seem to grasp it. I was stuck in my American clinical formation, attempting to know it medically, as diagnostic definition. I was searching for signs and symptoms, trying to form a clinical tableau. I came to learn that Hysteria is ever-shifting, that its presentation

changed with the time and the prevailing culture, that diagnostic definition as such was impossible- and yet I was told over and over that it was always present- despite changing form and presentation. I was pursued by the simultaneous presence and absence of hysteria. Unable to get a clear picture, I often wondered what I was really pursuing. I was told hysteria in a specific, Freudian sense, was disappearing in France. This status often made me question if I had simply made it up, misunderstood- if in reality France, like the US, had seen to its demise. I realized however that it was disappearing in very different ways in these two places. The French insisted that it was still present, despite being invisible, that one simply had to know what to look for. Further, the moments of its apparition had been so startling, like the lecture topic on American Hysteria, that I couldn't ignore it. I found that because hysteria was being described to me as an omnipresent, ever-shifting, entity, it seemed to be a language through which to talk about the gendered experience of women, how society and its structures create pathological subjects out of them, and who has the authority to understand and translate this process.

Further, my pursuit of hysteria was coinciding with other small disruptions. I learned that hysteria required recognition – that it was a very particular way of being known, enacted through encounters with (psychoanalytic) authority. However, even psychoanalytic authority was being disrupted in my experiences of the French clinic due to state and healthcare regulation of the psychotherapeutic encounter. Conversations with my host family and my colleagues at CPS alerted me to interesting tensions in the regulation of state

financing and psychotherapeutic practice in France. France's social security system, with universal health insurance, was often the subject of dinner table conversation. When I later learned that healthcare coverage was divided between psychiatric, (reimbursed) and psychotherapeutic (non-reimbursed) consultations, I couldn't help but wonder how a universalist notion of health coincided with this division. My confusion deepened when I realized that CPS itself was a government-subsidized structure, whose function was to provide services that may be otherwise unavailable to the public, and who also had a team of psychologists who were integral to the center. I couldn't help but feel that gender, pathology, and state structures were coalescing in interesting ways around the politics of universal health care.

All of these moments raised questions for me: what precisely is hysteria? what does it mean in a contemporary French context? How is it both present and absent? And what does this notion of absence signify about the intersections of gender with state, medical, and psychoanalytic authorities? Further, what did its presence illuminate about the French context? It was from these questions that my research process began to take shape.

Sites and Methods

Speaking in terms of field sites seems strange to me, because these pages are really an expression of the home that I created for myself in the space of a

year. They represent my familiarity and my foreignness. This research is based in dinner table conversations, and serendipitous art installations, in the casual workplace chatter in the queue for the microwave at lunch. This research comes from my classmates and their obsession with the recently released film *Split*. This research comes from relationships; it comes from reflection on the internal experience of spending a year between belonging and not-belonging, in attempting to find and to feel at home across an ocean.

This thesis was inspired by surprising, moments, encounters, and conversations. However, when I 'officially' began my research, friction developed between the hysteria I was gathering from my everyday exchanges, and the hysteria of the critical literature. I was already feeling somewhat adrift in the vast array of presentations hysteria represented, and this feeling only seemed to deepen the more I read. Further, my difficulty conceptualizing hysteria was not simply because there was material which didn't match my own experience, but because much of this critical literature was French in origin. Despite commenting from within, and about, the French context, many of the French theorists who engaged hysteria, or provided helpful analytics, were using it as a critical tool. As such, many of my colleagues would not necessarily have seen this as engagement with clinical hysteria, but rather as an interesting, but quite different project. I think it is for this reason that, while I have felt the conversation of French theorists to be deeply related to this project, I have had difficulty integrating French social theory into the analyses of the clinical and institutional settings.

Despite this, French theorists also seemed provide important windows into the history, context, and critique of hysteria, and indeed I found that hysteria itself, and its logics of relationality, provided a point of entry into a particular French construction of subjectivity within these critical discourses. As such, the theory that organizes this work, while sometimes called upon in the body of the text, will predominantly remain as orienting ideas within the introduction and conclusion. Hysteria in this text will be examined in multiple ways, it will be examined in terms of clinical practice and institutional place-making and, through the contextualization of critic, it will also be examined as a point of entry into a particular French intellectual ethos. This is responsible for the varied composition of this text, what we could call multi-sited and mixed method. As such there will multiple hysteria's circulating in this text, however, each invocation will reveal something about the context in which it is found.

With that in mind, my work in different places across Paris was integral to the conceptualization and development of this project. Three sites came to form the basis of this experience: CPS Paris, Universite Paris-Diderot, and Entra'ctes. In the spring, I interned at CPS Paris (Centre Pour le Prevention du Suicide). CPS was a not-for-profit, government subsidized, specialized therapeutic center that operated in the eleventh arrondissement. Through its management by the Association Recherche et Rencontres, and its recognition by the French government as a 'Centre Medico-Psychologique' it was open to anyone. The Center gathered psychologists, psychiatrists, social workers, and art therapists to provide holistic care and foster a sense of community, sociality, and continuous

care. Though the internship was a mere two months, I ultimately extended it to four months due to my fascination with the French clinical setting. My role was primarily observation, with occasional translational work. I sat in on psychiatric consultations, team meetings and art therapy groups, as well as meetings with partner organizations. This gave me a unique window into the French psy world and the professionals who composed it.

Through CPS I came into contact with several other therapeutic centers, such as Entr'actes. Entr'actes was a community, family-therapy center in the suburbs of Paris. Though I initially interacted with them as an extension of my role at CPS, I begin to work with their team independently. I was intrigued by their therapeutic approach; they practiced a systemics oriented therapy, which was pioneered in the US, and focuses on approaching the family system in terms of action and consequences rather than personal introspection or diagnosis. This setting served as an interesting counterpoint to my psychoanalytically oriented colleagues at CPS. The Entr'actes team allowed me to complicate my appraisal of the French psychiatric field and the place of hysteria within it.

Finally, I spent the year, in classes at different French Universities. Paris-Diderot was the only university to provide courses in psychology. Their curriculum was incredibly different from my own formation as an American student. Most notably, they were required to take psychoanalysis every semester of their undergraduate career. Each level took on different focuses: the social, melancholia, and narcissism were the courses offered (in ascending complexity) my term there. My time in France, particularly with the addition of my internship,

was saturated in the French 'champ psy' and (surprisingly for me) in psychoanalysis. Despite three years of study in psychology in the US, I had had barely any contact with the psychoanalytic institution. The concurrent experience of its pedagogy and practice was what initially drew my attention to hysteria's continued presence.

My methods of analysis varied as much as my field sites. The entry point into the thesis, the first chapter, is a study of French institutional structures. This examines the evolution of French history and health-codes to track the emergence of the French Medico-Social Structure. This historical work was compounded by a close textual analysis of the statement of intent of CPS Paris. In the second Chapter I focus on media representations. In an attempt to access the French imaginary, I analyze two versions of the same television series side-by-side, one produced in Britain, the other in France. This chapter closely examines differences in discourse and representation to illuminate what is particular to the French context. The final chapter, is an ethnographic analysis of my time in France. It predominantly focuses on cases of contemporary hysteria, exchanged during conversations with colleagues and professors. In this chapter I explore the assertion that hysteria is simultaneously disappearing and omnipresent. I examine this assertion as fundamentally tied to conceptualizations of modernity and the challenges that it poses in the contemporary period. However, before introducing the particular analyses of this paper, I will provide a brief overview of the theories of hysteria and French social theory that are orienting this text.

Background

Hysteria Historically

Hysteria has its origins in ancient Greek notions of the wandering womb, and circulated throughout the medieval period by way of humoral logics. However, it is often characterized as being reborn at the turn of the nineteenth century and delivered into the Parisien hospital Salpêtrière, by a doctor named Jean-Michel Charcot. Charcot pioneered the field of neurology and was fixated on proving the origins of hysteria in medical terms (Brémaud 2015;489). Within the hospital he separated hysteria and epilepsy from 'les fous' (the insane) believing them to be fundamentally different classes of pathology. In his article, "Panorama Historique des Definitions de l'hystérie" French psychologist Nicolas Brémaud, refers to the knowledge apparatus surrounding Charcot's hysteria as "La Clinique du regard" (2015;489). And indeed, Charcot's search for the invisible workings of lesions in the nervous system led him to meticulously record signs of pathology and their bodily demonstrations, most notably through photography. The spectacular nature of hysteria gained notoriety through Charcot's Tuesday lectures. In the lectures, Charcot used patients to demonstrate hysteria's codified stages, often induced through hypnosis, for crowds of (all male) doctors. The women manifested a seizure like showing- replete with rigid body contortions, frozen pelvic arcs, and the tearing of clothing. Further, as Georges Didi-Huberman's work, *The Invention of Hysteria* highlights, history has rewritten

these interactions (and their demonstrations of power, sexuality, performance, and mastery) as fundamental elements of the hysteric exchange. In his book, Didi-Huberman focuses on theatricality and the interplay of both seeing and being seen in the act of demonstration. He writes of "existence being authenticated, but through theatrical means…photography never stopped certifying presences, and at the same time never stopped ritualizing this certification" (2003;62). In this passage, he equates science to dramaturgy due to the simultaneous acts of bodily performance and validation occurring within these encounters.

Further, Didi-Huberman refers to 'the invention of hysteria as "a relationship of desires, gazes and knowledge" calling this period, "the fantasy of hysteria and the fantasy of knowledge" (2003;xi). One of primary insights to be drawn from Charcot's legacy, was the impossibility of ever fully knowing hysteria (Brémaud 2015;489). What came to characterize hysteria, indeed its only stable characteristic, was its refusal of scientific knowledge. Its presentation shifted between people and across time in endless mimetics of physical illnesses. Further, this mystery, this ultimate enigma is inextricably bound to the gendered nature of its pathology. Didi-Hubberman writes, "It was the symptom of being a woman- and everyone still knows it" (2003;68). Later he refers to hysteria as "the commerce between a women's head and her sex…and the physicians ever-suspended craving to penetrate more deeply" (2003;73-74).

Evelyne Ender also takes this up in *Sexing the Mind,* which emphasizes, "the complex mesh of discourses of knowledge, desire, and power that coalesce in the image of the hysteric. It focuses simultaneously on the emergence of a new

topography of the disease, which reveals, in its remapping of the body-mind divide, an increasingly complex image of femininity" (1995;31). She elaborates on this gender difference, writing, "Indeed, the nineteenth century study of hysteria participates in a conceptualization of a radical difference between the sexes, seemingly grounded in anatomical and physiological knowledge but in fact based on cultural assumptions" (1995;38). As does Huberman, she stresses the importance of this imaginary of femininity to the constitution of masculinity. Quoting Irigaray's *Speculum of the Other Woman*, which says, "The mystery that the women *is*, will then constitute the *aim*, the *object*, and the *stakes* of a male discourse, of a debate among men, which she will not question, which would not concern her. And, ultimately, why would she want to know about it?" Ender adds, "If a woman does not know herself, her mystery draws inexhaustibly, the doctor's science and curiosity" (1995;39). These origins in Salpêtrière still inform the construction of hysteria today.

The next figure I will call upon is Sigmund Freud. He attended Charcot's Tuesday Lectures and became fascinated by the allure of the hysteric. In true Freudian fashion, he found that Charcot's greatest failing was that he did not adequately address the centrality of sexuality in these women's presentations. Within his own worked he came to develop a theory that all neurosis had origins in sexuality (Brémaud 2015;493). Freud's work on hysteria is the basis upon which psychoanalysis is built. Through his collaboration with Breur in *Studies of Hysteria,* he developed the talking cure, which would become the primary mode of psychoanalytic intervention (Brémaud 2015;493). Rather than Charcot's

intervention into the body, this notion of healing was enacted through conversation and interpretation. Thus, while Charcot may have been la Clinique du Regard, Brémaud refers to Freud's era as "La Clinique d'ecoute" (2015;489).

However, it is important to note that Freudian hysteria shifts over the course of his career. *Dora* was his most famous case, and his theory before and after its publication is radically different. In Philippe Van Haute and Tomas Geyskens' *A Non-Oedipal Psychoanalysis? A Clinical Anthropology of Hysteria in the Work of Freud and Lacan*, they write that in Freud's initial conceptualization of hysteria, he attributed neurosis to "consecutive traumas that retro-actively affect each other" in other words to "trauma's deferred action" (2012;98). Freud's early work conceptualized hysteric manifestations within a framework of childhood sexual trauma. From this understanding, Freud pioneered the idea that "symptoms have a meaning…as a 'psychic traumatism' that was a 'returned memory of the unconscious' "(Brémaud 2015;493). However, in 1897 he broke from this formulation and developed a theory of symptomology from sexual stages of development and repressed libidinal tendencies (Bremaud 2015;493). It was from this theory that Freud published the case of Dora and introduced his formulation of the Oedipus complex. Through the case of Dora, as Brémaud writes, "He began to pass from notions of trauma to notions of fantasy" (2015;494). In addition to the rich language of the unconscious Freud provided in his theory, one of his most important contributions was that symptoms constituted a psychic symbolism- they represented the conversion of unconscious conflicts

into physical manifestations. In other words, “Symptoms which had a meaning to decode” (Brémaud 2015;494).

When French psychoanalyst Jacques Lacan entered the scene following the Second World War He took up Freudian theories of fantasy but entirely reformulated it. As Alain Vanier writes in *Lacan*, “He reinvented psychoanalysis for the post-war generations” (Vanier 2000;xxiii). Lacan’s most significant alteration was his de-biologization of Freudian theory. Vanier writes, “The Lacanian strategy always consists in rescuing Freud’s insights and resituating them in a context free of biological determinism” (Varnier 2000;xxii). Further, Lacanian theory was inspired by structuralism and linguistics. As Haute and Geyskens write, “Lacan’s interest lies not in the development of the subject, but its place in a structure” (2012;88). Lacanian psychoanalysis, and the structural logics that underlie it, will be central to the practitioners understanding of hysteria outlined in the following chapters.

In reimagining Freud, Lacan also had to reconceptualize hysteria. And indeed, in my own attempt to understand contemporary formulations of hysteria, his reinterpretation of Dora was a resource that many of my colleagues referred me to. Haute and Geyskens summarize this reformulation most succinctly, writing, “Dora’s hysteria concerns her place in a relational structure, expressing her battle with the question of what it means to be a woman” (2012;89). This question comes from the knowledge of gender difference that occurs during the oedipal stage. However, Lacan took up the question of language and relationality,

and completely reframed the Oedipus complex in terms of the Levi-Strauss' incest taboo and understandings of exchange. In this structural interpretation, he introduced the idea of the symbolic and imaginary orders of the world, mediated through desire and identification, as well as exchange and demand. This new formation of the oedipal complex rested the girl's recognition of her own lack- the absence of the penis. In the acquisition of this knowledge, she recognizes herself as an object of exchange. Through this understanding, she can only be a temporary vessel of phallic authority as it passes from one man to another. However, in a refusal of this status, the hysteric stays within the symbolic order in an exchange of desire, in an attempt to maintain the temporary subject-position she occupies through this exchange. The hysteric is therefore a woman who recognizes, but cannot reconcile, the oedipal crisis, and as such, her position in normative gender relations.

In order to accommodate this position, the hysteric subject remains in the unarticulated enigma of her womanhood. Jean-Michel Rabaté writes about the structural exchange inherent to Lacanian psychoanalysis in his article, "Dora's Gift". He writes that this exchange, "thus veils the cruel realities the define the symbolic- the structure of relationships" (2008;86). Understandings of hysteria as a structural logic will be central to this project. For Lacan, psychic structure is maintained through the ultimate unfulfilment of desire, Haute and Geyskens write, "According to Lacan, the incest taboo- and for that matter, the whole psychoanalytic tradition – refers to the impossible (ultimate) fulfilment of desire" (2012;92). Hysterics in their own refusal of knowledge, stay within this mode of

relating. In the therapeutic encounter, this is played out through the hysteric body and its articulation. Knowledge of the hysteric, the inability to satisfy the demand of knowledge, is what maintains the clinical encounter. Further, the structure given by unsatisfied desire is the only way an Other can exist (Haute and Geyskens 2012;104). "Every momentary fulfillment falls short and refers to a point that cannot be articulated in language (that cannot itself be demanded as an object). In other words, beyond what the Other demands is that which he desires" (Haute and Geyskens 2012;102.) This understanding highlights that the exchange of desire in Lacanian psychoanalysis formulates fundamental notions of self/other through which both an understanding of self, and an understanding of self in relation to others, is formed. This essential differentiation of self/other at the base of psychic and social structure will be invaluable to the chapters which follow. Lacan's formulation of the hysteric subject, as a structural logic that posed the fundamental question of what it means to be a woman, formed the theoretical basis of the practitioners that I worked with.

Hysteria, its manifestations, and its history have been the source of an incredible amount of analysis and writing. However, there is still room to add to this discourse. This project is of interest because it engages with the question of *contemporary* hysteria, and how practitioners imagine and understand the clinical encounter in light of changing demands in the contemporary moment. As such, this text will explore how hysteria imagined, and through it, how psychoanalytic authority is positioned. Further, I am deeply interested I what this reveals about

the stakes of these imaginings for the woman. I will explore these potentialities from a more critical perspective.

Theoretical Interlocutors and French Social Theory

In addition to offering a critical lens to hysteria, throughout this project, I have been interested in mapping French thought, and the way French social theorists both do and do not speak to one another. In this pursuit, tied to the formulations of hysteria I encountered, I began to notice the emergence of a particular French ethos within this discourse. Analyzing French social theory became central to the development of this project. In engaging with psychoanalytic formulations as well as this vast intellectual tradition, I found that despite very different theories and arguments, there was a central problematization that continued to be reimagined as different intellectual movements developed. This problematization surrounded the subject and its relationship to the social- particularly how the social is at once necessary to the subject, and also operates as a form of constraint. I found this understanding to be exemplified in Durkheimian theory, and then taken up by, and reproblematized through subsequent generations of thinkers. Drawing on key texts, *French Social Theory* by Mike Gane and *Durkheim's Ghosts* by Charles Lemert, I will give a brief summary of the foundational French intellectual movements of existentialism, followed by structuralism and post-structuralism and their relationship to Durkheimian formulations.

In his seminal text *Suicide,* Émile Durkheim explored his concept anomie, which Lemert defines as, "the state of mental confusion caused by the absence of workable norms for the conduct of daily life…the group, however massive (even global), must provide some effective grade of social regulation" (2006;11). Throughout his work, Durkheim was interested in the social whole, and its importance for the individual (Lemert 2006;11). He argued, particularly in *Suicide* that a feeling of connection to the social was absolutely necessary to the individual, and that the dislocation of a sense of social alienation could prove fatal. Throughout this project, I argue that a central tension arising out of this theory is how do we conceptualize the subject? And further, how do we conceptualize the subject in relation to others? This understanding of the individual's inherent necessity and constraint, is taken up by the theorists that follow.

While this paper will be thinking predominantly with structuralism and post-structuralism. This foundational French epistemology is first seen in the existentialist writers emerging out of the World Wars. The existentialist genre is centered on the Subject, and its sense of dislocation and supreme alienation. In this pursuit, they take up Marxian theory and the Durkheimian subject in their formulations. However, in the 1960s Durkheim began to be taken up in very different ways as the Structuralists reclaimed Durkheim and Mauss (Gane 2003;138). Structuralism moved away from the question of the subject and into a deeper engagement with the social (Gane 2003;138). Gane describes that this shift in interest is inextricable from the social movements of the 1960s, and attributes

the shift from structuralism's 'hegemony' into post structuralism as a need to "accommodate itself to the failure of may 68" (Gane 2003;138). Post-structuralism arose out of the de-colonial impetus and the colonial revolutions. Its thinkers branched into multiple directions. Some, like Foucault and Deleuze, returned to (in very different ways) the relationship of the subject and the state. Others, such as Althusser and Fanon, as well as Deleuze, approached it through notions of social organization and state power. Despite the very different theories being formulated in this moment, the post- structuralist project concerned itself with the de-centering of Power, and authority in society.

Throughout this text, key authors will be explicitly engaged with, or implicitly orienting the analytic approach. The author who appears most frequently in the text is Foucault. Drawing inspiration from his *The History of Sexuality*, I engage with how Foucault brings together law, family, medicine, psychoanalysis, and biopolitics into one conversation mediated by sexuality. In conjunction with Foucault's theory of subjectification, which states that the subject is created rather than purely repressed by the operations of power, I think with *The History of Sexuality*, to try explore how the various chapters of this thesis worked together, and why these disparate idioms may speak so well to each other in the French context. In interesting ways, Foucault's thought in this text both works to critic hysteria and the structures that give rise to its existence, as well as illuminate this central French epistemology. This understanding of subjectification and power, offers another theory of the social's constraint of the subject and the ultimate inextricability of the two. However, I also bring in

Deleuze as another way of investigating, and decentering, this central relationship. I use his theories of multiplicity to hold these theories of power and exchange somewhat apart, and in so doing allow for moments of disruption of the heavy inevitability of social constraint.

Further I argue that the subject-social relationship that is navigated in various domains of this text, is a relationship that is best critiqued in structural terms. In the second chapter, I argue that thinking about subjects in terms of structure is an inherently spectral pursuit. As such, I drew much of my inspiration from Jacques Derrida. Derrida, like many French theorists engages structure through Marx. *In Specters of Marx* (1993) he is concerned with how the origin comes into being through its absence, displacement, and repetition. He explores capitalism as a system grounded in the copy, and is interested in how the original requires doubling, in order to circulate/ be an object of knowledge- all the while without necessarily being rendered present. Structure itself is repetition, it is a displacement over time and an exchange that sustains, and is responsible for, the continuity of a relationship. This approach in many ways perfectly articulates the understandings of hysteria and of the French subject outlined in this paper. While Derrida is concerned with the symbolism, spectrality, and alienation of material objects, hysteria is concerned with the alienation of feminine as object and its symbolic circulation via desire. Further, what Derrida adds most to this discussion is the understanding that the specters, present but not present, are inherent to the construction and maintenance of structures themselves. This paper will be

concerned with how fundamental understandings of difference come to form the theory of relationality inherent to the French subject.

Another central piece of this analysis is a critical engagement with ideas of modernity. Durkheim stated "Modern societies are different from all others because, being divided themselves, difference is what makes them modern" (Lemert 2006;124). As the above paragraph intimated, I am interested precisely in how these understandings difference, come to form a fundamental part of how the contemporary moment is understood, and also how they contribute to new imaginaries of coherence. Further, Lemert writes of the post-structuralist/post-modernist project saying, "Modernism is taken as the centered, hierarchical, Europeanized, dominant world against which the principle of difference is thrust to assert the realities of those whose daily lives are marked by the experience of difference- women, non-whites, working class, and the third world" (2006;155). In this way, I will also be using post-structuralist thought to de-center the theories of difference and subjects that populate this text as part of my own feminist project.

However, despite this quote, throughout the authors I have read, I noticed a conspicuous lack of engagement with gender within these formulations of subject and difference. This text is precisely concerned with that absence and so, throughout the course of these chapters, will be thinking about the spaces that gender occupies within these structures. That being said, I did draw upon French feminism, whose work I found, fell within this French epistemology. I primarily bring Simone de Beauvoir's *The Second Sex* into conversation through her

assertion that the woman "is the other to man's self" the "object to the man's subject" (1976;xvi). Through this understanding, I engaged within this characterization of woman-as-lack, as the spectral presence that both creates and maintains the structures I am critiquing. The work of Luce Irigaray in *The Speculum of the Other Woman,* also engages the question of the woman, specifically in the psychoanalytic encounter, in structural terms. She writes, "For light to be spoken in the matter of (so-called) female sexuality, we can assume that difference is always already in operation although no acknowledgment is made of it…Out of this difference will be lifted one of the two terms- but determined in relation to what? –and this one term will be constituted as 'origin,' as by that whose differentiation the other may be engendered and brought to light" (1985;21). Further she writes, "psychoanalysis does not try to describe what a woman is…but sets about enquiring how she comes into being…the whole problematic of being has been elaborated thanks to that loan" (1985;21). This theory has inspired the critical analysis that orients this text and also has contributed to my analysis of the French intellectual ethos.

One of the most unique features of this thesis is its engagement with French social theory. While these writers have become central figures in the formulation of critique, their theory has less often been turned back on itself to critically examine the context from which it originated. As such, throughout this project I have been interested in contextually situating not just my research material, but also the voices I have brought in to critique it. In so doing, I have

mapped a particular French mode of thought, that is invested in a specific understanding of the subject and its unsettled relationship to the social whole.

Finally, central to this pursuit, to the text as a whole, is its engagement with the shifting circumstances of modernity. By this I am referring to understandings of modernity in terms of rupture, in other words, as a radical alteration of a past ways of being. Conversely, I am also interested in understandings of the contemporary moment, and the approaching future, in terms of increased interconnectivity, exchange, and movement. Indeed, several of the following chapters will be concerned with the circulation of media, pathology, and ideologies, as well how technological innovation fundamentally alters understandings of access and exchange.

Leaving French theory for moment, Andrew Lakoff's *Pharmaceutical Reason* was indispensable to the formation of this analysis, and serves as a touchstone throughout this text for thinking about global circulations, biomedicine, and its relationship to psychoanalysis. His ethnography focuses on the mundo psy of Argentina. He examines how psychoanalysis' dominant role in the medical space has everything to do with the historical and political circumstances of Argentinian State institutions and social ideologies. However, in his fieldsite, the growing circulation of North American biomedicine, and its economic pressures, are demanding a radical reconfiguration of experts and their subjects. In his work, this becomes a site of contestation between opposing biomedical and psychoanalytic hospital wards. This text reflected my own experience with the French clinical setting and the 'disappearance' of hysteria

within the clinical encounter. In many ways, this inspired my methodological approach.

What my writing adds to Lakoff's conversation is a deeper examination of notions of 'center'. The theme of circulation is vital to his argument, but this is often framed in terms of movement from center to periphery. In the way that he approaches the complex and fraught incorporation of biomedicine into the Argentinian psych world, I would like to offer a similar analysis of France, whose reception of American biomedical psychology has also been contested. Further, in keeping with the social theorists described above, one of the most profound absences I found in Lakoff's work was his lack of engagement with gender. Something that he does not address in his ethnography is that the competing biomedical and Lacianian wards are separated by gender, with the men in the biomedical ward and the women in the Lacanian ward. In fact, hysteria surfaces frequently in the debates between experts of these two units. In my own explorations, I will be deeply engaging the question of gender, within my conversation of institutions and their subjects.

In all of these sources I am interested in notions of absence, and particularly how absence, gender, and structure come to coalesce around hysteria. I have found that hysteria has not only been a fascinating point of entry into the French champ psy, it has also been window into a very particular French ethos. In an exploration of the institutional circumstances that give rise to the clinical encounter, the first chapter will explore the French creation of the Medico-Social institution. Through textual and historical analysis, it will examine what happens

when State (Public Health), biomedical, and psychoanalytic authorities come into conflict. This chapter focuses on explorations of a French ethos based in the problematizing of the self/social relationship, through a conversation of care and institutions.

The second chapter will be a media analysis of French cultural representations and the circulation of imaginaries of pathology and will more deeply explore the question of the woman. Through a comparison with a British television series, it will continue to plumb the particularistic French context. As a story of haunted homes, this chapter will examine the relationship between families, pathology, and authority. Further, it will argue that there is a spectral quality to structures, that highlight unbounded conception of the individual within the French context.

The third chapter will focus on the hysteric subject and gender in the clinical encounter. It will further explore the particular stakes raised by the contemporary period. Through an ethnographic exploration of the French psy world, and discussion with the professionals who populate it, this chapter will concern itself with the question of the woman and notions of exchange and authority. Through the tensions that arise between psychoanalytically oriented practitioners and American biomedical ideologies, it will grapple with understandings of domination, resistance, and global interconnectivity. In order to parse what is particular to the French context, each chapter will explore different notions of disruption as well as imaginaries of connectedness, and their relationship to the very particular construction of the French subject.

Chapter One

Exploring hysteria in France is particularly intriguing because it seems to uniquely encapsulate a particular French ethos. In fascinating and unexpected ways, it illuminates, and opens up to critique, an ideological mapping of concepts that create a certain discursive tradition in French thought. However, this chapter will set aside the question of hysteria for the moment, and will instead focus on the conditions that give rise to its continued relevance in the French 'champ psy'. That being said, it is not simply providing context for later ethnographic explorations, rather, this chapter uses historical and textual material as part of a critical analysis of the particular French subject and its problematization. By deconstructing the mission statement of my primary fieldsite, Centre pour le Prevention de Suicide Paris (CPS)- a medico-psychological center, I will place its aims within a broader historical and ideological framework, and will explore the creation of a very particular category of French institution, the medico-social.

The first page of the CPS Statement of Intent (Projet d'Etablissement) begins with an excerpt by Edgar Morin, and indeed is the perfect point of entry into this discussion. The quote comes from *L'homme et la Mort,* in which Morin writes, "All neurosis is a regressive attempt at reconciliation with the milieu. Suicide, the supreme rupture, is the supreme, desperate, reconciliation with the world." Further along in the passage he attributes suicide to "the product of a social emptiness" that "consecrates the complete dislocation of the individual and the civic."

Edgar Morin, is a French philosopher and sociologist who pioneered French transdisciplinarity which, as the name suggests, is a 'holistic approach' to research that spans multiple domains in its explorations of a specific topic (Max-Neef 2005;14). The research center CRNS (Centre Nationale de la Recherche Scientifique) housed in CPS is based on his research model, and indeed, it can be seen all throughout the methodological approach of the center. Though he was a social theorist writing in the same moment, Morin was not within the post structrualist tradition. However, as this quote intimates, he still carried a fundamental interest in Durkheim into his theory. The understandings of rupture and dislocation that Morin evokes, are central not only to the intervention of CPS Paris, but are also indicative of a larger French problematization of the relationship between the subject and the social. Durkhiemian notions of "dislocation of self and civic" echoes through the generations of French thought, and as was demonstrated in the introduction, served as a sort of origin that French thinkers continued to return to and reformulate. The Center lends itself particularly well to Durkheimian thought, given its focus on the prevention of suicide. Further, I've found that the center's central concerns of precarity, isolation, and rupture, illuminates the subject-social discourse that will be taken up in each of the chapters. In this chapter I will analyze how a problematization of 'dislocation' is addressed through different structural interventions of reinsertion. In other words, how public health, the medico-social structure, and the authorities they comprise, form different universalizing conceptions of the social, and how subjects come to circulate between them.

My own curiosity about the French public health structure was sparked by the production of seemingly stark boundaries between psychology and psychiatry. As we chatted over lunch at CPS, I learned from one of my colleagues that while psychiatric consultations were covered by national health insurance, psychological consultations were not. While there seemed to be very interesting acts of differentiation surrounding this distinction, I learned that this divide was not as simple as state misrecognition, and further was not explainable purely as a separation between medication and talk therapy- between biological and relational selves. In fact, there is a much more complicated navigation taking place at the intersection of public health aims, the subjects that they intervene into, and the institutions that enact these interventions. CPS sits at just such an intersection, as an "Interface between care (soin) and the medico-social, the structure [CPS] is situated at the heart of the Ile-de-France medico-social fabric". It is a liminal space in which psychological care is subsumed under the umbrella of Social Security financing, through its designation as a Centre Medico-Psychologique (CMP).

In exploring the infrastructures that surround mental health care in France, I discovered a complicated relationship between state, medical, and psychoanalytic fields and the ways they articulate themselves through the public health discourse in France. Out of these tensions arose a very particular category of institution: the medico-social. In this chapter, I highlight the medico-social's primary intervention into social exclusion as part of a larger public health project of coherence, and explore it as a site of conflict between the different universals

of the state, psychoanalysis, and biomedicine. I argue that within the larger structure of public health, different subjects are being created by the various authorities that intervene into them, and to bridge these vast differences, the term 'care' (soin) is used to enact the ideals of continuity and universal social inclusion of the public health model. I ultimately argue, that it is precisely these institution's subjects who both create and disrupt these structures and their claims to universality. Further, I argue that these interventions and initiatives, as well as their critique, are indicative of a French preoccupation with the subject (and its relationship to the social) explored throughout this paper.

My way of mapping these relationships will be through a textual analysis of CPS Paris's Projet d'Etablissement. Following the organization of the Project itself, this chapter begins with the historic contextualization of the center and will then move into a discussion of its mission and modes of intervention. In constructing this history, I have taken significant moments from the 'historique' at the opening of the Projet d'Etablissement and interwoven them into a broader contextual history. This history will inform the thematics of prevention and rupture that populate the latter half of the project. Together, they reveal very particular imaginaries of coherence and illuminate the ways that these imaginaries are both disrupted and made to correspond.

History:

This section weaves together the "historique du centre," which opens the CPS statement of intent, with a broader historical framework that highlights

significant events in French public health, psychoanalytic, and political histories. However, I will begin this history not with the Center in Paris, but instead with a tension that pervades much of this section and indeed this chapter: how psychanalytic and medical identities position themselves.

Tensions regarding the place of psychoanalysis within the French medical community, or within medically-oriented psych models, existed long before the Second World War. However, as Remy Amouroux writes in his article, "Marie Bonaparte, l'analyse practiquée par les laïques et les psychologues," following the war, this escalated to juridical actions against non-medical practitioners of psychoanalysis (2008;486). In 1945, the ordonnance of the 24th September was passed, which stated that the diagnosis and treatment of illness was exclusively designated for medical professionals, as such any non-medical practitioner would be held in violation of the law (Amouroux, 2008;486). The Affair Clark-Williams in 1950 was the first of a series of decisive cases for the psy disciplines. Over a series of trials, American lay-analyst, Margaret Clark-Williams was persecuted by the Official Order of Physicians for an "illegal exercise of medicine". While, this trial specifically problematized 'l'analyse laïque', or psychoanalysis practiced by persons without medical degrees, the questions it raised had implications for the entirety of the French 'champ psy'. Annick Ohayon writes in "La psychologie Clinique en France, element's d'histoire" that this trial questioned if psychoanalysis should be regulated, and if so, how. Further it asked, is psychoanalysis a medical speciality? Is it simply a method or is it an autonomous profession? (2006;15). The French psych field contains a multitude of factioned

voices, psychiatrists, clinical psychologists, psychotherapists, and psychoanalysts all have different aims and ideas regarding their own discipline, and their relationship to the other disciplines. As such, in questioning psychoanalytic authority, this trial simultaneously implicated the identity of medico-psychiatric practitioners, the development of psychology as an independent intervention, and the place of the state in regulating psychotherapies.

Margaret Clark-Williams was eventually acquitted in 1952 due to a lack of specific regulation of psychoanalysis. This ruling therefore understands psychoanalysis to be outside of medical intervention (treatment and diagnosis) and as such, not in violation of the 1945 ordonnance. In bringing these questions to the juridical platform, the Clark-Williams trial marked the beginning (and the ultimate incapability) of the government to regulate psychanalytic intervention. However, the tensions that permeated this affair continued to resound in the subsequent unfolding of history. Indeed, its echoes can still be felt in contemporary differentiations between psychoanalytic and medical authority, their regulation by health law, and the creation the medico-social space.

CPS Paris, as a medico-social association, is ideally placed to explore this continuing legacy. The first avatar of what would become CPS Paris was born in the 1956, in the wake of The Second World War. It began with the founding of groups called “Recherche et Rencontres” (Research and Meetings), which brought together researchers and intellectuals from the social sciences, medical, philosophical, and pedagogical fields. By 1958, the founders, Suzanne Nouvion and Jacqueline Marie de Chevron Villette, created a specialized center in Paris to

address the problems of post war society. Concerned with feelings of isolation, difficulties with familial reintegration, and threat of suicide, this early center's intervention was focused on addressing individual's ability to cope with the immense rupture of the Second World War. Meanwhile, the creation of this interdisciplinary center was co-occurring with international debates over Europe's own capacity for integration. Further, the social and economic context following the Second World War, had already lead, in 1945, to the creation of a new Social Security System. This included the beginnings of a national health insurance program.

This period of time is also significant because of the radical upheavals of French imperial power. 1954, the end of the Guerre d'Indochine- in which France was defeated in its attempted reclamation of Vietnam as a French colony- marked the beginnings of the wars of independence and the process of decolonization. The beginning of decolonization radically shifted the French political consciousness and intellectual conversations. The social theory that began to emerge in this moment, was deeply invested in critiquing and subverting not simply colonial power, but state power and modes of domination more generally. So, while the state itself began to shift to new models of social inclusion, theorists continued to problematize modes of domination and subjugation within these policies. In 1962, the Algerian war ended. Interestingly, that same year, following support from military psychologists, CPS was subsidized by the Direction Departmentale des Affaires Sanitaires et Sociales (DDASS) and thus began to operate within the sector of 'mental hygiene'. The advocacy for social inclusion

and the calls for deinstitutionalization in this moment, allowed for the first connections of a state public health initiative and community care centers.

An important consequence of the social consciousness that arose in the 1960s, was the development of the anti-psychiatry movement. The movement called for the abolition of asylums and the creation of a de-institutionalized (sectorial) structure for mental health. Though anti-psychiatry movements developed internationally, the response in France was particularly strong. The French antipsychiatry movement was a reaction to atrocities that occurred in asylums during the Second World War, in which thousands of patients died due to famine (Von Bueltzingsloewen 2002;I). As a result of these politics, sectorial care centers, les dispensaires d'hygiene mental (precursors to the medico-psychological centers) were emerging across France. Thus, the 1960s ethos of social responsibility extended to the mentally ill and culminated in advocacy for community integration and systems that facilitate autonomy.

This new interest in progressive mental health reform and ideals of community integration, challenged the existing models of mental health care in France. As the Affair Clark-Williams began to illuminate, a consequence of the shifting and expanding field was conflicting understandings of what constituted mental health professionalism and identity. As the trial demonstrated, psychological intervention and medical identity were constantly being contested. The succession of court cases that began with Margaret Clark-Williams, eventually led to a new law in 1978 that recognized psychoanalysis as a non-medical act that could be practiced by non-medical professionals, thus

decriminalizing it. However, contested identities were not simply occurring between psych disciplines, they were also occurring within psychoanalysis itself. While in this paper, psychoanalysis is often referred to in general terms, it too is a complex mix of conflicting opinions regarding psychoanalytic intervention, identity, and legitimacy within the French context.

Central to the contested psychoanalytic identity was the polemic figure of Jacques Lacan and his post-war reconfiguration of the psychoanalytic object. As was mentioned in the introduction, Lacan is a dominant personality in French psychoanalysis. His restructuring of Freudian theory caused major schisms in the psychoanalytic community from the 1950s until his death in 1981. Though the contributions of his theory will be more deeply explored in future chapters, it is important to note here that one of the most significant transformations from Freudian psychoanalysis, is the very intentional deviation from a scientific identity in its Lacanian uptake. In so doing, Lacan very purposely placed psychoanalytic authority outside of the perceived universalizing and categorical logics of science -and through it medicine (Vanier 2000;88).

All of these conversations have significant implications for France's public health model and the structuring of its mental health care system. These large-scale reforms, beginning in the 80s, are reflected in the subsequent transformation of CPS Paris from a 'Centre d'hygiene Mentale' to a 'Centre Medico-Psychologique". In 1981 the center was officially recognized as having public utility. This decree placed CPS in a position to be further absorbed into the shifting public health system as it reformed. In 1985 there was a large-scale

reorganization of the psychiatric sector. The law of the 25th July, 1985, legally placed mental health structures within the public health code. This absorption was concretized by the law of the 31st December which refinanced the structures "extra hospitaliers". By this decree they became attached to a public hospital, and as such, were absorbed under the umbrella of social security financing. In 1986, following the decree of the 14 of March, CPS transformed from a dispensaire d'hygiene mentale to a Centre Medico Psychologique inter-secteur. This restructuring changed somewhat the aims of the center, which became much more focused on psychiatric and psychological interventions. As the project states, "the statutes of the association were also modified by taking into account the attachment to Social Security, *and thus to [medical] care (soin)*."

Interestingly, the official absorption of mental health care into the public health infrastructure and financing, also occurred at the end of what, Martin Laxenaire, a French scholar of medicine and psychotherapy, deemed the era of "psychoanalytic imperialism" (2002;772). By this Laxenaire is referring to the pervasive influence of French psychanalysis within all disciplines of the psychotherapeutic and psychiatrique field. He claims this influence grew steadily until the 1980s and attributes its seeming stagnation since this time, to the death of Lacan in 1981 (2002;778). That the official attachment of therapeutic centers to hospital systems occurred at a moment when psychoanalysis' presence felt less preponderant, and after the death of a figure who insisted on psychoanalysis' distinction from scientific authority, is a notable concurrence. It would seem that since the 1980s there is an increasing sense of the medicalization of the French

champ psy, which threatens the French psychoanalytic identity. An identity that, due to this age of 'psychoanalytic imperialism', does not simply implicate psychoanalysts, but as it continues to inform the approaches of French psy professionals, implicates the broader identity of the field.

Despite the death of Lacan, psychoanalysis' desire to remain autonomous from medical authority persisted. In 1990, an ordonnance was declared that defined psychoanalysis as an unregulated profession, placing it outside of the restrictions and standardizations of public health law. The passage of this ordonnance reignited discussions within the analytic community that had surrounded the affair Clark-Williams, but once again psychoanalysis maintained its distinction from state, and thus medical, incursions. However, the French public health initiative, and its dream of universal coverage, marched on. In 1996, new reforms, the Juppé ordonnances of April 24th, restructured the operations of public and private hospitals. It created Agences Regionales d'Hospitalisation which attempted to facilitate into healthcare financing and improve geographical inequalities in care. These new structures were tasked with the allocation of limited regional funding in the hopes of addressing the difficulty of social security spending. As a public health structure, these changes in financing and institutional organization also effected CPS and the funding and allocation it received.

In the 2000s psychoanalysis and public health once again came into conflict. In 2003, la Loi Accoyer was the site of another controversy within the French analytic community. It was a reverberation of the initial debate in 1990 surrounding the proclamation of psychoanalysis as a nonregulated entity, which

itself had its roots in the affair Clark Williams. The law Accoyer was an attempt to finally, legally define and regulate psychotherapies. However, after an intense backlash from the psychoanalytic community, the lawmaker, Accoyer, ultimately excluded psychoanalysis from the amendment. This is an important moment for the positioning of psychoanalytic intervention and that of the healthcare system. A Nouvel Observateur article quotes Accoyer's response to the changes in the law, "henceforth, one must no longer include psychoanalysis in the field of psychotherapy, and thus in my amendment…one must only regulate the heavy (lourds) psychotherapies, those which take charge of mental disorders, and not simply the blues" (2004). The boundary work of this statement highlights that how each institution's objects of intervention are being characterized, is central to the construction of their authoritative identity.

Psychoanalysts, for their part, maintained their identity in opposition to this pressure from public health officials. In the same Nouvel Observateur article, Jacques-Alain Miller, a psychoanalyst, called the law an "Orwellian project of the minister of health with a point of view of "néo-hygiénisme" (2004). Neo-hygiénisme references a school of social and political theories that conceptualize the public and medical practice in terms of the hygienic preservation and public health prevention. Indeed, the rhetoric of preservation and prevention form a large part of public health initiatives that organize its intervention into mental health care. Miller added that medicalizing psychotherapy would reserve it purely for psychiatrists and other 'auxiliaries of the mental healthcare system' like psychologists (2004). These comments communicate a fear of being compromised

by government/medical regulation, and contamination of the therapeutic interaction from economic interests and projects of normalization. Furthermore, he communicated that the idea of any sort of standardization of practice seemed antithetical to the psychoanalytic project- its notions of subjects and its interventions into them being rooted in understandings of the singularity of individual experience.

However, this is not the only perspective within the psychanalytic community. Many other psychoanalysts were concerned that not being officially recognized as a psychotherapy would mean the public would not recognize psychoanalysis as a legitimate intervention (Nouvel Observateur 2004). The differentiations within and between the French champ psy and state and medical identities, are complex and multilayered. Further, while the quote in the above paragraph clearly differentiates psychologists from psychoanalysts, the reality is much less clear cut. Though what is being debated in this instance is the specific psychoanalytic identity (‘pure’ psychoanalysis) and how it positions its authority in relation to medical and the political authorities, these positionings also have implications for the practice of psychoanalysis in places of overlap. For example, psychologists can, and do, still practice psychoanalytically oriented psychotherapy within more clinical structures. CPS Paris, as a government-funded organization, is one such space of messy overlap. Despite its central place in the medico-social sphere of sectorial public health, all of the psychologists at the center are psychoanalytically oriented in their approach. Though they are often

complicated, the differentiations outlined in this section will have important resonances in the remainder of the chapter and those which follow.

Concurrent with the Accoyer controversy, in 2000 France was ranked as having the best healthcare system in the world by WHO (Gittelman 2009;6). This only appears to have strengthened a public health model based in coherence and universal coverage. In 2005 a policy of 'coordinated care' was initiated to further improve *continuity* of care and facilitate the movement of persons between care structures. Most recently, in 2016, a new system of universal healthcare coverage was instituted, titled "PUMA", which attempts to balance ever-more inclusive aims with the financial challenges it incurs. The most recent developments of CPS parallel these aims, and were enacted during my time there. In 2017 the association moved locations and decided to rename itself. From Centre Popincourt to Centre pour le Prevention du Suicide Paris (CPS Paris), the director changed its name to create greater coherence among the many regional and international centers now associated with the larger organization- Recherche et Rencontres. It was also changed create a more official image for the center and to more clearly articulate the role that it occupied in the French psychiatric and public health milieu.

What I hope to have demonstrated through this compilation of various historical moments is that much more is being articulated by the divide in insurance funding that leaves out psychological consultations. As this section should demonstrate, the separation in insurance coverage between psychiatric consultations and psychotherapy is not simply non-recognition of legitimacy, but

rather is related to a long history of purposeful declarations of authoritative identity and institutional independence. Further, I would like to highlight that the current model of French public health and its relationship to mental health care, is historically situated and deeply embedded in a feeling of 1960 politics of inclusion.

The remainder of this chapter will follow the thematics of the Project d'Etablissement, which explore the mission, organization, and rationalization for the association. With this historical context in mind, I am going to examine two central themes that dominated the latter part of the project: Prevention and Rupture. I will examine how the Center's positioning as 'preventative' is tied to a history of deinstitutionalization and a politic of social citizenship. I will then explore how characterizations of rupture and unity define the authoritative discourse of care and create the very particular space of the medico-social institution. These interventions in the name of social dislocation, have important implications for the subjects constituted within these institutional encounters.

Prevention and Precarity: Social Citizenship and the State

L'article L.6143-2: The Project d'Etablissement defines, on the basis of a medical project, general objectives of the establishment in the domains of medical and of healing care (soins infirmiers), of biomedical research, and the management of systems of information. *It understands/encompasses a social project.*

This code, which defines the legal parameters of an association's statement of intent, perfectly encapsulates the central tensions of the French Public Health system and the medico-social structure. The system of Social Security in France (of which health insurance is one part) is comprehensive. Seemingly sharp differentiations in what constitutes medical intervention, are complicated by the French government's publically oriented model of social security. So, while lines may be being drawn between healthcare, psychology, and psychiatry, the constant call of the state's mission of social inclusion creates a reality in which these designations are much less clear cut. Public services are divided into separate disciplines of 'sanitaire' (purely medical) and social, and come to overlap in the medico-social discipline. The sectorial care model, exemplified by CPS Paris, is used to bridge these domains and create an integrated care system for the citizens.

The government website defines the medico-social mission, "to bring an accompaniment and support (pris en charge) to the public, designated as 'fragile', in a situation of precarity, exclusion, handicap, or dependence." This intervention into the marginalized is central to the identity of its Public Health project and politic of social inclusion. Further, though French healthcare is 'universal' it also emphasizes consumer choice. A fundamental tenet of French law is the patient has a right to choose their doctors, services, and care. Therefore, in addition to the government funded public institutions there are also private medical practices and a concurrent structure of financial medical coverage called "mutuelles". These

Mutuelles are supplementary private insurance plans that individuals can purchase to cover gaps in national health insurance coverage and reimbursement. For example, they will pay for psychological consultations, or the remainder of the copay after national health insurance has reimbursed its limit. Therefore, despite a 'universal' model of care, there are still financially determined differences in the kind of resources one has access to.

However, in regards to public health structures and the medico-social, the sectorial model of French healthcare is exemplified in the Centres Medico-Psychologiques (CMP). These centers are attached to public hospitals, and have teams of psychiatrists, nurses, psychologists, social workers, and sometimes art therapists. Created to provide continuity of care and facilitate the reintegration of patients into the community following hospitalization, they are a direct result of deinstitutionalization. As such, care in these centers is reimbursed by health insurance, no matter the nature of the consultation being pursued. Psychological consultations thus become liminally included in the medical care structure, through their role either transitioning individuals from hospital to community, or as preventing hospitalizations of community members.

Further, as part of a project of universal social inclusion, the medical field in France is divided into geographic sectors that dictate the public hospitals and CMPs that one has access to. Financed by Regional Health Agencies, this system was created to both help fund public health initiatives, as well as to expand access to care in light of geographic inequalities of accessibility. CPS Paris is somewhat different in this regard, in that it is open to anyone from any area of France

because it is run by an Association and not purely by the Regional Health Agency. Additionally, it is a very particular kind of CMP because it has a specific axis of focus: the prevention of suicide and the fight against isolation. However, because it is partially funded by the government, the Projet d'Etablissement constantly aligns itself with the French State's public health aims. Thus, CPS Paris becomes incorporated into the state infrastructure through very particular discourses of action surrounding prevention, precarity, and medical pragmatism.

In *The History of Sexuality*, Michel Foucault writes about the transformation of power from the sovereign power over death to the protection of a 'right to life' (1976;143). Through this transformation, the state's responsibility became maintaining the lives of its members through regulatory and administrative apparatuses. He writes, "the law operates as more and more the norm, and the juridical institution is increasingly incorporated into a continuum of apparatuses (medical, administrative, and so on) whose functions are for the most part regulatory. A normalizing society is the outcome of a technology of power centered on life" (1976;144). He goes on to write, "It was life even more than the law that became the issue of political struggles…the right to life, to one's body, to health, to happiness, to the satisfaction of needs, and beyond all oppressions or 'alienations'…was the political response to these new procedures of power" (1976;145). This understanding aligns not only with the politic of social in inclusion in the public health model, it is also directly related to intervention of CPS itself as the 'prevention of suicide, and the struggle against isolation'.

The framing of CPS's intervention purposely mirrors the language and primary axes of the French government's mental health politic. It explicitly relates changes in the CPS structure to, "cooperation with political actors…To adapt itself to new juridico-administrative imperatives." Repeated throughout the CPS Project, was an emphasis on prevention, which is inseparable from the state's healthcare model. To recall the center's history, the basis upon which CPS was initially subsidized by the government (The Department of Health and Social Affairs) was due to its potential for screening and prevention of mental illness. This capacity lead to an official recognition of the center's public health utility in 1981, which coalesced with the creation of medico-social institutions. Before this time, the center was seen as having a primarily social focus, and though there were some psychiatrists, the staff was predominantly social workers and art therapists. Following the decree (in other words, when the center became absorbed into public health services and financing) the focus of the center shifted into a more therapeutic model and thus more psychologists and psychiatrists were brought into the team. Today, prevention and precarity are still central tenets of CPS's intervention. Particularly because the center's focus is suicide prevention, understood to be a consequence of social isolation, CPS's interest in the socially marginalized is aligned with the state healthcare identity. The project states, "The only structure in Paris and Ile de France, dedicated specifically to this question, complementary to the diapositive of care (soin), it is a pragmatic, useful, and necessary response." All of the language and self-styling of this Project is oriented to a very particular sort of place-making, a very particular mode of

intervention, and a very particular characterization of the population, that aligns with the public health expectations that predicate its very existence.

Despite its progressive ideals, a sectorial model of universal public health contains challenges. Indeed, many contemporary anthropologists have continued to trouble the violences and limitations of universalism based in social inclusion. In his ethnography *Pharmaceutical Reason*, Andrew Lakoff looks at the world of Argentinian mundo psy and examines how a politics of social inclusion and public health allowed the creation of medical structures that supported psychoanalytic practice within a medical space. He depicts a process of deinstitutionalization, that is very much reminiscent of (and was deeply influenced by) the French model of deinstitutionalization, describing the antipsychiatry movement as a response to the 'inhumanity' of the asylum (2005;44). He also discusses the birth of the 'political social imagination' that arose after WWII and gained momentum in the 60s (2005;45). He writes "This socially oriented mental health reform implied a redefinition of both the objects of psychiatric knowledge and the aim of its interventions… The logic of therapeutic intervention shifted from isolation in the hospital to reintegration into the community. Meanwhile, mental health reformers sought to expand the terrain of psychiatry outside of the hospital, developing office based practices that focused on less severe conditions and promoting a program of preventative mental health." (2005;45) "These services would focus on prevention…The new centers of care would also function as healing communities, providing a milieu of sociality that would also be therapeutic." (2005;48) This self-fashioning is

identical to the language used in the CPS project and its characterization of healing as facilitated by both individual and institutional 'sociality' and community integration. Through this discourse, Lakoff employs a notion of social citizenship- a definition of humanity through notions of sociality. He writes, "The social was not only an object of thought, but a mode of governing. More generally, the project of salud mental was bound up with the ideals of social citizenship…the task of expertise in salud mental then, would include the overall welfare of the population." (2005;46) However, he also writes about the potential dangers of a humanity based on sociality, giving an example of powerful antipsychotic medication prescribed to a patient for the purpose of improving his group participation.

Miriam Ticktin takes this understanding a step further. While Lakoff posited the decentralization of psychiatry as a humanitarian response to the 'inhumanity of the asylum'. Ticktin explores the problems created by humanitarian reason, particularly when they are based on interventions into precarity and social exclusion. She asks, "what conditions evoke compassion and why and what hierarchies are reproduced by it?" (2006;44). She worked with marginalized populations (in a 'situation de precarite') in Paris, writing. "In the clinics, social workers and doctors worked hand in hand, driven by the conviction that social and medical issues are intertwined, particularly for those designated 'les exclus' by the French- society's excluded" (2006;34). She continues "I am particularly interested in the growing emphasis on the role of compassion, sympathy, and benevolence in political life- sentiments that play a crucial part in

the discourses of what some call 'global civil society'…Yet how does the recognition of suffering result in a political program for change?" (2006;34) As Ticktin observes in both her book *Casualties of Care* and her article "Where Ethics and Politics Meet: The Violence of Humanitarianism in France" even a politic of social inclusion and a language of care produce their own violences, exclusions and power discrepancies. Ticktin demonstrates this through her work with immigrant populations in Paris, in which the criteria upon which they are granted citizenship (their suffering recognized) is only through serious illness. This creates a situation in which contracting a major illness (such as AIDS) becomes necessary. Thus a system is formed in which their humanity is predicated on their status as fragile, precarious, and requiring a very specific intervention of care.

As Ticktin notes, the state's intervention into exclusion and marginalization binds together a particular medical personhood with state subjects. Therefore, even projects of social integration are mediated through interventions into the body. This is understanding is relevant to the mental health field, and particularly to the conflict that arises when different authorities within the care system have conflicting constructions of medical or social personhood. The state's responsibility for people in situations of precarity relies on treatment of 'serious' illness (suffering). However, understandings of treatment as a medical category are contested in the French psychiatric milieu. Psychotherapeutic intervention, driven by the French psychoanalytic movement, resists the incursion of certain biomedical logics and thus state regulation, in its notion of healing. This

creates difficulty as the state attempts to balance both its social identity, and its understanding of intervention. This tension is addressed by the creation of medico-social structures. The concept 'Soin' (care) is used to bridge these categories and connect notions of medical treatment to social responsibility. Thus, when attempting to call upon institutional and political structures, as well to create a notion of unity, or a shared project amongst said structures, the CPS statement of intent uses the word 'soin' as a signifier.

This section explored the social identity of the public health model and its interventions and through it revealed that ideals of universality contain their own exclusions. In the following section, aims of social inclusion and continuity of care were further developed in the center's characterization of its mission. The latter half of the project was focused on ruptures, which here referred to a disconnection from the social. In this regard, the project was primarily concerned with cultivating a sense of connectedness and sociality, not simply for its patients, but for its own professional milieu. This section will reveal that the imaginaries of coherence inherent to this aim require a simultaneous attention to difference and demonstration of unity.

Ruptures and Unifications

> "CPS Paris : Lutte contre l'isolement et prévention du suicide…une structure intermédiaire, travaille particulièrement la question de la réhabilitation du lien social. Il répond à une population en souffrance

psychologique liée à la rupture d'anciens réseaux de socialisation, à l'isolement social, pour qui l'exclusion n'est pas encore vécu comme une 'fatalité inéluctable' entre l'hospitalisation d'urgence et l'accompagnement médico-social habituel (de type CMP)." – Mission statement CPS

"CPS Paris: The fight against isolation and the prevention of suicide… an intermediary structure, which engages specifically the question of the rehabilitation of social connections. It responds to a population whose psychological suffering is tied to the rupture of old networks of socialization, to social isolation, but for whom their exclusion is not yet received as an 'inevitable fatality' of the cycle of emergency hospitalization and typical medico-social accompaniment (such as medico-psychological centers)."

As this quote demonstrates, CPS's primary mission is the 'struggle/fight against isolation'. Throughout the document, the language of 'rupture' is used to articulate the dislocation of individual from the social world. To recall the historic origins of CPS, the center was a response to the 'immense feelings of rupture' following the Second World War, and was developed during the dissolution of the French colonial empire. The social considerations, and politics that arose from these moments are directly implicated in the center's problematic. The mission statement explicitly addresses the marginalization of hospitalization, which

sectorial models such as CMPs are responsible for improving. As such, the healthcare intervention outlined in this document is indissociable from a project of social and civic unity.

Further, the problematizing of their public in terms of rupture and isolation, shows that how unity is imagined is a foundational consideration of the self/social discourse discussed throughout this paper. The center's interventions are concentrated on re-establishing social networks and facilitating sociality through group therapy and community engagement. However, this goal of strengthened sociality extends beyond the individual patient, into the institutional aims of the center itself. Understandings of rupture and imaginaries of connectedness will be an important thematic I will return to in future chapters. I will posit that rupture, and its problematization, is a central characteristic of how we understand and grapple with modernity and its radical upheavals of understandings of connectedness.

Nowhere is this better exemplified than the medico-social structure. The interventions into marginalization and suffering that were the focus of the previous section are concretized here. One of the medico-social's most important functions is that it creates coherence between institutional authorities. The impetus for a 'global' approach in the government documents (in which the healing of individuals is enacted through intersectorial cooperation and societal unification) forms the fundamental structure of CPS. In the language of the project, there is an overwhelming emphasis on coherence and cohesion. While this was explicitly enacted through CPS's intervention into the individual's

isolation, creating coherence among different institutional structures was also foundational to its mission.

However, tensions in this desire for coherence are also seen throughout the project. while up to this point, this chapter has been concerned with how CPS aligns itself with the public health model, the projet d'etablissement also reveals that the medical subject created by the universal healthcare system, is not the only way of conceptualizing individuals within this care structure. While it states that, "coordination plays a fundamental role, as much for the patient, as for the therapeutic team, and is an interface between the internal and the external" and later refers to itself as part of "the medical and social, institutional and *associative* milieu". On the other hand, it is also focused on articulating difference. CPS must make a case for what makes it unique and singular amongst other medico-social and medico-psychological associations. Further, it must articulate why it is at once a continuation of medical care, and yet is also a provider of care that is distinctly non-medical. It must be open to a public of both serious (lourd) mental illness in "moments of crisis" as well as "any person living in an isolating situation" or those who are simply "traversing a difficult period". While space is made within the center for people in danger of hospitalization, there is also a very purposeful appeal to other notions of distress/isolation. Appeals to different populations, signal other forms of care and healing, outside the strictly medical, such as psychoanalysis.

The distinctions between the social, the medical, and the medico-social are exemplified by the various therapeutic approaches offered to the clients. There are

social workers, psychiatrists, and psychologists, as well as art therapists on staff. The project differentiates between their roles saying: The social worker "ties together the necessities of medical and psychological involvement as well as the social and economic reality of the moment". The psychiatrist is responsible for "consultation, coordination and liaison with medical care structures (soins). His role as technical referent is preponderant: bringing the 'clinique' and the therapeutic to all levels of intervention." The psychologist's role is to facilitate "a work of elaboration to rediscover a state of balance that will be the most satisfying for the patient themselves, to engage in fundamentally therapeutic or supportive work, which is psychoanalytically or systemically (family therapy) oriented." And finally, the art therapists develop "interpersonal relations and communication… to rediscover the inseparable taste of struggle and pleasure, to encourage narcissistic shoring (l'étayage) to facilitate/ restore exchanges with the other."

Each of these self-stylings, implicate radically different projects. The role of psychiatrist, as the medical specialist, is "preponderant" and he is responsible for "bringing the clinic to all levels of interaction. This characterization reflects the opening ordonnance which stated the projet d'etablissement is "primarily a medical project… that understands a social project." From these descriptions, a subtle hierarchy is established. Further differentiations are made in that the social worker is responsible for the *immediate* concerns of the *external* world. Whereas the psychologists and art therapist's role is much more loosely defined, drawing from psychoanalytic therapeutic approaches to support more internally focused

work and facilitating social interaction. Further, how these fields are defined is deeply tied to the politics of governmental regulation and the purposeful separation of psychanalytic objects of intervention from medical ideologies, or purely social considerations. As was mentioned in the historical section, French psychoanalysis has a long history of resisting medicalization while advocating for its autonomy and legitimacy as an intervention. Therefore, as is seen in these descriptions, psychoanalysts and psychotherapists are careful to keep their language from slipping into one of 'treatment' and instead tend to use expressions such as 'understanding' and 'elaboration' of self. In this way, each of the team members maintains their own distinct authority, despite sharing common patients. This reinforces that while the sociality of the individual is the focus of CPS, so too is the 'sociality de travail' of the medico-social milieu, and the way these domains are made to cohere.

The excerpt that opens this chapter (and also mission statement of CPS) comes from Edgar Morin. The center's mode of intervention is founded on his transdisciplinary logic, which centers a 'holistic' approach to patients. In this approach, understanding the specificity of the individual allows for engagement with multiple forms of knowledge in the practice of care. However, it is clear from the CPS project that it also creates a discourse that is predicated on the simultaneous reification of difference and constant demonstration of coherence. As the project states, "The interface created between the medical, the medico-social, and the social is integrated in [CPS's] therapeutic practice and contributes to its identity in the field of individual accompaniment and reinsertion… Thus the

center offers a response that is holistic and specific (not uniquely curative) and inscribes itself in the regional diapositive of care and of medical and medico-social accompaniment." This single sentence perfectly encapsulates the delicate balancing of interests within the liminal structure of CPS.

Thus, throughout the document there is careful attention to the maintenance of authoritative differences between various institutions and their interventions. To preserve its authority, each institution must be intervening into a different aspect of the individual. If we follow Foucault, and consider that institutions, actually create their subjects (1976). Then these various ways of knowing are creating radically different formulations of subjects in these encounters; and yet, they are simultaneously impelled to an ideal of continuity. The bridging of various authoritative voices is here achieved through the invocation of 'care' (soin) and the liminal space of the medico-social. The medico-social particularly, allows for a coexistence between psychoanalytic and biomedical subjects, and thus maintains a certain ideal of coherence in the French public health structure. CPS, as a medico-social, medico-psychological center, acts as intermediary; and attempts to navigate multiple systems of knowing and contentions over the differing subjects that they create.

As the historical section demonstrated, psychoanalytic authority often positions itself in opposition to, and outside of, biomedical or state conceptualizations of subjects. However, psychoanalytic approaches are still preponderant in the French psy world; therefore, as a state-funded centre *medico-psychologique*, CPS must reflect the identity of both institutions (state and

psychoanalytic). The characterization of the CPS public in the earlier paragraph is a perfect example of this. An openness to 'serious mental illness' as well as to any person 'traversing a difficult period,' tags both psychoanalytic and state objects of intervention. Indeed, it is highly reminiscent of the language of the Accoyer affair discussed earlier. The Accoyer controversy, surrounded an intense backlash from the psychoanalytic community about its inclusion in a law regulating psychotherapeutic practices, which ultimately resulted in the removal of psychoanalysis from the law. This controversy led the lawmaker, Accoyer, to differentiate state intervention as responsible for 'serious illness,' and psychoanalytic intervention as encompassing a broader public of people with a desire for therapeutic support who may or may not identify as ill. In its characterization of its public, CPS's implication of 'lourd' mental illness, as well as a more general appeal to persons 'experiencing isolation,' supports both kinds of authority by creating a space for both medical and psychoanalytic subjects. The Center both sits at the site of, and creates the circumstances for, their intersection. Through a project of continuity and an attention to difference, the center mediates the contested ground of treatment and healing in the various structures that intervene into psychological suffering.

The attention to authoritative positioning throughout the project, combined with an understanding of the historical background, illuminates important tensions in how psychoanalysis positions itself within the French context. From the affair Clark Williams to the Loi Accoyer, and continuing into the present day, psychoanalytic identity opposes itself to universalizing projects, to therapeutic

encounters influenced by state or economic interests, to the use of diagnosis as categories of illness- in short it opposes itself to biomedical ideologies. This positioning illuminates a foundational concern with protecting the distinct psychoanalytic identity- its intervention into the subjective. In maintaining a separate space for itself, psychoanalysis protects its authority by protecting its object of intervention: the absolute individuality of the subject.

Though it positions itself as outside of state regulation, as this chapter and as CPS Paris as a structure should demonstrate, the boundaries between psychoanalysis and public health are constantly intersecting and asked to cohere. Therefore, despite the clear saturation of the project with public health logics, the document reveals a much more complicated story; one that surrounds conflicting creations of subjects and understandings of their relationship to the social body. As such, the center's central aim of civil cohesion is not limited to their clients. Rather, it is integral to the functioning of the center and its therapeutic aims. Further, it is indicative of how these radically different projects can find common ground, in other words how unity is both imagined and disrupted. The paragraphs above demonstrate the balancing of illness and isolation, specific and subjective, all through a particular imaginary of coherence: the relationship of the individual to the social. This foundational interest social inclusion, mediated through a rhetoric of care ('soin') bridges the divide between public health and non-medical interventions. In this pursuit of coherence, the medico-social structure is established within a broader public health system and is able to navigate the many ways of knowing.

Conclusion

"Chacun dans sa role et sa fonciton, est rassemblé autour d'un projet qui donne (l'esprit general) du soin…"

"Each in its role and its function is reunited around a project that gives (*the general spirit*) of care."

Internal and external, unity and rupture, pervade this project through the individual, the institutional, and the historical. However, each system of knowing (biomedical, political, and psychanalytic) conjure a different unity- a different universal-constructed around its object of intervention. The biomedical creates a universalizing discourse through diagnostic categories, which are treated as distinct entities moveable across people, and creating uniformity of pathologies and persons (Lakoff 2007;13). The state's legislation of 'universal' health care and public health interventions create a very particular construction of social citizenship. As both Ticktin and Lakoff show, this social and humanitarian focus is fraught with its own exclusions, violences, and invisibilities. Psychoanalysis, despite claiming pride in its fractures, pluralities, and impassioned defense of the individual experience, is still caught by the paradox of its own existence. Through the formation of psychoanalysis as an authority, it already has created a certain universalism. Thus, the center of psychoanalysis, the radical individuality of

subjecthood, has already become its limit. While they come into conflict and differentiate themselves from one another, there are also many instances in which these conflicting logics come to overlap and coexist within the public health model, the medico-social institution is one such space.

This public health structure is based on ideals of inclusivity and accessibility. In this case, the imaginary of coherence is founded on interventions into the 'dislocation of the individual and the civic'. Thus, these ways of conceptualizing the social whole, are ways of problematizing the movement of subjects within the care structure. In the model outlined in this chapter, the system operates through an understanding of 'continuous care'. However, this obscures that in actuality, multiple selves are being enacted as individuals move through the system, and come into contact with different authorities. This has interesting implications when put in conversation with the transdisciplinary care model of CPS. While founded on notions of a 'holistic approach', as the previous section demonstrated, such an approach to the totality of the individual is only achievable by simultaneously enacting and obscuring difference.

Annemarie Mol writes of a similar contradiction in *The Body Multiple*. In her ethnography, the many interventions into patients with atherosclerosis, despite being radically different ways of interacting with the body, do not imply fragmentation, but rather, are made to cohere. (Mol 2002;viii). Mol writes, "Atherosclerosis enacted is more than one- but less than many. The body multiple is not fragmented. Even if it is multiple, it also hangs together" (2002;55). This is highly reminiscent of the subject(s) of the system of continuous care. As this

chapter should demonstrate, these histories, ideologies, and institutions are disrupted, de-centered by the very conjuring of their subjects. Despite the attempt to create a seamless system of care, disruptions are being signaled through the fact that the subject exists in multiple.

This perspective creates an interesting dialogue with Foucault. From a Foucauldian perspective, the individual is instantiated into a particular subjectivity by their interaction with institutions (1976). In his work, Foucault weaves together the many ways of knowing (and normalizing) oneself into one continuous narrative, and as such the myriad forms of power that populate his writing become compounded into the (singular) inescapable fate of the subjectivized (1976). However, an engagement with multiplicity, allows us to complicate this view of the subject by temporarily holding these given subjectivities apart while still allowing them to 'hang together'. This understanding of enacted subjectivity that arises within certain encounters allows for different engagements with questions of power and difference that pervade structures and their universals. This kind of engagement will be important to think with, in the figurings of structures and subjects in the chapters that follow.

Further, emerging from this space of overlap, the medico-social, is a particular French ethos, a discursive tradition that concerns itself with questions of the subject, the social, and their relationship. All throughout this chapter, echoes of this ethos are seen. Whether replicating or problematizing Durkheimian notions of the isolated self, these engagements are woven into the subtext of this chapter. Written into the World Wars, into decolonization, into the May 68

protests, and their aftermath, French theory underlies and engages this topic everywhere from a politics of social citizenship, to institutional ways of knowing, to their critique by social theorists. From psychoanalysis's fierce protection of subjectivity to the Foucauldian understanding that institutions create their subjects, the question of the subject returns again and again.

However, this chapter raises further questions about the implications of this discourse for the people populating these structures. Given our focus on gender and hysteria, what are the consequences for women within these formulations of inclusion and subject-hood? The following chapters will more deeply explore these stakes. While continuing to engage with modernity, structure, and imaginaries of connectedness, the next chapter will further examine femininity and formulations of the pathological. Through a media analysis of television series about haunted families, the following chapter will examine the relationship between absence, authority, and the woman. Additionally, it will further examine the modes of power and authority outlined here, but mediated through another structure, the family. In so doing, it will illuminate the spectral quality of structure itself, and ask how the problematization of *lack* effects the subject of the clinical encounter.

Chapter Two

"The uncanny as it is depicted in literature, in stories, and in imaginative productions, merits in truth a separate discussion. To begin with, it is a much more fertile province than the uncanny in real life, for it contains the whole of the latter and *something more besides*, something that cannot be found in real life." (Freud, 1925;18)

My introduction to hysteria was an American film, Split. As I recalled my run-ins with hysteria's chimeric presence, I quickly realized that media representations could serve as a valuable window into hysteria and its relation to French society. I noticed that in many of my conversations with colleagues, American media was cropping up. When discussing the psychotraumatic elements of hysteria, the CPS psychiatrist, Dr. Pons, and I got into a long discussion of the aesthetic of trauma in Hitchcock's film Marnie. Within minutes of our discussion of cases, one of the psychologists, Vincent, had recommended the film A Dangerous Method. Later in that discussion we got onto the topic of media representations of gender pathology. He brought up American television series like Mr. Robot, and we discussed gendered differences in these popular imaginings. Further, these practitioners were always emphasizing that hysteria was a cultural manifestation. That its presentation was a constantly shifting, social reflection. Thus, engaging the social imaginary seemed to be an important point

of entry in understanding not only what was particular to the French context, but further, what was particular to this particular moment in the French context.

I was surprised to find my time in France was saturated by American media products. The college students I went out with, my host siblings, my coworkers, all listened to American music and watched American shows on Netflix. I found these interactions to be indicative of the contemporary moment, and the implications of global interconnectivity. Indeed, a foundational consideration of modernity is an interest in movement, and the circulation of products, people, and ideologies (Lakoff 2005;41). I myself was interested in these circulations, and role technology and media play in these new configurations of connectedness. While, I wanted to explore explicitly French cultural products, to understand the specificity of the French context, I was also taken with the overwhelming amount of cultural mixing I had witnessed during my time there. Serendipitously, I stumbled across a television series that provided access to both worlds, a show titled, Le Secret d'Elise, which was an adaptation of a British television series. Like the chapter preceding, this chapter is not explicitly focused on hysteria. However, the series is an exploration of gendered pathology, and as such, the analyses of this chapter will greatly illuminate the understandings of hysteria outlined in the next section.

Though it initially caught my eye because of its own history of circulation, le Secret d'Elise was also a popular series. In 2015, it was the most watched show in France. After researching the show, I found that the series concept, titled The Oaks, actually originated in the US, but was canceled after the pilot episode. It

was then taken up by a British production company and was developed into the series Marchlands in 2011. In 2014, it was adapted into the French series Le Secret d'Elise. The narrative follows one house over three separate time periods, 1969, 1986, 2015 (In Marchlands it's 1968, 1987, 2010). The story begins with the drowning of a little girl (Alice/Elise) in 1968. She then haunts the house through the subsequent generations of families. The series follows the intersecting families and storylines of the people who inhabited the house. This was a fascinating study of the feminine pathological, of mothers and daughters, of girls and ghosts. In order to try and parse out what might be particular to the French cultural imaginary, I watched Marchlands and Secret d'Elise side by side. I compared each subsequent episode back to back. I watched these series to look for both culturally distinct and shared discourses of pathology circulating in this imaginary. What I happened across was a rich and intricate discourse of gender, structure, and authority mediated through the presence of a spirit. The haunting in these series, opens up intriguing questions about how the spaces female pathology occupies become not only visible, but voiced- and to whom and under what circumstances. This reading will inform our exploration of authorities and their subjects, the particular French ethos, and questions of pathology in an age of global interconnectivity.

While the previous chapter explored the workings of institutional structures, it did not address the stakes of the care structure for its subjects. This chapter will more deeply engage the pathological femininity and thus will begin to explore the question of the woman, which has been largely absent from the

discourses outlined thus far. In the remainder of this chapter, I am going to analyze how gendered pathology is situated in each of these cultural imaginaries- with a particular eye for what is distinct about the French context. I will first explore the relationship of sexuality and pathology within the elemental structure of the family, I will then look at characterizations of the woman in terms of absence and repression, and finally I will draw from these two sections to examine authority and subjecthood in the clinical encounter. These sections will illuminate very different logics of intervention, and institutional alliances in British and French representations. Within each of these sections I will critically engage with representations of haunting, absence, and disruption in these encounters. In so doing, I will argue that notions of haunting illuminate the spectral quality of structure itself. I will further argue that this spectrality quality of structure, particularly as it relates to gender, aligns with French problematizations of the self-social relationship as a particular imaginary of totality. The considerations of sexuality, authority, subjectivity, knowledge, and absence outlined in these sections will be helpful to the discussion of hysteria in the following chapter.

Family, Displacement, Deployment

Whereas the previous chapter explored the state structures that legislate public health intervention, this section will analyze a more fundamental structure, the family. Whether one wanted to think with Mauss and Levi-Strauss and their

influence on Lacan, or with feminist critiques of psychoanalysis, there is a wealth of options from which to consider French thought and family structure. However, Foucault best facilitates a transition from the public health considerations of the previous chapter to considerations of the family. Indeed, Foucault understands the family to be integral to this distribution of power, he argues that the family binds together these domains of power through the deployment of sexuality (Foucault 1976;110). Indeed, in many formulations of family within French thought, whether implicitly or explicitly present, sexuality is central to the creation and maintenance of the social structure. This section will consider representations of sexuality and pathology within the family, and how normativity is established within this structure. The families' efforts to normalize their members, lead to very particular incorporations and exclusions of interpretative authorities. This will have implications for the following sections, which will take up understandings of feminine absence as well as the clinical encounter and the subjectivity imagined in each of those representations.

In future chapters I will explore theories of gender difference through the family and its origins in oedipal development. However, here I would like to explore it as part of a different conversation of power. In *The History of Sexuality*, Foucault uses sexuality to tie together the various modes of subjectification in the vast workings of biopolitics, medicine, religion, psychoanalysis, and the family. As the previous chapter explored, state responsibility for maintaining life is achieved through the regulation of, and intervention into, the body (1976). Sexuality, as bodily practice engaged in the reproduction of life, and thus the

social system (population) therefore became a technique of power. In discussing the transformation of systems of power into a responsibility to maintain life, Foucault writes, "broadly speaking, at the juncture of the 'body' and the 'population', sex became a crucial target of power and is organized around the management of life rather than the menace of death" (1976;147). As such, he cites the deployment of sexuality, as one of the first and fundamental sites of normalization, in which the individual comes to be constituted through this technique of power (1976;108). Further, while the family is by no means the only site of power through which people become subjectivized, it is however a fundamental one. He writes, "the family is the interchange of sexuality and alliance: it conveys the law and the juridical dimension of in the deployment of sexuality; and it conveys the economy of pleasure and the intensity of sensation in the regime of alliance" (Foucault 1976;108). Using this analytic, this section will concern itself with the constructions of pathology within these family relations, and the authorities which are permitted entrance into the domestic sphere. Particular attention will be paid to the subjectivities that are enacted in these encounters. Further, this chapter will be interested in the ways that sexuality becomes obscured or emphasized based on the logic of intervention.

In Marchlands and Secret d'Elise, sexuality permeates the families and is in fact responsible for the haunted domestic space. Alice and Elise witness their grandfathers in the act of an extramarital affair, this is the 'secret' responsible for their death. After happening across the scene, the girls fled blindly into the marsh and drowned. Thus, the driving force behind both series is the arresting trauma of

the primal scene. In the subsequent storylines, pathology comes from the disruption of 'normal' family relations by the ghost, whose presence is a result of unarticulated sexual secret. As such sexuality underlies these familial relations and the formation of the pathological in the series.

While there are many figurings of sexuality in the shows each indicates either a deviation from the family structure, or its replication. This section will focus specifically on the 1980's plotline. In this narrative, nine-year-old Amy/Valentine and her parents and brother, move into the haunted property. Trouble arises when Amy/Valentine begin talking about their friend Alice/Elise who also lives in the house. The remainder of this narrative revolves around revealing the pathology perturbing these girls, who form a double for the ghosts. Indeed, the first scene of this plotline is a direct replication of the primal scene. In the scene, the parents are about to have sex, when the teenage son and nine-year-old daughter come bounding into the room. In both versions, the teenage son covers the eyes of Amy/Valentine and comments that they're are going to traumatize her. This becomes ironic, given the ghostly secret haunting the family. In all of the plotlines and families throughout the two shows, whether it is extramarital affairs, grieving mothers refusing sex, or the teenager's first love, not only does sex provide the intrigue for these series, it is their raison d'être.

Further, sexuality is not only significant in terms of the reproduction of the family system, it is also the primary means through which understandings of the pathological is formed. In *A History of Sexuality*, Foucault relates, family, sexuality, and pathology to each other, writing:

> "In the family, parents and relatives became the chief agents of a deployment of sexuality which drew its outside support from doctors, educators, and later psychiatrists, and which began by competing with the relations of alliance but soon 'psychologized' or 'psychiatricized' the latter. Then these new personages made their appearance: the nervous woman, the frigid wife, the indifferent mother- or worse the mother beset by murderous obsessions- the impotent, sadistic, perverse husband, the hysteric or neuroasthenic girl, the precocious and already exhausted child, and the young homosexual who rejects marriage or neglects his wife" [1978;110].

As the above paragraphs demonstrated, many of these characters populate the narrative. However, rather than simply demonstrating their connection to sexuality, I'm interested in how different authoritative alliances, mediated by the psychopathology, come into being within these family structures. I would like to look at this specifically in relation to the 1980s plotlines, where sexuality is most explicit. In both series, there is an assumption that trauma, particularly incest, is the cause of Amy/Valentine's pathological behavior. However, there are striking differences in the way these conversations of pathology are carried out within the family. Sexuality, while explicit in the French version, is much less so in the British. Further the role different authorities are permitted within the domestic space alludes to different logics of the pathological. Both of the series invoke a

multitude of different institutional players in the attempt to diagnose Valentine and Amy. However, the kinds of alliances that are occurring, emphasize very different values in healing- and the knowledge systems that underlie them. In both series, the relationship of the girl's psychopathology, to their sibling's parallel illness, illuminates the space psychopathology occupies within broader medical logics.

In the series, Amy/Valentine are made into objects of intervention due to their insistence on the presence of Alice/Elise. Foucault writes, "Caught in the grip of this deployment of sexuality, which had invested it from without, contributing to its solidification into its modern form, the family broadcast the long complaint of its sexual suffering to doctors, educators, psychiatrists, priests, and pastors, to all the experts who would *listen*" (1978;111). This is precisely what transpires in the series. The two narratives follow a similar arc: upon moving into the house the younger daughters start speaking of their new friend Alice/Elise. However, as Alice/Elise's presence becomes more and more explicit, both sets of parents choose to take their daughter to doctors, who bring in various authorities to identify the true nature of the problem. The psychologist first sends Amy/Valentine for a battery of scans to determine if her pathology is 'physical or psychological'. In the absence of physical causes, the psychologist then invokes the expertise of the social worker. Frustrated with this approach, both fathers also bring a priest in to intervene. Further, in Secret d'Elise, the social worker interprets Valentine's behavior as a sign of sexual abuse and has the father

arrested. Thus, even the law contributes to the compounded gaze trained on the pathological child.

Very quickly, what Amy/Valentine are communicating gets lost in the optics imposed by these bodies. Instead, what takes precedence is how authority is being imposed and negotiated in the interpretation of the two girls. The family is at the center of this process. Understandings of normalcy, and authorization of those permitted to intervene, are transmitted by the parents. However, this is a site of conflict as the characters, particularly in Marchlands, are constantly questioning who this interpretation of pathology is actually for. The family troubles themselves over what it means to be perceived as ill, and asks for whom is the performance of wellness?

These conversations are particularly explicit in Marchlands, and take up the vast majority of the 80s plotline. Though pathological behavior is initially identified by the parents, its origin must also be legible to the correct authorities. This is exemplified in the following exchange:

> Husband: How long do you think this is going to go on for?
>
> Wife: Until she gets better.
>
> Husband: Better than what? She used to be really happy, look at her now. What if Amy is telling the truth about Alice, what if Alice is real?
>
> Wife (flatly): Amy's invisible friend.
>
> Husband: What if she's like a ghost?
>
> Wife: She can't be real like a ghost because ghosts aren't real.

Husband: What if they are real? What if Amy's not ill, what if she's just haunted? It would explain everything.

Wife: To who?? Do you think the social worker is going to report: no signs of historic trauma Just supernatural activity? No Eddie stop it.

The irony of this scene is that Amy is indeed signaling historic trauma- however that trauma did not originate with Amy, but rather, was reproduced across generations of families, such that reverberations of the initial violence continue to unsettle 'seamless' domestic relationships. Further, while sexual etiologies are implicit to the psychologist's interpretation of Amy, in this plotline they are subsumed beneath a dominant conceptualization of Amy's pathology in objective, medical terms. In Marchlands, Amy's mother is constantly establishing Amy as ill and needing to get better. She insists that Amy only be understood through the 'legitimate' language of illness. The registers that she invokes constantly link Amy's pathology to biomedical constructions and refuse other potential understandings such as hauntings. Further, I would like to point out that in both series, the fathers recognize the true nature of their daughter's pathology, while the mothers refuse to believe it. While the mothers insist on normalizing the behaviors through various institutions, the fathers have the ultimate authority to declare their daughter's (and Alice/Elise's) voices as legitimate. This is exemplified by two further interactions:

Husband: I don't know why you're reading them (psych books). The doctor doesn't even know. The thing with the scissors, I was just thinking about what the doctor said, about keeping an eye on her…I don't want to be thinking about her like that, or talking about her like she's a set of symptoms or a case study.

Wife: She's not well love. We have to find out what's wrong. That means doctors, clinics, medical jargon.

(The wife comes home and finds the husband has brought in a priest to bless the house) She yells at her husband: You bring that mumbo jumbo in here and wonder what harm it could do?

Husband: What about the mumbo jumbo in those psychology books, from someone in a white coat.

Wife: So you'll drag us back to the dark ages where someone like Amy would be burnt at the stake. Do you think it helps her to know that her father believes in the healing powers of magic water?

Husband: She's been telling you for months and you haven't listened to her. You're scared you might not know everything.

Wife: Because she's sick. She. Is. Sick. What you need to do is keep out of my way. Stop dealing in stupid, hand-knitted solutions and leave Amy to the professionals

These dialogues are interesting because they highlight a very particular understanding of pathology. The first excerpt acknowledges that becoming a medical object involves a radical reconceptualization of self, and part of this process is the acquisition of a new language of interpretation. The second excerpt emphasizes the legitimacy of medical rationalism by opposing the enlightened knowledge practices of the present to the occult fascinations of the 'dark' ages. These brief dialogues demonstrate that an immense amount of work is being done to bridge 'legitimate' medical registers and psychological phenomena, whereas stark boundaries are being enacted between psychopathology and spiritual mediations of religion or ghostliness (in other words, the decidedly unscientific).

This emphasis on bodily, biomedical pathology is compounded by the discovery of 'legitimate' illness in the household- Amy's brother Scott. Scott contracts a neurological illness- epilepsy. This culminates in a climactic scene in which Scott nearly drowns while seizing in the bath. Interestingly enough (given that she symbolizes the unarticulated and the secret) the only times that Alice is visible to Scott are the times that he is having a seizure without anyone's knowledge. The equivalencies being made form a very particular notion of the pathological. This work implicates psychopathology into a deeply bodily logic of localizable illness, treatment, and cure. This results in an intense defense of boundary-making surrounding Amy, such that all intervening authorities are reframed in a language of diagnosis and cure, or are excluded. Biomedical logics and its language of intervention are thus intertwined with psychology, such that pathology is only legible through certain occupations of subject-hood and certain

ways of knowing them. Most importantly, the primary site in which these understandings are being fashioned and challenged is within the family. Notions of the pathological, and the authorities permitted intervention, are first formed, and solidified by the family structure.

This particular framing of pathology is a noticeable departure from that of Secret d'Elise, which does not place its emphasis on the biomedical. Arguments over Valentine's depiction as ill are not the dominant focus of this storyline. While there is an effort made to understand Valentine 'rationally' (the wife pushes back against the presence of priests and ghosts) she otherwise seems relatively disinterested in conceptualizing or treating their daughter as sick. This is not to say in Secret d'Elise the family is not the first and primary site of pathologization, but rather, that discourses of boundary-making takes up much less space than those which attempt to understand the *function* of the pathological behavior. Pathology here is formulated in terms of 'anti-social' behavior. Whereas the social worker did not even have a speaking part in Marchlands, the scenes of highest dramatic intensity in this storyline surround the social worker's entrance into the household and her interpretation of the social relations of its members. The authoritative alliances are here enacted between psychology and sociality rather than around a nameable illness. Further, sexuality plays a much more explicit part in this narrative.

The climactic focus of this storyline surrounds the social worker's investigation of the home. While she correctly identifies Remy's hidden psychological distress, she believes Valentine's pathology to be a result of sexual

abuse by her father. The social worker's vague and innocuous questions illicit equally ambiguous answers from Valentine, which the social worker interprets as signs of sexual abuse and reports to the police. After being informed Valentine's father has been acquitted, the social worker gives a dire warning to her mother, saying, one day she will find Valentine has committed suicide, and the fault will lie in not have having recognized the signs early enough. She references another family, who found the daughter 'hanging from the rafters'. This warning aligns exactly with the pathology of Remy, who, later that same episode, attempts suicide. The origin and language of pathology for Remy and Valentine, mirror one another. Indeed, when the social worker inspects the house, she uses the same language of defense and escape as the psychologist discussing Valentine (which will be discussed in the next section):

> Social Worker: A child that drinks is a child that is not well. I found a bottle of alcohol in his desk.
>
> Mom: you went through his desk?
>
> Social Worker: It's my job. I don't think that your son is well either. If he's drinking he's looking to escape something…

As with Valentine's pathology, which is framed in terms of a-social behavior and social isolation, Remy's is signaled by isolative alcoholism. A sexual origin could also be theorized from this pathological response. The suicide is his attempt to escape from a love interest's rejection. Further, in both cases,

brother and sister, lends itself to analysis of pathology in terms of oedipal imaginings with spectral transgressions of the incest taboo and the refused love-object. This interaction summarizes the differences between the French and British formulations of psychopathology. In the French series, the question is what are they escaping? The focus is not placed on categories, rather the concern is a fundamental understanding of pathology as communication. Therefore, the language that is invoked is not a biomedical, but rather a psychoanalytic logic that is exploring the person's functionality within the family structure.

Both these storylines grapple with imposed and 'legitimate' forms of pathology, and in both cases the family is the primary site in which the pathological is identified and where acceptable interventions are authorized. Further, in the French version, the literal entrance of social authority into the house, and the false imprisonment of the father, evokes an anxiety of the subject's constraint by the social. In Marchlands, conversely, anxieties surface surrounding the radical reconfigurations of personhood that result from being conceived of as ill. As such these series illuminate subtle and yet stark differences in the imaginaries of these two places.

Once again, these approaches to pathology seem to signal very different ideas about subjects in the British and French version. While Marchlands is focused on biomedical enactments of psychopathology, Le Secret d'Elise is more focused on sociality. As such the French version is centered around understanding the individual in relation to others, as opposed to Marchlands in which pathology is contained within the individual. Further, while sexuality is present in both

shows, this conversation gets subsumed in the British version by a certain scientization of sexuality. Therefore, conversations surrounding Amy as a medical object take up much more space. In the French version, conversely, sexuality is a central component of the storyline. Further, as I alluded to in the above paragraph, the emphasis on social relations, and a much more explicit connection to sexuality in the French version, easily lends itself to various structural analyses such as psychoanalytic interpretations. Structural interpretations, as found, for example in Lacan understand sexuality and exchange, particularly as it relates to the family structure, to be fundamental social systems and the place if the individual within them. Further, alignment with sexuality will be important to understandings of the hysteric subject as well as the positioning of French psychoanalytic authority, explored in the next chapter.

This section explored sexuality and pathology through the family structure as a deployment of authority. While the use of Foucault in this section was interested in techniques of the body as a construction of subjectivity, the next section will probe representations of dis-embodiment and voicelessness. It will engage theories of repression which are not as much a part of Foucault's project, and will ask what are the circumstances and stakes upon which one is provided a body to begin with? The next section will more closely explore ghosts, girls, and authority, and will examine the role of absence in the creation of subject-object relations.

The Woman, The Voiceless, The Dis/embodied

In both of the series, the episodes are frequently punctuated by long lingering shots of empty, interior spaces. Breaking up scenes, the camera will cut from shot to shot of empty hallway or half-open doorframe. Occasionally, these shots will be disrupted by slight movements, the rustle of a curtain, the creak of a door, or the eventual entrance of one of the characters into the house. For the most part however, the camera rests stagnant for the entirety of the frame, and the silence, the claustrophobia, and an uncanny feeling that something is present but invisible, invades the viewer. The focus on haunted interiors, is symbolic of pathological femininity, for whom the unseen specter of gender difference lurks, unaddressed. This presence disrupts the contained space until it is correctly diagnosed, interpreted, released… and life can return to normal.

In an interview with ITV1, Marchland's writer Stephen Greenhorne commented, "What really interested me as a writer, was to compress the grief experience in that claustrophobic, sexist environment- where she's struggling to express it in an environment where everyone else is repressing it." This representation of haunted homes is indivorceable from Freud's notion of the uncanny. As Freud theorized, a feeling of the uncanny arises from an involuntary return to the same situation (1925;11) and thus from "something familiar and old that has been repressed and returns to the mind" (1925;13). The representations of repression and the uncanny in this series (seen through the ghosts and their relationship to the female protagonists) implicates understandings of absence and othering as fundamentally fixed to the question of the woman. How the woman is

represented as bounded by her body, and is portrayed as voiceless, is tied to an understanding of the woman as an object to man's subject, an Other to man's self (deBeauvoir 1976;xvi). This understanding will be central the subsequent sections and their focus on constructions of the pathological woman within structures. It will also have implications for the understandings of hysteria outlined in the following chapter.

To demonstrate the explicit relationship between the alien, the unarticulated, and the woman, I will use Freud's notion of doubling. Freud identifies the double as, "the one possesses knowledge, feeling, and experience in common with the other, identifies himself with another person, so that his self becomes confounded, or the foreign self is substituted for his own- in other words by doubling, dividing, and interchanging the self. And finally, there is the constant recurrence of similar situations, a same face, or character trait, or twist of fortune, or a same crime, or even a same name recurring throughout several consecutive generations" (1925;9). In the previous section, Foucault's analysis was interested in understandings of power that were constitutive rather than repressive. However, the ghostly presence in this series asks that we also take seriously the position of the invisible, the disembodied, the repressed in considering how it is provided a particular subjectivity (a body). In all of these examples, the characters disrupted by Alice/Elise are women, they are the figures who provide the ghost with a body. Though it is the women in the series who have the knowledge to voice the unarticulated, their voices are either subsumed, or determined to be legitimate, by various authorities (men). Through the female

protagonists' entwinement with the character of Alice/Elise, the non-being of ghostliness becomes synonymous with, and reflects the lived experience of femininity.

Many of the female characters in both series reflect a sense of claustrophobic containment. This dynamic is shown most clearly in the haunting of the 'present day' pregnant mothers who become literally confined to the house in the late stages of their pregnancy. From the outset, their experience is set up to mirror that of Alice/Elise's. Further, we are introduced to Nisha/Julie during their renovations of the nursery (originally, the childhood room of the ghost). This scene of uncovering and resettling, is followed by a decision to name their unborn child Alice/Elise. In Nisha's case this decision occurs during the scene of an ultrasound, which, like the mothers themselves, provides an optic through which to view the invisible- the specter and infant having already been symbolically intertwined. The identification of baby with ghost also serves to symbolize a replication over time- the displacement of the mother daughter relationship and legacy of becoming a gendered body. As the mothers spend more time in the house, this effect is only heightened. During the renovation, both mothers remove the wallpaper from the nursery and uncover a mural of Alice/Elise. This project of rendering her visible, becomes nearly an obsession for each of them.

The longer the women spend alone in the house, the more Alice/Elise makes her presence known. However, when the mothers try to vocalize this experience, they are patronized, painted as paranoid or childish. In other words, they are silenced. Both mothers often complain about their sense of isolation in

the house and the feeling of going mad. They're told that they're being irrational or imagining things because of the exhaustion of new motherhood. The mother's positions reflect that of the ghost, who herself is confined and isolated within the house, and cannot be heard. In one episode, Nisha vents saying, "I feel like I'm going mad up there sometimes. Mark told me I was being hysterical, like I'm some little girl." Julie as well, refers to herself as hysteric twice in the show, when anxious about being perceived as paranoid and jealous. She frets, "If I press too hard I'll look like a jealous hysteric." Indeed, the more the presence disrupts 'normal' life (the more visible the specter) the more pathologized the wives become. Though in the series, the word is being employed casually, it is still signaling a certain operation of power within the hermetic expectations of womanhood.

Another woman with whom Alice/Elise is closely intertwined is the character of Olive/Catherine, who is deaf. The fates and experiences of these women are bound to Alice/Elise as both living and ghost. Olive/Catherine appear in each successive time period, beginning as Alice/Elise's childhood friends in the 60s, and ultimately, holding the secret to their release. While Alice/Elise must find a way to communicate the identity of their secret keepers, it is Olive and Catherine who must be understood for the ghosts to move on. In short, when the ghostly consequences of silence and continual return loom over these feminine figures, they must find a way to make themselves heard. In the case of both ghosts and women, their ability to communicate is mediated through the body and its interpretation.

However, this was where one of the greatest differences between the two representations was found. While both represent being unheard, the two characters vary greatly their portrayal of pathology, both physically and psychologically. Olive cannot hear because of a childhood illness that caused irreversible deafness, but can still talk as well as lip read. Her communication with others is not really affected by inability to hear. Consequently, Olive has a much smaller role, and the dramatic reveal of Alice's secret comes down to the simple truth that "no one ever asked me". Catherine however was born deaf and is completely mute. Her only means of communication is sign language and writing. There are countless scenes in which she is visibly distressed and trying desperately to say something, and the person she is talking to can't understand her, or is not even looking at her. In this way, both communication *and* recognition of that communication, are of tantamount importance.

In the show, her character also represents a much more severe psychopathology. Catherine in 2015 is still deeply in love with Yanis. They have an affair and when he ultimately chooses to ignore her, she attacks Yanis's wife, steals their child, and then attempts to commit suicide with the child (a surrogate for the child she secretly had by Yanis in the 80s, who died prematurely). Apart from a potential desire for heightened drama in the French version, it is undeniable that her lack of recognition, leads to a much more pathological manifestation. Presence for both Elise and Catherine, is communicated by modes of embodiment. Valerie Kaprinsky who played Catherine, spoke of how she learned to speak sign language and reflected, "Even if sign language changes

from one country to another, it really helped me gain the realization that one must always look each other in the eyes. That understanding changed my way of playing the scenes with the other actors, because there were more questions than I signed, which meant they weren't paying attention. So, I had to stamp my feet or knock on the wall to get their attention." Elise too knocks books off bookshelves, taps on walls, writes in glass- she finds ways to signal her presence. However, as disembodied, her fundamental absence is given form through the bodies of the women who act as her double. This mirrors the position of the women themselves, whose communications also require recognition and *interpretation* to be released from a status of non-being.

This understanding of gender aligns with a French formulation of the woman. In *The Second Sex*, Simone de Beauvoir, writes of Aristotelian conceptions that "the female is a female by a certain lack of qualities" and that the woman's body is a "prison, weighed down by everything peculiar to it" (1976;xvi). These notions of inherent confinement and absence certainly lend themselves to the representations of woman and ghosts outlined in this section. In taking up these idioms of womanhood, de Beauvoir articulates these formulations of femininity as absence, as a necessary condition for masculine presence. She writes, "He is the essential, she is the inessential. He is the subject, he is the Absolute, she is the Other…The subject can be posed only in being opposed- he sets himself up as the essential, as opposed to the other, the inessential, the object" (1976;xvi-xvii). Therefore, when speaking of absences we are also speaking of subjects and objects, of self and other, we are speaking of difference.

This is perhaps exemplified in Lacan's theory of the cut, in which separation from the *Mother* allows for the creation of a subject through the production of an object (Razon et al. 2017;1). In this formulation, the first conception of self as a totality, comes from understanding oneself as separate from, but dependent on, the mother. For Lacan, there is no subject without the other (Vanier 2000;37). I would like use these understandings to more closely examine this act of absenting and the origin and reproduction of structures. I would like to posit that there is a particular spectrality to the structures explored throughout this paper, in that the subjects which form the structure are predicated on an opposition- they are constituted by an object/other through which the subject/self becomes. This is also the process by which these exchanges (the structures) are perpetuated because the relationship between subject and object is always unsettled. This is because the object/other is a necessary condition of the subject, but simultaneously, for the subject to exist it must always mark the other as the *not* self/subject (as lacking). In other words, though the system might be predicated on difference, the boundaries of incorporation and separation, as exemplified in Lacan's cut, are never fully resolved. These systems are populated by the present-absence.

Therefore, though de Beauvoir speaks in stark distinctions between subject/object. This is in reality, a much more complicated exchange. To return to Freud's concept of the uncanny, and our series. From de Beauvoir, one could argue that the representation of ghostly presences in these homes, and the haunting of multiple generations of women, is derived from their continual return

to a status as voiceless, repressed, and alienated figures. From the confined mothers to the mute secret-keeper, in the entwinement of Alice/Elise with these protagonists there is an implicit parallel between inherent absence and the status of the woman. However, I would like to point out that Alice/Elise is also disrupting these domestic spaces. Though she binds together this storyline and this succession of families, she also unsettles the 'normal functioning' of these relationships. Through these encounters, the ghost of Alice/Elise is actually disrupting such fundamental distinctions as present/absent or embodied/disembodied. In fact, these spaces are disrupted by way of her simultaneous presence and absence, the moments in which the ghost appropriates a body through her doubles; the moments of temporary subjectivity that recognize and thus incorporate the alienated. So, while we can view this story line in terms of normalization, I would also ask that we take the ghosts, and their disruptions seriously, in their subversion of stark binaries.

This is an understanding of spectral presence that I would like to carry forward in the sections and chapters to follow. In the next section on the clinical encounter, I will posit that it is precisely the intervention into 'lack' that allows authorities to constitute themselves as authorities to begin with. Thus, the following sections will more deeply explore the stakes of these formulations of subjectivity (as objects of intervention) for the woman. Further, these understandings of femininity and authority as well as absence and structure, will be invaluable to our discussion of hysteria in the following chapter.

Experts and Origins

While the previous sections focused on subject-object relationships, and their disruption, as it related to a gender system. This section will focus on the clinical encounter itself. Here we will explore how Amy/Valentine, and through them Alice/Elise, become an object of intervention; and how through that process of interpretation, the woman is given access to a very particular subject hood. In short, this section looks at differences in how 'abnormal' behavior comes to be recognized within the psychological encounter, and the logics through which it is articulated and intervened on. I am going to analyze the similar process by which either bodily or behavioral signs are interpreted as psychopathology and embedded into particular value systems. I will argue that what is made visible through this interaction, highlights differences in how pathology and its intervention, is conceptualized in predominantly biomedical or psychoanalytically situated understandings of illness. I will argue the two interventions, in addition to constituting different subjects, are actually invoking very different ideals of totality through their interventions.

In Pharmaceutical Reason, Lakoff describes psychopathology as, "a practice of interpretation which cannot be disarticulated from predominate value systems and deployments of power in which people come to be constituted as beings of a certain kind within the psychiatric encounter" (2007;4). The assertion that subjects are enacted within the clinical encounter, is now familiar from the

first chapter. In light of the preceding sections, I would argue that the clinical encounter- and the institutional structures it represents- are also a space of spectralization. They, like the other structures explored in this chapter, require a presencing of the absent (or absencing of the present as it were) as a necessary condition for both their creation and continuation. Their authority relies on their capacity to interpret; it relies on knowledge that the person themselves must be alienated from or inherently lacking. For example, in the case of psychoanalysis, the unconscious is fundamentally inaccessible to the analysand, and can only be voiced and interpreted, by the analyst. As such, absence becomes necessary to authoritative presence, a position as an object of intervention is what constitutes the authoritative subject. Particularly for the question of hysteria in the chapter to follow, authoritative interventions into absence will take on a particular significance, For the remainder of this section however, I would like to think about what kinds of beings are constituted within the encounters outlined below.

The previous section discussed, how particularly in the British version, there is an insistence on medicalized understandings of psychopathology in terms of illness. Within the clinical encounter, this is seen most clearly in Amy's diagnosis:

> Psychologist: "None of the tests have found anything wrong with Amy. That means we now treat it as psychiatric illness
> Mother (shuffling through psych books): What to do you think is wrong with her?

> Psychologist: maybe some kind of dissociative amnesia- it's like a problem in the way the mind files memory- usually triggered by some sort of trauma. It's this trigger we'd be looking for. It could be anything, school, friends, family. That's why we usually link up with social services."
>
> Amy's father: "where's this trauma usually located?"
>
> Psychologist: "it's usually something that happened at home."

In this interaction, the focus is placed on localizable pathology: *Where is the trauma located*? Additionally, Amy's mother is looking for a nameable entity, and the psychologist provides a preliminary diagnosis- dissociative amnesia. As was shown in the previous section, the constant reference to medical logics leads to an emphasis on the discrete and categorizable- in short, diagnosis. These two impulses surrounding morality and diagnosis coalesce around the figure of Alice. Throughout the whole series, in diagnosing Amy, they are attempting to categorize Alice's presence. In the final scene of this narrative, after the family has all seen Alice and they prepare to leave the house, the mother explains to Amy that "Alice was actually a *good girl* all along. I think she was looking out for us, trying to warn us." Thus, the recognition of Alice's presence ultimately comes down to a moral designation, which is its own form of diagnosis and categorization. As such, the assertion that pathology in this show operates in biomedical terms, does not obscure the operations of gender and normalization at work in these encounters. In fact, the diagnosis given to Amy is particularly

interesting because it is euphemistic of hysteria, for which dissociation is a central tenet. While hysteria's relationship to diagnosis will be explored further in the next chapter, many of the tensions that populate these representations will be relevant to understanding its place in the clinical encounter.

However, to continue exploring how these interventions position themselves as different, in the British version, their interactions with naming categories of illness/wellness place them into an overarching framework that constructs pathology as discrete and localizable. In Secret d'Elise, the focus is not so much on naming, as on uncovering and communicating the function the pathology serves and why its development would be necessary in the first place. It concentrates on practical considerations of uncommunicated desires being signaled through the pathology. This approach leads to explorations of social systems. The subject's navigation of relationships is the signifier of pathology and of what is being intervened into. In short, they reflect a more psychoanalytic approach to pathology. To explore this more deeply, I am going to return once again to the character of Valentine.

The first example comes from Valentine's initial mention of Elise in the first episode. As the father frets over Elise's mention, the mother says that she finds it to be "beautiful, intelligent, perfect" explaining that they've only just moved and Valentine "hasn't had time to make friends yet, so she invented one". In this way, Elise becomes a practical, adaptive invention of Valentine's *imagination* to combat the social isolation of moving to a new place. This too signals a logic that will be explored through hysteria: a refuge and reliance on

imagination to obscure inherent lack and relational difficulties. However, an emphasis on functionality continues even after Valentine's behavior becomes more dramatic. Her mother responds to her father's concerns by saying, "it's simply an illness to avoid getting in trouble." Similar logics persist when Valentine is brought to the psychologist. She initially asks, "Do you do it so your parents pay more attention to you? You can tell me." Once again Elise's presence is couched in social terms, as a set of behaviors adapted to combat difficulties relationally. As Elise's presence becomes stronger the question moves more in the direction of what unresolved concern is being hidden by the behavior. This is exemplified in one scene, in which they return to the psychologist after having found Elise's journal in Valentine's room. Her mother thinks that she has solved the whole mystery:

> Mom: See, (pointing to journal) that's where it must've come from.
>
> Psychologist: Yes and no, she took this journal as the basis for her imaginary friend, but the real question is why did your daughter need to invent an imaginary friend?
>
> Dad: What do you think?
>
> Psychologist: She is fleeing something; taking refuge in her imagination. What she's running from I don't know, but we're going to figure out what's perturbing her. So a social worker is going to pass by your home, speak with Val, ask her some questions.

This scene parallel's Marchlands, in that the mother attempts to place Valentine's pathology within a logic of localizability. However, her theory is refused by the psychologist who insists that the question is not where the pathology came from, but rather what unexpressed thing is being both signaled and obscured through the pathological behavior. As the father says following this interaction, "we need to try to understand what is presenting itself in her head, we need to be more attentive." Thus, the recognition of pathology is formulated in terms of its function, and the way it is rendered recognizable is through the subject's relationality to others. This formulation of pathology is consistent with a psychoanalytic orientation, in which unresolved/repressed conflicts manifest themselves in social relations. The subject's relationship to herself is measurable through how she is able to interact with other people and the wider society.

Further, in the last scene in the 80's storyline, each version's final appraisal of Alice/Elise succinctly summarizes how the series positions pathological presence. While Marchlands was focused on Alice "being a good girl all along," In the French version it problematizes Elise's isolation. The last words of Valentine are, "I hope she's (Elise) not too bored. It must pass slowly, being here all alone." The clinical formulations of Elise/Valentine in the French version, are reminiscent of the previous chapter. They recall CPS Paris, and a health politic, focused on sociality and inclusion. Interestingly, one of the greatest differences between the two shows is the representations of female connectivity. The French version is populated by strong, adaptive female partnerships. They solve mysteries, they face ghosts, they offer consolation in times of grief.

However, in the British version all the women are in adversarial positions to one another and everyone is completely isolated. I believe this is reflective of the moral logics that underlie these idealizations of intervention and healing. Through biomedical logics, the British version is focused on healing as bounded within the individual. However, in the French series, more rooted in psychoanalytic logics, the individual is accessible by way of their sociality, and incorporation is indicative of healing.

This is seen through the release of Alice/Elise in each of these series. The series end with two very different scenes in the 'present day' setting. In Marchlands, Nisha and her husband Mark are shown painting over the mural of Alice. Mark says, "Do you think she'll mind?" to which Nisha responds, "Alice isn't here anymore, Ruth came back for her and let her go. This place is ours now." In Le Secret d'Elise, the final scene is outside the house. Julie is speaking to Ariane (Elise's mother) and says, "You are truly a beautiful person Ariane, you will be missed. Come see us… for Elise." To which Arianne responds, "She's leaving too, I'm in the middle of saying goodbye." The British version is all about erasure, the covering over- a definitive end. This scene forefronts the beginning of new and different story, something totally distinct, discrete, and separate. Le Secret d'Elise on the other hand, is all about incorporation and relationships. The focus of the scene is Ariane, Elise, and Julie's relationship. Julie's invitation for Ariane to 'come visit Elise' implies peaceful cohabitation, and strengthened sociality now Elise's message has been revealed. In short, it applies the healing logics of psychoanalysis, in which cathartic release is achieved

through the voicing of repressed trauma that is interpreted and reincorporated into the psyche.

This section has been an exploration of subtle authoritative differences in representations of the clinical encounter. These variations of the same narrative indicate different fundamental assumptions about the individual, and support the assertion of the first chapter that very different ideas of subjectivity are being enacted through healing interventions. This is not simply to rehash distinctions between biomedical and psychoanalytic logics. Rather, looking at this narrative and how it is adapted to different cultural contexts can reveal the operation of different value systems when confronted with something that appears easily moveable. Further, this understanding of pathology in circulation, will be central to the following chapter's explorations of hysteria and the pressures of global interconnectivity. What this section highlights are very different understandings of the individual as bounded within the two contexts. Saying that biomedicine relies on atomized notions of the medical subject and psychoanalysis on a more relational understanding, is one way of formulating this. However, I would like to frame it differently, by saying both of these authorities are intervening into the individual as a totality but with very different imaginaries of what that constitutes. The psychoanalytic subject, as opposed to the biomedical, calls for a constant incorporation of others and the self. As the previous section demonstrated, this a perpetually unsettled pursuit. Not only does this reinforce a particular French interest in unbounded totalities, it also shows that French imaginaries of connectedness are inextricable from their imaginaries of the subject.

Conclusion

Exploring these stories of haunted homes and gender pathology, has revealed much about the particularity of French imaginaries. In the first section, we explored the family structure and its relationship to pathology, authority, and sexuality. We found that the discourse of Marchlands favored biomedical logics, and subsumed the sexual implications of pathological presentation. However, in Secret d'Elise we found that sexuality is implicated in fundamental understandings of personhood in relation to others. An understanding which supported structural logics. In the second section, through the doubling of ghostly presence and female protagonists, we explored a characterization of women in terms of absence and repression. In so doing we evaluated understandings of woman as the object to man's subject, the other to his self. We revealed a certain spectrality of structures founded in subject-object distinctions, finding them to be inherently unsettled. This lead us to pay particular attention to moments of temporary disruption and subjecthood within these structures. This formulation of unsettled subject object relations was then expanded in the following section.

In the last section, we looked at the different understandings of personhood enacted within the clinical encounter. We found that though both medical and relational ideologies were intervening into the individual, they were however, very different understandings of the subject. Whereas in the British, biomedical, understanding the totality of the individual was bounded, in the

French storyline this was not the case. These formulations, of structure, of absence, and of individuality, coalesce instead around a particular idea of coherence founded in an unsettled totality. Different problematizations of incorporation and difference have been present throughout these chapters. Thus, the imaginaries of connectedness, and the discourse of subject-social that we have been exploring throughout this text are a product of the open totality of the individual.

In truth, the title of each show summarizes their differences succinctly. Marchlands refers to a territory that surrounds a boundary; a borderland. The British series is focused on a project of boundary making in the construction of the pathological- on discrete, medical, units of illness and indeed is operating on a bounded notion of the individual. Le Secret d'Elise on the other hand, places its focus on unarticulated knowledge of an invisible character. This highlights understandings of present-absence, that both disrupts and reveals relationships and thus structures. Both series however, explore the limits of the dominant optics through which interpretation of pathology is made possible, and thus are both interested in the workings of power within these processes.

Both these shows trouble how healing and personhood are intervened into and made legible. In exploring the circulation of medical ideologies Lakoff writes, "As we have seen, the field's aims, projects, and modes of authorization vary according to the social and political milieu in which it is practiced. The context in which expertise is called for structures how illness is seen- and divergent systems of knowledge lead to quite different modes of intervention"

(Lakoff 2007;164). These two representations of the same show highlight global circulations of narratives of gender and pathology. However, they demonstrate that the same concept interacts with, and is taken up, very differently in different cultures. The differences between these shows better illuminates the tensions surrounding the use and incorporation of biomedical ideologies into the psychiatric field, which were alluded to in the first chapter. These understandings will be invaluable to the next chapter's exploration of hysteria and its conceptualization in clinical setting.

Further, though throughout this paper I have set biomedicine and psychanalysis as diametrically opposing, their aims and interventions often overlap and intersect. Even the differences between the two shows that I have outlined in this chapter are quite subtle. However, I have purposely signaled these distinctions throughout this project as a way of clarifying the authoritative positioning of the practitioners in the third chapter. While in reality, biomedicine and psychoanalysis are both equally culpable of the characteristics they most critique in each other, the ways in which psychoanalytically oriented practitioners defend their authoritative identity is integral to understandings of contemporary hysteria. The critics of biomedicine outlined throughout this project are therefore a result of a very particular positioning. I believe this posturing stems from anxieties provoked by imaginaries of contemporaneity that render psychoanalytic authority obsolete.

In the following chapter, I will further explore the creation of particular conceptions of personhood via hysteria, as well as its role within the

contemporary champ psy. In doing so I hope also to continue to explore the role of gender in understandings of how people are made into medical objects and intervened into. Further, I will examine hysteria as an integral piece of French understandings of the impact of modernity and global interconnectivity and their impact on imaginaries of connectivity.

Chapter Three

"In choosing hysteria, you've encapsulated the entirety of French psychiatry."- Vincent Lapierre

In all of the discussion of media, absences, and institutional structures, hysteria specifically has yet to appear. Hysteria's relationship to specificity is precisely what this chapter will be concerned with; in particular, the contested status of diagnostic specificity in the French psy world. In the previous chapters I have discussed tensions between the French state and psychoanalytic authority. While I have alluded to psychoanalysis' posturing as a reaction to medical logics, I did not deeply explore those relationships. This will become the focus of the following chapter through imaginaries of modernity and the disappearance of hysteria. Further many of the tensions outlined in the previous chapter will be helpful to understanding hysteria in the clinical encounter. This chapter is an analysis of my fieldwork, and of a strange contradiction: the paradoxical claim that hysteria was disappearing in the contemporary context, and yet simultaneously, would always be present for those who could perceive it. It will explore the contemporary hysteric subject, the authoritative differentiation of structure versus diagnosis, and narratives of hysteria's continuity. In doing so this chapter will highlight understandings of movement and the global circulation of medical ideologies and their objects of intervention. This chapter will explore

how psychoanalytic and biomedical imaginaries of modern connectedness come into conflict, and the stakes of such a conflict for their medical subjects.

Drawing on field notes from various sites in and around Paris, the majority of observations come from interactions with my colleagues at CPS Paris (the subject of the first chapter) and the site of a four-month internship. However, I have also included observations from my experiences working with faculty and students in an undergraduate psychology program at Université Paris-Diderot, as well as some observations from brief consultation with a secondary site. This second site, Entr'actes, was a family therapy oriented community center in a suburb of Paris, with whom the director of CPS also worked closely. My aim was to incorporate as many perspectives as possible in my pursuit of hysteria and its meaning.

While in the previous chapters I have discussed the boundary work of differentiating psychoanalytic authority from state and biomedical authority, I do not want to give the impression that these bodies are not constantly overlapping. Given their place within a medico-social structure, the intervention of many of my colleagues was not 'purely' psychoanalytic. Even still, my colleagues informed me that psychoanalysis formed a significant basis of their educational foundation in the psy field. Indeed, in the program at Paris-Diderot, psychology students were required to take psychoanalysis every semester of their undergraduate career. As such, most everyone I worked with (psychologists, art therapists, psychiatrists, even the social worker) were psychoanalytically oriented in their training and often in their approach.

However, I do not want to give the impression that psychoanalysis is the only orientation that is practiced in France. For example, the secondary site I worked with was based on an American systemics model. As family intervention specialists, they did not work in diagnosis or causes, but rather in the immediate conflicts and consequences experienced by the family. Further, movements for more biomedically oriented psychology, empirically based treatment, and CBT, all make up components of the French psychiatric community. Thus, while psychoanalysis has occupied a central role in the French psychiatric world, the form its influence takes is varied. The tensions, and notions of disappearance, with which this chapter is concerned occur precisely because of the plurality of psychiatric approaches within the contemporary French psych field. A sense of hysteria's simultaneous presence and absence is directly related to these spaces of overlap.

Further, despite my own approach being based in a thoroughly American idea of discrete diagnostic categories, hysteria, it turned out, was formed through an entirely different set of logics based in function and psychic structure. The plurality of hysteric manifestations and their plasticity throughout the course of history, did not render hysteria a meaningless category for psychoanalytic practitioners, much the opposite. It was precisely an engagement with idiosyncrasy of individual experience, that marked hysteria as particularly psychoanalysis' object of intervention. As such, the understandings of hysteria I encountered were only discernable through psychoanalytic and particularly Lacanian theories of subject formation, and were inextricable from the French

psychoanalytic identity. That being said, my own difficulty 'seeing' hysteria, is also indicative of a larger tension within the French psychiatric world, of navigating modernity and conflicting knowledge practices. Imaginaries of coherence, mediated through the different structural conjurings of psychoanalysis and biomedicine raise important questions about the stakes of universalist discourses and the theories of subjectivity and difference upon which they are built.

This chapter will first concern itself with an exploration of the hysteric subject and psychoanalytic logics of intervention through contemporary case studies provided by my colleagues. The following section will discuss how impressions of disappearance are implicated in conflicts between psychoanalytic logics and those of American psychiatric medicine. This section will reveal that within a debate over structure versus diagnosis, is one surrounding science and the subject in the contemporary period. The final section will explore discourses of continuity: narratives that still locate hysteria in the contemporary setting, and advocate for its continued presence in the future. The questions posed by this narrative are central not only to psychoanalytic identity, but also questions of exclusion and subjecthood in the contemporary period. Throughout this chapter, particular attention will be paid to how various structures (hysteria, psychoanalysis, biomedicine) operate within different understandings of dispersion and rupture felt to be inherent to the modern period. Once again, themes of disruption and continuity will orient this exploration of structure and the subjects (or lack thereof) that both create and maintain it.

The Hysteric Subject

Before further exploring notions of invisibility and disappearance, it is important to grasp what precisely was disappearing. How is hysteria understood? And what does it represent for practicing clinicians? From my own point of view, hysteria seemed to encompass every major symptomological category of the DSM. Tracing its history and speaking to professionals, only seemed to broaden the tableau and complicate it. I eventually realized the diagnostic lens made it nearly impossible to see hysteria. Indeed, the American psychiatric system of categorization, the DSM, was designed specifically to erase any traces of psychoanalytic organization from the American psychiatric milieu. Thus, my attempt to encounter hysteria as a diagnosis could only ever lead to an impression of absence. How I ultimately came to know hysteria, is indicative of the methodology of psychoanalysis itself; hysteria was revealed to me through discussions of individual cases containing 'hysterical elements'. However, as with Freud, these cases served as a window more into the French psychological imaginary, than into the individuals themselves. Though definitive cases of hysteria were not presented to me, the aspects of the cases identified as hysteric, and their nondefinitive nature, illuminated much about psychoanalytic intervention and the challenges it is facing in the modern period.

Through these cases I learned hysteria is foundationally a structure not a diagnosis. It was accessible therefore, not through symptomology, but

understandings of individual relationality. In all of these cases, the body, and its communications, were central to understanding how the hysteric relates to both herself and others. Further, there were several potential avenues through which the analyst could interpret hysterical communications. The hysteric's subjecthood (or lack thereof) was illuminated through demonstrations of trauma, dissociation, somatization, seduction, or theatricality. Further, the practitioners I worked with favored Lacanian interpretations. This meant that each of these potential presentations was ultimately founded on one central question: what does it mean to be a woman? What is it to understand oneself as a gendered body? Through such questions, discourses of knowledge, power, sexuality, and science are engrained in the reification of gender difference which produce and maintain not only the hysteric's psychic structure, but the authoritative structure of psychoanalysis itself.

Trauma/Dissociation/The Body:

The colleague at CPS Paris with whom I worked the most closely, was the team psychiatrist, Dr. Pons. As a result, he was one of the first people I approached with questions. In hearing about my project, he had already begun referring me to cases that I might find of interest. However, I couldn't understand their relationship to each other, and to the other cases I was being given by team members. When I first described my confusion, I asked him, but what exactly is hysteria? What does it look like? He was quick to qualify (as were many others I

asked) that he was no specialist in hysteria. Before saying another word, he pulled his phone out of his pocket and had googled the definition of hysteria. After some scrolling he found a description he liked, "Ah yes, it's this: psychotraumatic neurosis," noting its bodily manifestation could fall on the side of hypochondria or dissociation.

It is interesting that he highlighted these two axes, because …Dissociation describes a sense of disconnection in thoughts, memories, or identity, and is often deeply intertwined with presentations of trauma. While this relationship is exemplified most dramatically in Dissociative Identity Disorder, it also manifests in more subtle ways. One such case was a school teacher, into whose consultation Dr. Pons brought me in to observe. When I asked what aspects of her case were hysteric he replied that there was a dissociative element to her functioning. For example, she couldn't bring herself to do practical things; she couldn't unpack her house, tasks like buying tickets were difficult. He elaborated the problem wasn't that she didn't prioritizes these tasks, but rather she didn't know how to go about them. He also highlighted an element of performance during the consultation- her frequent and unwarranted laughter. As with all of the cases that were given to me, she was discussed in terms of 'hysterical elements'. The traces of hysteria in this case were signaled by her inability to connect to the practical realities of everyday life.

While dissociation is a sort of distancing from self and body, hypochondria centers the relationship of body and mind, particularly the relationship between body and psychological distress. Indeed, if one looks

historically at understandings of hysteria, one of its primary manifestations is pathological communications that take bodily form (somatization). The theory being that unaddressed psychological distress translates itself through the body and takes on the appearance of other physical illnesses. This manifestation is precisely what can make hysteria so difficult to spot- its presentation is often-times under the guise of another illness. When explaining the relationship of trauma and hysteria, Dr. Pons described the case of an Algerian immigrant. At 20 years old she had cranial trauma, and when she turned 40 she began to experience vertigo and pains on the side where the trauma had occurred. Though it was a very complicated tableau, with depression, somatic elements, and anxiety, ultimately, Dr. Pons surmised that the problem was her struggle to come to terms with the fact that 20 years had passed. She couldn't accept that she had aged 20 years, but also that her parents had aged (and particularly her father had aged 20 years). The resurfacing of old trauma, and her various somatic complaints, were the manifestations of this distress.

However, one of the most compelling cases I was given was a woman who had suffered unimaginable childhood abuse, and later in life struggled with bulimia, hypochondria, and suicidality. She articulated everything in bodily complaints and concerns, and was followed by at least six different medical specialists. In addition to being followed by the psychiatrist, she was also seen by one of the psychologists at the center for over 10 years. I sat down with her psychologist, Vincent, to learn more about her history and her story. Her childhood was characterized by psychological, physical, and sexual abuse. This

trauma was deeply engrained in the specific presentation of what she experienced. For example, as a child the consumption of food was an enormous point of contention. If she refused what her mother gave her, she would be forced to sit at the table for hours and would often throw up what she had been given. She would then be forced to eat what she had thrown up. Though the children were eventually removed from the home, in the face of such horrific violence it seems unsurprising that she struggled the rest of her life with bulimia and with her relationship to food- ultimately requiring a gastric by-pass surgery.

The trauma of the abuse affected her in other ways as well. Her psychologist shared with me that she had infantile perversions that structured her relationships with other people. However, he was not speaking in sexual terms when he said this, he was referring to her constant engagement in sadomasochistic relationships with others. One of their primary therapeutic aims was to develop her capacity for independent thought. He recounted the greatest challenge was she only thought in operational terms. For example, she'll pass directly from 'My sister said that I am useless' to 'and I took medications to kill myself'. In that line of thought, she isn't really present, there is no reference to what she was experiencing. In other words, there is no subject, and thoughts construct themselves independently of her. Vincent is trying to strengthen her ability to engage with her own responsibility and decision making. In discussing his approach, he recounted, "she doesn't talk about who she is. She has partial object relations- and because she can't communicate who she is, she can't really understand others. You see, she doesn't develop her thoughts, she doesn't have

the apparatus- it's a defense mechanism. She gives the impression of being influencable and fragile but she isn't; it's is a choice she makes to protect herself. She is the victim all the time to hide the fact that she carries a lot of hate and anger and violence, and it never surfaces at the right moment. She isn't able to express herself or her internal experience, and thus to communicate, everything passes by way of the body."

These cases begin to highlight some of the myriad ways in which hysteria can manifest itself. Already, they begin to illuminate the central problematic of the hysteric- a lack of subject-hood upon which their need for interpretation is predicated. Whether through a detachment from one's identity, or demonstration of an unreachable self via the body, the inaccessible is what structures these relationships. A denial of subject position both creates and maintains the circumstances for the hysteric presentation *and* the therapeutic interaction. However, dissociation and somatization are not the sole, defining features of hysteria. A central element in understanding the hysteric mode of relation, is that it often includes an aspect of performance and seduction. This understanding of sexuality and theatricality is one of the primary critiques of hysteria in the US. However, in the French context this is a space not only for an interplay of desire, but is also a space of constant invention- an invitation into the fantastical world of the hysteric. As with the cases above, this form of relationality is dictated by the lack of subject of the hysteric.

Theatricality and Seduction:

One of my impressions, particularly in the US, is that notions of overt sexuality and dramatism are often what remains of hysteria's legacy. The second site I worked with was systemically oriented, and did not deal in psychoanalysis or diagnosis. However, when I relayed my project of trying to understand hysteria, they all pulled potential cases to share with me. In brief, two of the cases were women whose characterizations by the clinical team were focused on elements of theatricality and seduction. A particularly strong element of both cases was an exuberant demonstration of motherhood- despite the fact that in both instances their children had been placed into other homes. In these cases, the women constantly emphasized themselves and their victimization, but were completely incapable of considering the experience of their children who had been removed on the basis of neglect. In both examples, the clinical team highlighted the women's fragile sense of self, which in turn, meant that they could not distinguish or take into account, differences in self and other. I highlight the following brief examples, to begin to complicate understandings of the role of seduction and performance in hysteria. I would like to emphasize the centrality of these understandings in the questions of power and subject that underlie hysteric structure. While this often serves as the basis of critique (particularly in American discourses) elements of performance and sexuality are central to understanding hysteria as a mode of relation to self and world, and are essential to understanding the women's ability to occupy a subject-position.

Seduction, particularly, was a side of hysteria that often came up in the examples given to me. The social worker, Isabelle, at CPS described one of her clients saying, "she is always sick and coughing, and passes her days in doctor's offices. She says she's been this way since her childhood and often remarks, "I was always fragile". She always makes sure she is well put together, and is continuously commenting on and describing other people's appearances. And there is an element of seduction when it comes to men. For example, when I had to call several of her doctors, she would give constant commentary, 'doesn't he have a beautiful voice?'" Further, Isabelle relayed to me that everything has to be valorizing for her (even though she is quite poor and receives her meals from a soup kitchen) and she is always in the act of demonstration. Due to this, she is not able to participate in the center's art therapy groups. Isabelle commented, "it doesn't work because she exists through others, other people have to constantly reinforce her. You see, how she understands herself is through this way of relating to the world."

This sentiment was echoed by other psychologists at the center. For example, Vincent worked primarily with elderly patients, and said most of his experience was with what happens to hysteria when it ages- when it no longer works as a method of relation. One of the primary ways he characterized hysteria was an eroticization of relations with other people. One such example was an 88-year-old, who now that she had aged, felt she wasn't seen any more. This invisibility led her to feel that nothing in life was satisfying. A further note of interest is, she had subsumed terrible trauma when she was younger. At age 20

she got into a car accident in which her husband died and she was in a coma for 3 months. Elements of this first accident, continued to color her experience and her relationships with future men. Another example he described to me was that of a 55-year-old, who had uterine cancer. She was eccentric, seductive, but she lost her hair and her uterus and it was an enormous rupture- a 'pris de force'. From this rupture, there was constant somatization, in the form of pain everywhere, extending beyond the end of treatment. Further, in losing this form of relationality, she stopped leaving her house. Vincent said in these cases, the question of treatment is difficult, stating, 'it's a tricky to re-erotisize the body'. Since the hysteric neurosis didn't function anymore, his therapeutic aims consisted of developing another neurosis to reestablish a line of relation with self and others.

Finally, in this same discussion of the interplay of desire and the erotization of relationships, theatricality also surfaced as a characteristic of hysteria. For example, Vincent spoke of a strange occurrence that sometimes is reported on the telephone hotline for mistreated children. Occasionally one child will call and create a whole scene, playing multiple characters (with multiple voices) entering the scene/call. The psychologist referred to this as a 'hysterionisme' in the 'mis en scene' saying, "they want to make believe in something; and they want to bring another into an alternative reality." This notion, of desire and imaginary is central to contemporary approaches to hysteria.

The emphasis on theatricality is not to delegitimize the suffering experienced, but is a demonstration of a fragility of selfhood and a need to invent

and create, and have others participate in and reinforce that invention. Further, the expression of sexuality, is not simply a pathologization of female promiscuity, but in a similar sense, is a theory of how one relates to others, and through that mode of interaction, is able to form a conception of self. Foundational to understanding hysteria as a psychic structure is the understanding that these are theories of functionality, and are often supported by therapeutic intervention as they are seen as integral and adaptive means of their functioning. Further, not only are they questions of self, they are questions of self that are often navigated through understandings of the body, and particularly of what it means to be a gendered subject.

The Woman/ The Subject/ The Void:

One of the psychologists at the center, Manuella, summarized hysteria most succinctly. She said, "hysteria is the question of the woman." When I questioned her further, she elaborated that "hysteria is theatricality, but one which also poses an existential question; it signifies emptiness, and is a way to fill the emptiness. It's a problem of identity- the unconscious question of what it is to be a woman, of what it is to be a subject. Hysterics are not sure of themselves, they are always in doubt. So, they identify with people and situations. For example, it used to be that one would get the vapors- you don't really see that today. But at the time, it was the fashion for women to faint- it was a performance of femininity. Hysterics copy, you see, the symptoms of psychosis, of fashionable

illnesses, ect… But they truly suffer. The neurosis is that their manner of existing is by way of that; it's a mode of relation with themselves and with the world. Hysteria isn't a principle of reality, hysteria has a fantastical side- they are constantly in a state of invention."

One of the examples she provided me was an article written for a popular audience called "Une Hysterique Modern". The subject of the text was a woman who suffered from an eating disorder and was always searching for the love of her life, but was incapable of maintaining intimate relationships. There was a constant tension between achieving a feminine ideal through body and marriage, and an identity of a 'liberated woman' through the cultivation of a libertine persona in her sexual identity. (The author attributed the subject's difficulties to a constant relation of seduction with her father, and a sense of competition and resentment of her mother). The psychologist I worked with found this this interpretation somewhat essentializing and 'cru'. However, she used it to point out that what is really driving the text is the question of what it is to be a woman- how does one navigate the performance of the feminine ideal. Even in this very simplistic vignette, the essential elements of comprehension of body and comprehension of self are driven by underlying questions of gendered experience.

Manuella, along with many of my colleagues, was more Lacanian oriented. Therefore, she understood hysteria in way that centered a woman's understanding of herself as a woman. Despite disliking the above interpretation, Manuella's formulations of hysteria also began in the difficulties of castration in the Oedipal phase. In other words, in the moment the child becomes aware of

gender difference. In the case of the girl this is a recognition of her own lack of authority/ ability to occupy a subject position. Through her lack of a penis, she is thus excluded from the circulation of phallic authority except as temporary receptacle during sexual/kinship exchanges. However, the hysteric through demonstrations of body, sexuality, and imagination, finds a means of filling this sense of absence.

Hysteria, it turned out, was many things. However, the complexity of its tableau does not mean that it had no meaning as a designation. These clinicians acknowledged that its presentation shifted, across people and across time; that it often took the form of other illnesses; that it is deeply tied to trauma, to invention, to desire, and to the body. Most importantly they acknowledged that hysteria is the primarily the question of the subject; of how one relates to oneself and to others through an understanding of body as gendered. The plurality of its forms was due to a psychoanalytical understanding of subjectivity. Psychoanalysis engages with the idiosyncrasy of individual experience through the formulation of pathology in terms of psychic structure rather than diagnosis.

To close, I would like to return to my initial conversation with Dr. Pons. After he finished googling hysteria, he expanded his appraisal to say "it's true, hysteria encompasses a little of everything… but ultimately it is an expression of suffering." He acknowledged, "it is really fluid (foggy)" but added that "life is really fluid". He ended by saying, "it's always complicated, it's always a real 'salad' of the psychological and the physiological." However, this plurality did not trouble him in the slightest, because he conceptualized everything in terms of

the individual, and saw his primary function as a collaboration with his patients to understand the meaning of what they do. He emphasized that each individual develops, incorporates (accueil) and expresses things differently, and maintained that there is always a personal sense/meaning in illness presentation. He repeated that people are not neat and "encadré" (framed, squared away). I learned from this conversation and these cases that hysteria is a structure. It is perceived through relationality rather than specific symptoms, whose focus on the individual and the subject precluded it from being understood in terms of strict diagnosis. Through this exploration of hysteria, that I began to sense larger epistemological tensions as biomedicine and psychoanalysis were pushed into overlapping territory. This was primarily articulated through criticisms of diagnosis and the place of the individual.

Structure & Diagnosis, Function & Individuality

While my 'diagnostic approach' to hysteria is partially responsible for the impression of absence, it is also indicative of a larger tension within the French psychiatric world. In addition to my own difficulty perceiving it, the clinicians I spoke to also noted that hysteria is seen less frequently in the contemporary setting. I believe this observation to be inextricable from the influence of American psychiatry in the circulation of global medicine. This was primarily articulated through a conversation of 'structure' and 'diagnosis'. Through an examination of psychoanalytic and biomedical epistemologies, this section will

explore the distinction made between psychic structure and diagnostic specificity. However, I will ultimately challenge this distinction. Instead I will argue, these formulations are not diametrically opposed, and indeed often overlap within each of these respective logics. I will posit instead that they serve as particular imaginaries of connectedness in an increasingly connected global world, and represent an attempt to retain an authoritative position in the within a structure that is more and more defined by notions of global relationality.

Psychoanalytic Structure

Dr. Pons, was adamantly opposed to Anglo-Saxon psychiatric approaches, and in my four months working with him he often took the opportunity to criticize its logics. When I tried to ask about diagnosis (particularly hysteria as a diagnosis) he would reply, "I don't work in diagnosis. For the purposes of treatment, I try to figure out if their presentation falls more on the side of psychosis or neurosis, because that orients the kind of intervention necessary. But I work with the individual, with their history, their circumstances, the meaning." During another conversation, he explained this approach through an analogy of rafting and rivers, saying, "It's like rafting. There are people who stand on the banks and will say 'the river you're rafting is called Long River' but what they're doing and what you're doing is entirely different. One gives diagnoses to observe and study, they're not for when you're in the river- when you're doing the rafting. Now, of course it's good to orient oneself, to be a little conscious of what direction you

should take. But regardless, you're there on the journey with the person, and you have to navigate what is in front of you. Diagnosis doesn't do much for that process." As one might imagine, he was strongly opposed to the DSM. he found the manual, and diagnosing in general, too "cadre" too ordered and mechanistic. Using the metaphor of a cabinet, he said the DSM had stuck symptoms into one drawer or another without any sense- and if you tried to open it, it was a disaster! ('C'est quoi ce bordel?'). However, as a result of overlap between public health and psychoanalytically oriented practice, he was required to write diagnosis for the CPS documents. He was firm that these diagnoses were because of mandatory statistical reporting dictated by government regulations and not for working with people. Even given this necessity, he remained adamant that with diagnosis, "you lose the human element- the psychodynamism." He added, "Life is like water, if it doesn't pass this way, it passes that way. There isn't a sense of the holistic in diagnosing. The Anglo-Saxon method wants everything to be all classified and squared away."

This sentiment regarding diagnosis was echoed by many of the people I worked with. As the above contradiction between practitioner and government regulation shows, there is increasing pressure to conceptualize people in biomedical terms, which is met with ambivalence from psychoanalytically oriented professionals. However, I slowly realized that this distinction was being articulated in an emphasis on structure, which tagged a psychoanalytic formulation of subjects. Psychic structure refers to a continuum that opposed psychosis and neurosis, upon which all mental 'troubles' were organized.

Troubles that fall on the side of psychosis are ‘crises d’angoisse’- breakdowns. Neuroses, however, are patterns and modes of relation that have been created by the individual to protect against precisely that. Vincent stated that despite real difficulties, neurotics generally have a more adapted relationship to reality. Thus, where people fall along this continuum is central to determining how to proceed and intervene therapeutically. This structuring comes from Freud. However, even this system of organization is facing challenges in the modern period. Vincent claimed Freud had had very clearly defined neurosis, but today, those distinctions are no longer ‘encadre’. He felt that everything nowadays fell into a state of ‘etat-limite’ (borderline) between psychosis and neurosis- that presentations were completely intermixed.

This observation was something that I often saw in the cases, and why I believe the examples given to me were always discussed in terms of hysterical ‘elements’ rather than as ‘Hysteria’. Nearly everyone I spoke to formed their understanding of structure by differenting between psychosis and neurosis, despite often complex intermixing of the two. For example, Manuella shared the case of a patient whose origins were psychotic, but who had traits and characters “tres hysterique”. The patient had delusions that were both neurotic and psychotic. Manuella recounted, “when it is a neurotic delirium it is better than psychosis because she communicates through it. It permits her to hold on to something- there’s something it fills. Her psychotic delusions, on the other hand, invoke more emptiness, incapacitation, alcohol, suicidality. On the therapeutic

level, it is better to support the hysteria, 'delire un peu avec elle' because it's providing something, it's serving a purpose."

In a further example, the social worker Isabelle (who had just opened a private practice for psychoanalysis) shared a similarly mixed case: a schizophrenic tableau with hysterical manifestations. Along with many other psychotic presentations (and a schizophrenic mother) this woman had a delusion that her stomach would grow to impossible proportions before her eyes. This was significant because she had recently begun menopause, and had the impression that her life had completely ended. Her entire adult life she had had problems with her uterus, but the onset of menopause was particularly symbolic because it definitively marked that she could no longer hope to have children. Further, she was another patient who somaticized her distress, and was constantly recounting bodily complaints. When I asked what differentiated a presentation as psychotic or neurotic, Isabelle replied that in neurosis, the body is placed in question- the body is a symptom. In schizophrenia however, the body itself is delirious. These examples demonstrate that psychoanalytically oriented practitioners continue to formulate their subjects in terms of a classically psychoanalytic structure, despite an often-complicated intermixing of presentations that challenge such binary constructions. Further they take the increasing complexity of their cases as further evidence of an individualized approach to treatment, thus reinforcing their own form of therapeutic intervention.

Further, there is something interesting about the assertion that Freud's 'clear cut' neuroses are disappearing into complicated, liminal presentations. This

would imply that discrete entities do indeed exist within psychoanalysis, even if they don't follow the particular rationalization of diagnostic *specificity,* and are shifting in the current period. Indeed, notions of structures and continuums still evoke certain logics of categorization and universality. Though the emphasis may be placed on an opposition to diagnosis, what is really being contested is the alignment of therapeutic identity with certain tenets of science and modernity. Contested subject creation comes to form the stakes of this authoritative differentiation. In this section I have already alluded to the presence of anglo-saxon approaches in this conversation, and will continue to explore how the global circulation of ideologies impacts psychoanalysis within an ongoing discourse of dispersion, movement, and connectivity in the contemporary world.

Diagnostics and the DSM

> "Technical protocols such as diagnostic standards *structure* the production of a space of liquidity: they mediate between the domains of science, industry, and health administration. These devices are part of an infrastructure, both material and conceptual, that enables goods, knowledge, and capital to flow across administrative and epistemic boundaries. They link social needs such as health to profit seeking ventures and to scientific communities…Popular discussions of globalization processes typically describe an increasingly rapid flow of information, capital, and human bodies across national borders in the wake

> of technological innovation and political-economic transformation…The negotiation of institutionalized regimes of coordination or harmonization- the linking of places through the creation of commensurable standards- is often necessary to make such circulation possible" [Lakoff, 2005;41, emphasis me].

While psychoanalysis occupies a special place within French culture, it is by no means the only discourse. For example, in Lakoff's ethnography, the company searching for a 'bipolar gene' in Argentina was a French biotech company. Movements for 'empirically based treatments' and for CBT- Cognitive Behavioral Therapy (known in France as TCC) are also presences in the French psychiatric world. In his book, *Lacan*, Vanier writes, "the limited success of ego psychology [American psychoanalysis] in bringing psychoanalysis into the domain of science has left psychoanalysis in need of a metapsychology that is able not only to withstand the pernicious challenges of psychopharmacology and psychiatry but also to accommodate the findings of cognitive and developmental psychology" (2000;viii).

In my own experience, built into the University curricular requirements, six semesters of psychopathology classes were required alongside the six semesters of psychoanalysis. Though many of the students brought their psychoanalytic coursework into conversation, from the outset the class was defined as being non-analytic. The basis of the course was to learn the practice of diagnosis, as designated by diagnostic manuals. The DSM was one among several

sources that we could draw from. Further, whether or not it was ever opened, the DSM was on the office shelf of nearly every practitioner I came into contact with- including Dr. Pons. and has come to form a cornerstone of contemporary conversations of psychiatry. However, as Lakoff writes, the DSM signifies not only the incursion of American psychiatry, but is indicative of a logic of globalizing modernity constituted by circulating ideologies of diagnostic liquidity and disease specificity (2005;17).

Tensions between psychoanalytic structure and diagnostic practice concern the moveability of pathology: of how it *made* moveable across geographic borders, populations, practitioners, and institutions. It is about the displacement of medical subjects within the larger structures of care, that more and more frequently are pressed to cohere to international standards of equivalence. These notions of equivalence and standardization facilitate a 'sociality' that can mediate various research, economic and political interests on an expanding, international scale. Where this is seen this research, is in the quiet omnipresence of the DSM explicitly or implicitly evoked in these conversations with practitioners. These practitioners resist the seeming replacement (displacement?) of the hegemonic position of psychoanalysis in Western psychiatric ideology with the biomedical model's reimagined vision of universality and connectedness.

Lakoff's concept of 'diagnostic liquidity' is invaluable to this discussion. He adapts it from Carruthers and Stinchcombe's notion of market liquidity, cited as, "the creation of general knowledge about value out of idiosyncratic personal

knowledge. Producing equivalencies among disparate kinds of things involves both social regulation and political negotiation. It is a social and cognitive achievement: buyers, market makers, and sellers have to share the conviction that "equivalent" commodities are really the same" (2005;21). This term is extremely helpful in considering diagnosis as a site of contestation in the French psychiatric world. The diagnostic model seeks to universalize- to create equivalencies among people and illness experiences for the development of generalized modes of intervention. Through their insistence on structure and individuality, psychoanalytically oriented practitioners refuse this notion of equivalence. However, a focus on universality allows for the circulation of pathology, which grants new forms of access to the authorities who take this illness as their object of intervention. In a contemporary world of global interconnectivity, the call for models which facilitate movement become ever greater and more difficult to ignore.

This generalized mode of intervention is facilitated by the development of 'disease specificity' which Lakoff defines as "illnesses understood to be stable entities that exist outside of their embodiment in particular individuals, which can be explained in terms of specific causal mechanisms located within the sufferer's body" (2005;11). He later writes that, "the constant identity of disease specificity is what enables the DSM to function as a connective tissue for biomedical psychiatry, linking populations as they are formed in multiple domains: the clinic, insurance, scientific research" (2005;13). From a scientific and administrative standpoint, the standardization of pathology is extremely practical and growing in

use. However, psychoanalysis differentiates itself from this notion of specificity, because it takes issue with the assertion that pathology is separable from the individual and the context in which the individual operates. As the structure of hysteria should demonstrate, it is certainly not a *stable* entity that exists outside the embodiment of the individual. Thus, hysteria is not capable of the same capacity for standardized circulation among disparate domains and practitioners that make diagnostic logics so appealing.

In his ethnography, Lakoff discusses the global circulation of North American biomedical psychiatry. Though he primarily frames this in terms of movements from center to periphery, I would like to complicate this picture through the exploration of movements of ideologies within the 'center'. As in Argentina, these new epistemologies that would reconfigure both experts and their subjects, are not seamlessly integrated into French society. They are incorporated unevenly, and often met with criticism and resistance. I would like to posit that it is precisely the authoritative reconfigurations demanded by these global ideologies which give practitioners the impression that their hysteric subject is disappearing. The criticisms of the DSM, and of diagnosis more broadly, center on a discomfort surrounding psychiatric alignment with scientific rationalism and universalism as a tenet of global modernity. Indeed, the epistemological tensions of structure versus diagnosis are articulated through theoretical discussions of science and sexuality- or objectivity and subjectivity.

Science and its Discontents

Originally, Freud attempted to fashion psychoanalysis as a science, however, this impetus has since shifted within the French psychoanalytic movement. In France, unlike in the US the effort has been made to de-biologize Freud. Psychoanalyst and scholar, Alain Vanier writes, "While [their American counterparts] often tend to situate their work as a reaction to Freud, the Lacanian strategy always consists in rescuing Freud's insights and resuscitating them in a context free of biological determinism" (2000;xii). This act is seen as central to psychoanalysis' engagement with modernity. In another of his publications, *Introduction à la Psychanalyse*, Vanier writes, "[psychoanalysis] develops *herself* at the most critical point of our modernity. In this sense, she proceeds from a discourse of science, in the words of Lacan, but strictly speaking, does not constitute one. She attempts to respond to what science has pushed aside to constitute itself; she supports the most delicate question of the present, which is the question of the subject" (2010;119).

Perhaps things have begun to seem slightly contradictory. Clearly while psychoanalysis may not be a 'diagnostic' 'logic of specificity' it has still been a widely circulated ideology which contains its own 'specific' objects and universals. For example, in *Unconscious Dominions,* Alice Bullard writes that in its own global circulation in the twentieth century, psychoanalysis was often used as a universalizing tool that ultimately reified the difference of the colonial other (2011;46). Indeed, psychoanalytic encounters with indigenous populations were used to rationalize this modern intervention, and further legitimize the European

psyche (Bulard 2011;46). However, how psychoanalysis now differentiates biomedical universals from its own, is by positioning itself outside of science. This shift in the French psychoanalytic movement can be attributed to the radical influence of Jacques Lacan. Vanier describes French psychoanalysis's return to Freud as, "The wish to return to Freud's writings was also a wish to challenge the current representation of psychoanalysis as comparable to the scientific disciplines… This critique on Lacan's part of a certain scientism, then current in analytic circles, is an initial question about the status of psychoanalysis in the field of established disciplines" (2000;3). Psychoanalysis had to create a distinct space for itself, so as not to be absorbed by the rise of other authorities. The fulcrum upon which this distinction is balanced is the language of desire, and the privileging of sexuality.

For Lacan, language- and language as a communication of desire- was how the subject was constituted. Of his psychoanalytic interlocutors Lakoff writes, "For the analysts, the human was defined by language and subjectivity, as opposed to the animal-like body. Their objection to biomedical psychiatry was to its refusal to admit that humans are distinctive, and therefore require a special kind of technique for knowing…the subject of desire is what is left out of psychiatry and what psychoanalysis concerns itself with. Whereas psychiatry's emphasis on the biological threatened to erase subjectivity, psychoanalysis was concerned precisely with bringing it out" (2005;86). Lacan's reinterpretation of Freud's original insights developed from linguistics and structural anthropology. He reframed Freud's emphasis on sexuality through the transformation of the

oedipal complex into the Name of the Father and the circulation of the symbolic phallus. Further, how individuals navigated these imaginary and symbolic orders, led to than understanding of relationality as the 'jouissance' of desire. These central concepts of sexuality and power that undergird all of psychoanalytic theory, were developed through Freud's contact with hysteria. Further, the Lacanien theory that emerged from this work (desire, imaginary, emptiness, gender difference, and authority) are what form the contemporary definitions of the hysteric subject outlined in the above section. Despite his initial interest in psychosis, Lacan could not engage Freudian psychoanalysis without engaging hysteria and thus sexuality. Thus, hysteria itself sits at the origin upon which French psychoanalysis marks itself as distinct.

I have read innumerable French sources that situate sexuality as the foundational difference between American and French psych worlds. Countless French critiques locate the erasure of sexuality in American psychology as an attempt to achieve scientific legitimacy through alignment with the biomedical. French psychoanalysis very purposefully moves in the opposite direction. It places itself outside of science through its engagement with the sexual. Therefore, in this differentiation between science and sexuality is a differentiation between objectivity and subjectivity, between diagnosis and structure, between hysteria and the DSM. In short, it is psychoanalysis' fight to maintain authority over its objects of intervention, despite the mounting threat of disappearance within global, biomedical relations. While this section has been primarily concerned with anxieties surrounding the displacement, and moveability, of the psychiatric

subject, through a discussion of structure and diagnosis, the next section will focus on understandings of return. In other words, the following section will interrogate psychoanalytic origins, and how it imagines hysteria (and thus itself) as a continuing, and continuous, entity despite dramatic changes in presentation and the cultural circumstances that provoke them.

That which remains: Science, Psychoanalysis, and the Female subject

If hysteria is disappearing in this diagnostic age, if Freudian neuroses no longer hold, then what is being asserted by its narrative of continuity? In nearly every interaction I had, there was an insistence that though its presentation may change, in looking closely enough, one could always find hysteria. In "Panorama Historique des Definitions de l'hystérie" psychoanalyst Nikolas Brémaud describes the refusal of the hysteric to be classified, writing, "this doesn't signify that hysteria has disappeared, much the contrary. In attempting to push it out the door, she returns immediately through the window" (2015;497). There is certainly a way of reading hysteria's continued presence and projected relevance as a means of arguing the continued significance of French psychoanalysis' in a changing and increasingly connected global world. However, there is another way of critically evaluating this assertion, by interrogating psychoanalysis' origins in the subject, and particularly the hysteric subject. By taking up the question of gender, and looking at the spaces and subjects that psychoanalysis creates as an institution and a form of intervention, we can critically evaluate the stakes upon

which these structures are built. In considering this narrative of hysteric continuity, and the imaginaries of coherence it promotes, we may ask what are the limits and potentialities of this way of knowing? How does this differ from the limits and potentialities inherent to the biomedical subject?

The Return

One of the reasons I had such difficulty conceptualizing hysteria initially was because of its plasticity over time. A sense of continuity despite radical change in presentation was inherent to the understanding of hysteria. As the psychiatrist I worked with said, "hysteria is a good choice of topic because it is a cultural reflection. It's manifestation and formulation changes completely with society. For example, in the time of Charcot, society was very corseted, so you had these massive explosions of expression, that's not at all what you see today. All categories operate in this way. They shift and evolve. You could apply the same approach to schizophrenia and you would find much the same thing." Thus, inherent to the discussion of hysteria is historical and cultural reflection, and a narrative of omnipresence emerged from its implicit plasticity. If the form of hysteria was always changing, then it could always be found through a critical eye to the Social. In my discussions, not only did people define hysteria as what it is no longer, but they also offered up theories of its current presentation and were interested in forms it may take in the near future.

There is much that could be said about the differentiations between past and present hysteria. Each person I asked highlighted a different fundamental transformation between the two. As was seen in the above sections, the rigid bodily contortions of Salpêtrière were no longer, nor the fainting spells of the Victorian era. The dissociative symptom of the splitting of personality (popular until the 80s) had since gone out of vogue. One of my professors described how diathesis (hysterical hyperventilation) manifested itself twenty years ago, but was no longer seen today. He also informed me that spasmophilie (spasmophilia) was very popular some years ago, but had since disappeared. One of my colleagues found that today there was less of the hallmark of Freudian hysteria- conversion. Within each of these examples there is a rich potential for historical and cultural theorizing, in which my colleagues often engaged. However, what I will focus on here, is how the imaginary of hysteria in the present is conceptualized. This will be explored with a particular eye for the stakes of this assertion of presence in the contemporary context.

In all of these definitions of what it is no longer, one may wonder what is left. One of my professors explained the difficulty is that hysteria is incredibly flexible (plastique) It is always changing its manner of expressing itself. So, an argument for contemporary hysteria was always an observation of present culture, and a rationalization of which aspects of the hysteric structure were reflected in the relationship between subject, the presentation, and the social. Again, each person I talked to, highlighted a different axis of presentation. One of the professors focused on fibromyalgia and “crises de tetanie” (tetany). One of my

colleagues found that today hysteria occurred in much more 'mixed' forms, asserting that the neuroses one saw most frequently nowadays were phobias. Another professor focused on the relationship between woman, the body, and symbolization. She cited food intolerances to be particularly in vogue, and focused on theories of eating disorders as the new hysteria. The final assertions that I heard repeated were in certain places hysteria was still visible and in some cases, was growing. Multiple people informed me that today one sees an increasing number of male hysterics. I also heard that one could still find hysterical manifestations in immigrant populations. All of these assertions implicate the centrality of shifting circumstances of modernity in the how the subject relates to herself and to others. Further, they also point to interesting implications of static or dynamic conceptions of difference and otherness within such a project. This is precisely what I will further explore in the following section.

Modernity, Science, and Medicine

What I have alluded to throughout the chapter is that the changing conditions of hysteria, and of psychoanalysis itself, are largely founded in the circumstances of modernity. Through the imaginary of contemporary presentations, how clinicians conceptualize hysteria provides a unique window into how forces of modernity and French culture shape the interaction of individuals and institutions. Thus far in the chapter it has demonstrated how

shifting global discourses have challenged psychoanalytic logics of subjecthood- and the authorities responsible for them. It has shown psychoanalysis' refusal of biomedicine, and its scientific identity, through an insistence on the subjective. In doing so, it placed itself outside of science, allowing, "psychoanalysis to question the effects of modernity associated with advances in the discourse of science" (Vanier 2000;88). In positioning its authority as highly contextualized, cultural, and historical- as well as beyond scientific institutional structures and logics- psychoanalysis places itself in a unique position for metacritique. I would like to use this capacity to explore how psychoanalysts interpret contemporary culture and the role of psychoanalysis within it.

To this end, I will refer to a conversation with Alain Vanier about hysteria in the contemporary context. He is a professor at Paris-Diderot who researches psychoanalysis, modernity, medicine, and metapsychology. Interestingly, though he is deeply Lacanian-oriented, he believed Lacanian neurosis has disappeared. Despite this assertion, he was not claiming that *hysteria* itself has departed. (He too believed it remained, despite changing its manner of expressing itself.) This distinction was a critique of how current psychoanalytic theory adapts to the modern period given its basis in relationality. He reflected, "we live in a society of saturation, surrounded by objects to satisfy desire- this encompasses everything- people, one's love life, everything. You can jump from object to object." Therefore, Lacanian relationality, based in the exchange of desire, does not carry the same weight as it once did. Just as Freudian psychoanalysis and its scientific identity needed to be rescued, so too, it would seem, does Lacanian

intervention in the contemporary world. In his books, he often challenges psychoanalysis to reimagine itself in the face of modern circumstances or consign itself to being obsolete.

He had several theories as to why hysteria is seen less frequently at present. One such theory was hysteria's disappearance was due to the wide dispersion of psychoanalysis in French culture. In a similar sense, he also attributed its disappearance to the dispersion of medicine in the contemporary period. He reflected, "on the one hand, we live in a medicalized world- it's everywhere. On the other hand, there is a sort of suspicion of medical authority. With the internet, and the accessibility of information, the doctor is no longer what they once were. The doctor used to be a god, a figure of mastery." This is a problem for Lacanian understandings of hysteria, because in a Lacanian formulation, 'the hysteric is always searching for a master'. This statement refers to the hysteric's lack of identity, which causes her to search for identification through others. The ultimate form of this relationship is self-knowledge through the eyes of the doctor. In such an interaction, the basis of neurosis revolves around the position of 'le lien social' social connectivity, in the interaction of being known. The hysteric, therapeutic interaction is based in the interplay between visibility of being known, and the ultimate refusal to be quantified by knowledge or its gaze. It is a play of knowledge and resistance that subverts notions of 'mastery'. Vanier phrased this as, "Hysterics contest the knowledge of science." Nikolas Brémaud writes,

> "She wants the other to be a master, for him to know many things, but all the same not know enough to disbelieve that she is the prize of all his knowledge. In other words, she wants a master over which she reigns. She reigns and he doesn't govern. This demonstrates the ultimate failure of Charcot…thus she provokes knowledge, but guards it as a failure; no knowledge fits her perfectly, all knowledge is at once called upon and idealized and also degraded, and is finally, fundamentally, unsatisfying. Therefore, the hysteric presupposes a mastery of knowledge, of knowledge of her proper enigma, of the enigma of her desire, of the enigma of her sexuality, of her jouissance, of her femininity. Thus, she indicates that 'that which is important is that the other knows what a precious object she becomes in the context of this discourse. Lacan refers to this discourse as 'le lien social'" [2015;496].

What happens to mastery of knowledge when it becomes so widely available and omnipresent in the contemporary period. How does that fundamentally change how we understand relationships to others? Further, how does it change how we imagine global connectedness? If psychoanalysis' intervention is based entirely on logics of relationality, how does it accommodate this? From this characterization, it seems as if the structure and identity of psychoanalysis itself is so deeply intertwined with hysteria that the two cannot be separated.

Gender Roles and Peripheral Populations

One could end the analysis with a hypothesis that practitioner's insistence on the continued presence of hysteria is simply a way to assert the continued relevance of their authority. However, I think that it is important to examine stakes upon which these assertions are made- the subjects themselves. Who biomedicine and who psychoanalysis take as their objects, who they exclude from their universals, and through what logics, are of tantamount importance. In my own observations of the American clinical setting and diagnostic practice, it is no less gendered, it is just less explicitly so. Diagnosis is still deeply culturally and temporally situated, it still presents and is interpreted along gendered fault lines, however interaction with this reality is simply subsumed under claims of scientific objectivity. As this chapter argued, the distinction between psychoanalysis and biomedicine, though staked on a differentiation between structure and diagnosis, was in reality a differentiation between imaginaries of connectedness and the systems that organize them. To return to the quote that introduced the above section, "diagnosis structures a space of liquidity," idealizations of movement and interconnectivity of biomedicine are maintained through diagnostic specificity and an alignment between the body and scientific language. Psychoanalytic idealizations conversely, focus on relational structures revealed through the body and a language of desire, and is transacted through communications with an other. Through this focus psychanalysis positions itself as uniquely oriented to the question of individuality.

In the remainder of this chapter, I will continue to engage with psychoanalysis and the understandings of difference that predicate its very existence. How we understand the displacement of medical subjects, and the imaginaries of connectedness that bind these relationships together, is based on their connection to a structural origin. By this I am referring to the very objects that create the circumstances for an authority's existence. I would argue that structures and their perpetuation are predicated on (often violent) understandings of difference, separation of self and other, and a fundamental notion of absence. Indeed, the structures explored throughout this work, are based in denials of subject positions- except in very particular encounters- in so doing, they constitute the subjects who populate the structure, and as such are actually fundamental to the maintenance of the structure itself. Specifically, this has been discussed in relation to the origin of psychoanalysis, the hysteric subject, whose psychic structure is characterized by lack, and who is, for that very reason is fundamental to the maintenance of psychoanalytic identity.

The violent consequences of foundational otherness in psychoanalysis have been deeply engaged with. This has been noted particularly in post-colonial observations of racialized difference inherent to psychoanalytic theorizing and praxis during (and following) colonialism's imperial reign. The claims of some of my colleagues seemed to suggest a continuation of these dynamics in the assertions that hysteria can still be seen in immigrant populations. Such a characterization of stagnation is striking and noteworthy, given all of the arguments made for radically shifting modern circumstances. Further, an assertion

of growing male hysteria, raises its own questions. In all of the talk of disappearances, this begs the question: how do shifting definitions of the woman change shifting definitions of its counterpart, and its effect on understanding of social relations in the modern period? I am also curious about how power is deployed through these understandings and thus how notions of modernity, universality, and interconnectivity are influencing, and are influenced by, a changing notion of relationality predicated on shifting definitions of gender and otherness. Further I am interested in how this interaction with 'modernity' and identity through relational theory, influences how we relate to 'peripheral' populations.

Hysteria, by definition, is a deeply gendered diagnosis. Naturally psychoanalytic theory is employed in ways that reify this. However, the ultimate question reverberating through this chapter, that is posed by hysteria, is how do how women understand themselves as gendered bodies? and how does their relationship to that body both change, and is changed by contemporary circumstances? In its engagement with hysteria, the crux of psychoanalytic theory is developed from the ultimate significance of knowing oneself as gendered. Levi-Strauss and Mauss (who were central to Lacanian psychoanalysis) place the foundation of culture and the structuring of society and human sociality, in sexual difference and the exchange of women. Through these logics, femininity is defined in terms of lack- in terms of that which it is not (the phallus, the authority, the one who gives and receives). It is defined in terms of absence. However, in these theories it is precisely this absence that creates and underlies everything we

consider uniquely human. Developed from theories of hysteria, comes a foundational understanding of relationality. Thus, how a woman understands herself to be a woman dictates how others can know themselves through their own understanding of the question of the woman. She is the sociality that binds humanity together, she is how we understand ourselves to be connected. The hysteric power is in her very absence, in the way she simultaneously enacts the temporary subject hood given in the clinical encounter, and also disrupts and refuses it. She both resists and enacts the absenting inherent to the exchange of the clinical encounter, through the denial of knowledge. In her knowledge that she can never be known- she remains the ultimate object and the perpetual subject, and is ultimately impossible to master.

Finally, it may seem that this kind of theory gives an inevitability to gender oppression. French feminist theory even seems to get trapped in this sense of universality. However, I would like to propose a slightly different outlook. In "The Traffic in Women, Notes on the Political Economy of Sex" Gail Rubin writes, "if [Levi-Strauss's] analysis is adopted in its pure form, the feminist program must include a task even more onerous than the extermination of men; it must attempt to get rid of culture and substitute some entirely new phenomena on the face of the earth." (1990;46) If we add psychoanalysis' theory to the mix, the mere fact of human sociality- of interaction with self and other- is predicated on our relationship to gendered bodies, the feminist task could seem insurmountable. However, I believe that the discussion of contemporary hysteria leads us to an interesting place because it brings us to a new potentiality of modernity. In the

radical shifting of relations, and thus identities, how will the power of the disruptive be mobilized?

Conclusion: One or Many Specters?

Throughout my encounters, I was repeatedly told that hysteria was a cultural reflection, deeply situated in the moment in which it was manifesting. I was advised that in finding hysteria's modern-day apparition, I would really be finding society. Indeed, the hysteria I encountered in the clinical setting, was precisely that. What was made apparent through these conversations was that hysteria, as a theory of relationality, was questioning what it means to be a self- and to be a self in relation to others- in the contemporary moment. Additionally, it turned out to be a fascinating choice because it captured and spoke to so much of the French imaginary. Not only does it reveal its own logic of connectedness, it also reveals, a larger French epistemology (as well as its critique). These chapters have served as a mapping of this thought. I will briefly summarize what they have illuminated, and then explore the limits and potentialities of a French understanding of the unbounded individual in the contemporary moment.

Further, one of the foundational facets of this investigation is that it is an inquiry into conceptualizing modernity. As the above paragraph demonstrates, imaginings of hysteria are themselves imaginings of contemporaneity. In talking about French formulations, I do often speak in general terms of the French. However, this paper's predominant focus on structuralist and post-structuralist thought- and their specific problematizations of the individual- is an exploration the moment in which the individual *becomes* unbounded. While I formulate this as part of an ongoing conversation (that flows from Durkheim to the

existentialists and on) which centers the subject-social relationship, I'm not arguing that French thought (writ large) is fundamentally unbounded. Rather, I am arguing that there is a development in the ways that the individual comes to be conceptualized as such. I posit that this transformation is directly related to understandings and imaginings of modernity.

Much of this text grapples with how we as individuals navigate the constant call of interconnectivity in the contemporary era- a seemingly inevitable unboundedness. In different ways, these chapters examine the navigation of such a call, given the equally strong presence of boundaries, ruptures, separation, and *differences.* They contend with the reality that these differences constitute much of how we experience and understand the world. I argue that this is a fundamentally unsettled position, which asks us to think about incorporation and separation in new ways. These tensions are explored throughout the chapters that compose this text.

In chapter one we explored ethos, institutions and multiplicity. Here we laid the historical groundwork of the French context. This highlighted a central interest in the subject and their relationship to society, which in addition to shaping social theory, informed institutional politics and their objects of intervention. The investigation of the French medico-social structure revealed a site of contested authority between psychoanalytic, state, and biomedical ways of knowing. It illuminated the different universals being enacted through different understandings of subjects, and problematized the exclusions inherent to them. Further, the notion of care enacted continuity between the multiplicity of selves

being created by these competing institutions. Care allowed the semblance of a cohesive structure of intervention despite the reality that each institution was creating, and intervening into, very different, but shared subjects. This chapter introduced what I called the French imaginary of connectedness, and showed it to be fixated on the simultaneous articulation of coherence and difference.

In Chapter two we explored media representations of spirits and families. The comparison of multiple series provided a window into the particularistic in French Culture. This chapter introduced us to notions of haunting, absence, and disruption through the elementary structure of the family. Indeed, it demonstrated that ghostliness allowed for a profound engagement with gender, subject creation and authority. While the previous section focused on subjectification, this section questioned the subject's very conjuring to begin with, and the state of non-being that predicates their *becoming*. This led to the argument that there is a spectral quality to the structures explored in this paper. Therefore, these structures and the understandings of connectedness they represented are based on fundamental difference (a.e a fundamental alienation, assertion of lack, exclusion). However, an engagement with psychoanalysis revealed that this was an unsettled difference, and in fact it was precisely this present-absence that both maintained the structure and left it open to disruption. An understanding of the specter as necessary to the subject, revealed an understanding of the individual as unbounded. This illuminated that the French imaginary of connectedness explored in the first chapter was also a problematizing of the subject/social as an unsettled totality.

These understandings, and their comparison with Anglosaxon biomedical logics, allowed us to better understand the authoritative divide that was examined in chapter three, which articulated a differentiation of structure and diagnosis. In this chapter, we further explored the clinical encounter, the hysteric subject, and modernity. In this section, the stakes of subject-hood, posed by the previous chapter were examined. Through, once again, an interest in continuity and disruption, we explored contemporary representations of hysteria and investigated claims of historical omnipresence. In doing so, we found that new demands of modernity and global interconnectivity are shifting notions of relationality and psychoanalytic structure. This has significant implications for the hysteric subject and thus for psychoanalysis itself. Investigations into hysteria and womanhood, opened up questions of power in the embodiment of difference, and in a critical turn, asked us to consider how absences inherent to the production of subject-object relationships are operating and being reimagined. However, my engagement with hysteria in this chapter was not simply a critique of psychoanalysis or endorsement of the biomedical. Rather, my aim throughout this project has been to show that power is operationalized *and critiqued* in different and complicated ways *within* different systems of knowing. Indeed, the formulations of hysteria in the clinical encounter, worked to complicate understandings of psychoanalysis as a purely oppressive practice or hysteria as a purely resistant response. This chapter asked instead that we imagine them as important moments of disruption.

Throughout this project, I have been interested in what was peculiar to the French context. Over these disparate domains, I followed the many constructions and problematizations of self and social (of rupture and unity) through what I called imaginaries of connectedness. These imaginaries led me to a very interesting set of ideological mappings that problematized in different ways, the unsettled, co-constitutive nature of the subject. hysteria itself was one of these mappings. I will briefly explore how each of these ideological idioms, employed throughout the paper, capture an important element of this relationship. All of these imaginaries of connectedness, as well as many others not directly mentioned in this section, illuminate a certain French ethos. Further, not only do they say something about a particular assumption of subjectivity that is at once connected and separate, these imaginaries of coherence also map on to particular understandings of modernity understood as a simultaneous experience of rupture and increasing interconnectivity.

In the exploration of these mappings, structure itself formed a particular idiom of coherence. Thinking in terms of structure allowed us to examine power in the creation and maintenance of social systems. Throughout these pages, they have been invoked numerous times and in different ways, for example, in care systems and medico-social institutions, in families, psychic structures, and gender systems. Even within the different theorists who have acted as interlocutors, theories of structure have been key, for example, Foucault's sexuality, Lacan's desire, Derrida's spectral capitalism. Contained within them, are different theories

of how people relate to one another, and how that mode of relation creates a larger collectivity. Interactions with structure have allowed us to consider how and under what circumstances subjects are created by, and move within, a system. Further it has illuminated key French imaginations of the subject-social relationship. Through an understanding that subjects and their objects are co-constituting, and that the social is both necessary to and constraining of the self, individuals in this imaginary are understood to be unbounded. In other words, the foundational characteristic of these structures is that they are open to disruption.

Further, I highlighted spectrality in this work as a way of attending to the voices I often find to be absent, but integral to imaginings of collectives and connectedness. I linked it to a structural logic precisely because of this capacity for disruption. I also engaged spectrality because even in theory coming out of Marxist and de-colonial projects invested in exploring structural reinforcement of difference and domination, I felt that in much what I was encountering, the woman was largely absent from these considerations. In many cases she was absent from the theory despite being integral to its production. This is not limited to psychoanalysis, rather the many theories of socials and subjects that arise out of social theory can be inclusive of some notions of difference and exclusive of others; they each contain their own universals. Further, in the spirit of absence and difference, there are other violent embodiments and otherings that have not been discussed at length in this text, but are indeed present. Gender is not the only system of difference that operates within the subject-object structure outlined here. For example, queerness is written into the definition of hysteria almost as

deeply as gender. Further, racialized exclusions and otherings color the history of structure and the circulation of psychoanalysis, psychiatry, and medicine. These presences could not go unmentioned. Though, these iterations of difference are not discussed at length here, I consider them to be foundationally interrelated, and indeed as the origins of the structures and systems that we see as ordering our world. Spectrality asks what are the stakes upon which structures and ideologies of coherence are built? And who, by their very presence, do they absent? Further, not only does this kind of attention ask us to consider what is [made] absent, but it is also precisely through the spectral present/absence that we can begin to unsettle this whole endeavor.

Finally, Hysteria itself has been a way of examining all of these imaginaries of connectedness, as well as their relationship to the contemporary moment. Through its understanding of structure, absence, and exchange, Hysteria is an ideal crystallization of these dynamics. It is particularly helpful in thinking about disruption. As I mentioned above, hysteria is not reducible to a rhetoric of oppression/resistance, and neither is the understanding of subject/object relations I have outlined here. The hysteric encounter is fundamentally based on occupying a temporary subjectivity through the provocation and denial of being known. As such, it simultaneously disrupts, and operates within a relation of power. This is exemplary of the spectrality of the object explored in the previous section, and is important to our engagement with other sites of power in this text. Throughout this text we have seen how different subjects are enacted in different moments through competing knowledge practices. What I would like to encourage, is that

rather than focus on the inevitable constraint of these encounters, we train our attention instead on the potentiality of disruption.

The primary questions raised throughout these chapters are how do the circumstances of modernity change our interactions with structure and its subjects? Who are the specters both creating and disrupting these systems? What happens when technological and global interconnectivity change notions of connectedness? And how then do we deal with difference? These questions have implications for hysteria, for psychoanalysis, for biomedicine, and for the state (and international) structures attempting to create systems founded on the notion of coherence. Further, they have implications for the understandings of subject-hood enacted within them

Throughout this text I have tried to remain attentive to my own feminist project, and the ways in which my analysis fits into these mappings. Understandings of subject-object distinctions are often criticized because of their very restrictive view of personhood and for an inability to engage with intersectional difference (Abu-Lughod 1991;155). Even the notion of disruption that I have outlined here could be critiqued because regardless of moments of interruption, the object remains within the same power structure. With this in mind, I would like to bring this text to a close by engaging with one more French thinker: Gilles Deleuze. Deleuze also critiqued totalities and projects of coherence (Gane 2003;150). As such he proposed a radical form of de-centering by way of multiplicity (Gane 2003;150). This text is well adapted to a Deleuzian approach

because in its very composition, it is comprised of multiplicities. From clinicians to theorists, there are many different voices, proposing many different theories, offering many different interventions, and imagining many different hysterias. This means that within this text, there are different structures and different subjects within them- there are different universals and as such, different differences. Thus, this text and the multiple differences operating within it, are themselves a means of unsettling, without simply reifying or masking, the subject-object analysis that propels this work. Therefore, if we can manage to hold the multiplicity inherent to this text, this story, these specters- then Deleuze may argue that we have succeeded in a radical subversion of the subject-object relationship.

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