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# Hysteria in Four Acts

*Paul R. McHugh*

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IN 1973, the journalist Flora Rhea Schreiber collaborated with Cornelia Wilbur, a Manhattan psychiatrist, in writing *Sybil*, the story of a young woman who, while under Wilbur's care, developed sixteen "personalities." In each distinct "alter"—alternative personality—she behaved in a different way, at one time or another "depicting" aggressive males, defenseless children, and intellectual women.

In their book, which was an enormous bestseller in both hardcover and paperback and inspired a hugely popular four-hour movie for television, the collaborating authors proposed that the "disintegration" of *Sybil*'s mind into several personalities was the result of her having repressed the memory of sexual abuse she had suffered at the hands of her mother in childhood. Although the abuse itself was never confirmed, the book and the television movie ignited a craze. Schreiber heard from numerous women who credited her with opening their eyes to their own multiple personalities. Other biographies soon appeared. (Only one, *The Minds of Billy Milligan* [1981], remains in print.) Like *Sybil*, they all linked multiple-personality dis-

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order (MPD) to childhood abuse—a practice that, at the time, was being reported with distressing frequency by pediatricians.

What went unmentioned in *Sybil* was a serious difference of opinion between Wilbur and Herbert Spiegel, a fellow psychiatrist whom she had consulted. In a May 1995 interview, Spiegel told of having come to know *Sybil* well, examining her many times and arriving at the conclusion that she was not a multiple personality at all. Instead, Spiegel characterized *Sybil* as "a wonderful hysterical patient with role confusion, which is typical of high hysterics. It was hysteria." But Schreiber, he related, rejected his interpretation summarily and insisted that they stick to the original diagnosis—because "if we don't call [her] a multiple personality, we don't have a book!"

Looking back in 1995, Spiegel was impressed with how the publication of *Sybil* had started "a whole new cult, a whole new wave of hysteria . . . a hysterical response to hysteria." In his view, therapists specializing in MPD were "taking highly malleable, suggestible persons and molding them into acting out a thesis that they [were] putting upon them."

But what did Spiegel mean by hysteria? And what clinical and historical background was he drawing on to confirm his diagnosis?

IN EVERYDAY parlance, "hysteria" is used loosely to describe a state of being overly emotional, wildly dramatic, or out of control. When psychia-

trists use the term, they mean to identify something more specific: namely, a perverse human behavior in which individuals act in ways that imitate actual physical or psychological disorder. On account of their extraordinary ability to mimic disease, those subject to the condition always present a special challenge to doctors and psychiatrists. In the words of Thomas Sydenham, the illustrious 17th-century physician, hysteria is

remarkable for . . . the numerous forms under which it appears, resembling most of the distempers wherewith mankind are afflicted. For in whatever part of the body it be seated, it immediately produces such symptoms as are peculiar thereto; so that unless the physician be a person of judgment and penetration he will be mistaken, and suppose such symptoms to arise from some essential disease of this or that particular part, and not from the hysteric passion.

It is no doubt for this reason that physicians often view hysterical patients with suspicion or disdain. Upon grasping the psychological source of the complaint, they may even presume some fraudulent intent on the patient's part. To psychiatrists, by contrast, an essential feature of hysteria is not duplicity but a vivid form of self-deception. That is, patients suffering from hysteria sincerely believe they are sick, and are acting on that belief. It is on this basis that they ask to be admitted to what sociologists call "the sick role"—that is, to be accepted as sick and to be given the benefits of care and social support.

To be sure, self-deception is hardly a trait limited to hysterics, being instead a universal and sometimes consoling human characteristic. We all occasionally "forget" to perform some onerous obligation, "ignore" a painful conflict, or "expect" more than we deserve. In hysteria, psychiatrists confront this human capacity in what may be its most radical form. In their search for the social, psychological, and even physical factors that contribute to it, they must begin by recognizing that hysteria is not something a patient *has*—like a rash or a fever—but something the patient is *doing*.

What precipitates hysterical behavior? Occasionally, a dramatic, emotionally laden event—a family crisis, or a report of the death of an honored public figure like Princess Diana or Pope John Paul II—can provoke the sudden onset of hysterical paralysis, muteness, or fugue (loss of identity). More often, hysterical conditions emerge out of some mixture of discouragement or demoralization tied to temperament and life circumstances. A pa-

tient may sense and resent a lack of concern by others, or feel overwhelmed by responsibility. He may feel unable to continue with military service, or to follow through on his promises or on others' expectations of him. Some may come to believe that they are sick because of difficulties faced at work—difficulties that could be avoided by, for instance, extending a hospital stay. Or they may be bewildered by a family conflict from which assuming the "sick role" would free them.

In imitating a medical, surgical, or psychiatric disorder, hysterical patients may complain of subjective symptoms—such as pain, faintness, or confusion—or display physical signs like seizures or paralysis. To confuse matters, they may indeed already *be* genuinely sick, with such physical or mental ailments as epilepsy, toxicity, depression, and the like. In any case—and this is key to understanding the condition—their hysteria often builds incrementally, beginning with minor complaints or weaknesses that then worsen until the features become incapacitating.

This process, in the past described as the "incubation" of hysteria, usually indicates that patients are gathering information about their "sickness," frequently by way of suggestions inadvertently supplied by physicians, nurses, or other patients. These days, they may also be consulting the Internet, where they can find a vast wealth of information on how sicknesses "present," which symptoms run together, and which attract prompt attention. Whatever the source—and it may just be the sight of someone else with symptoms—patients learn how their behavior affects others and then justify, mostly to themselves, the attention they are receiving by amplifying those symptoms. This suggests that appearing sick is not a goal calculatedly chosen so much as it is one gradually assumed—and learned.

**H**YSTERIA IS NOT disappearing. Its incidence waxes and wanes, and so do its modes. Today, psychological guises—amnesias, fugues, multiple personalities—tend to be more common than neurological ones like the seizures, paralyzes, and sensory losses that were in vogue a century ago. And the imitations of illness that hysterics display can be convincing—particularly if the patient is himself a nurse or doctor.

True, progress in the basic skill of examining patients and advances in technology over the past century have made it easier to identify these synthetic illnesses. In a counterfeit epileptic seizure, for example, there will be no evidence of brain changes on an electroencephalogram (EEG); paral-

ysis will occur without any of the customary changes in tendon reflexes (like the knee-jerk); fainted and fugues are usually performed in ways that do not endanger the patient physically. Moreover, the dysfunctions of hysteria tend to be limited to those that burden others—nurses, doctors, physiotherapists, relatives—rather than (as in urinary incontinence) the patient.

Despite many efforts to account for hysterical behavior by tying it to some specific underlying brain disorder, none has succeeded. For this reason, the psychiatrist Thomas Szasz famously claimed in *The Myth of Mental Illness* (1961) that hysteria was not a “legitimate disease.” But most psychiatrists who accept the reality of hysteria do not regard it as a disease. They see it, rather, as a behavioral disorder. It derives not from an identifiable change within a cell or neural pathway, as in the case of disease, but from provocative events within the uniquely human world of self-consciousness—the world in which one is aware of one’s own individuality and in which one’s perceptions of reality can be powerfully shaped by social structures, language, symbols, and the ideas and assumptions held by people of influence.

A look back at historical mini-epidemics of hysteria illustrates how collusions of attitude about health and sickness lie at the heart of what are often grim affairs—and, as well, at the heart of successful efforts to confront and overcome them.

**I**N AMERICA, perhaps the best-known such epidemic is the late-17th-century witch trials of Salem, Massachusetts. The business started when a group of girls between the ages of eleven and sixteen began to complain of pains, weakness, and other melodramatic miseries. The local physician, unable to find a better explanation, thought that they might be victims of witchcraft. Asserting that “the evil hand is on them,” he referred their case to the local magistrates and clergymen.

The doctor had a clear enough concept: Satan, through the agency of witches and wizards, was able to distress and abuse people by, among other things, provoking illness and ailments. For their part, the girls went along with the doctor’s judgment of the dramatic behavior they displayed—screaming in pain, falling to the floor, shaking, twisting, and contorting themselves. By virtue of his “diagnosis,” moreover, they were given license to name others in the community as the witches who were torturing them—mostly by pinching and beating but also by appearing at night to wake them from sleep, frighten them, and threaten them.

No less crucial to the development of the story were the assumptions of the Salem townspeople, including the magistrates. Tradition held witches to be sly and deceptive, ever seeking to do harm. They were also thought capable of being in two different places at the same time—for instance, invisibly torturing girls in Salem at the very moment they were visibly meeting with friends in Boston—and of provoking pain in a courtroom even as the jury’s eyes were on them.

The legal concept was similarly clear. European witch-hunters in earlier centuries had abundantly described the powers of witches and offered “operational” means for recognizing them, including by skin defects and freckles that were said to represent physical contact with the devil or his imps. Since a witch’s capacities derived from powers imbued by Satan—an unseen force—a person plausibly identified as a witch could be found guilty on “spectral” evidence: in plain English, evidence no one could disprove. The relief of the girls was therefore sought through prayer in churches and through the indictment and imprisonment of the accused and the execution of those who stubbornly would not “confess” to being witches.

Unfortunately, imprisonment or even execution of the supposed culprits failed to suppress the girls, who began to accuse more citizens—including the wife of the governor of Massachusetts Bay Colony. Only then did the voice of doubters begin to be heard. But it took exceptional courage to speak out, since those who did so often found themselves in the ranks of the accused. More critical to putting an end to the episode was something that occurred to the girls as they were on their way to testify in the town of Gloucester.

While crossing a bridge in Ipswich, they passed an old woman, promptly fell into fits of screaming, falling, and twisting, and accused the woman of torturing them. But the citizens of Ipswich were not impressed. They had not summoned the girls, thought little of their accusations and behavior, and simply ignored them as they lay bellowing on the bridge. Unaccustomed to neglect, the girls became confused. Although they eventually recovered from their fits, remounted their horses, and rode on quietly to Gloucester, their courtroom testimony (to quote Marion L. Starkey in *The Devil in Massachusetts*) “lacked its usual conviction and led to no arrests.”

Cotton Mather, the Puritan divine and Harvard professor, wrote a book about the Salem trials, *Wonders of the Invisible World* (1692), in which he dramatically indicted Satan and his supernatural

powers while also expressing some reservations about spectral evidence. Sir William Phips, the British governor whose wife had been accused, was of no such divided mind. He requested a second opinion on witchcraft from a group of distinguished ministers in New York. Although they too believed that witches were persons “throwing off the yoke of God,” they denied that it was easy to identify them and specifically condemned the use of spectral evidence. Phips thereupon redefined the nature of admissible evidence in witch trials, ruling out every “spectral” claim of being pinched and choked, paid ghostly visitations, or transported. He also signed reprieves for all who had previously “confessed,” and released them from prison.

No one listened to the girls again, and eventually several retracted their accusations. One, Ann Putnam, stood tearfully in the Salem village church as the minister read out her confession of error and false charges. Samuel Sewall, one of the judges, similarly took upon himself “the blame and shame of it” before his peers and neighbors in church. John Hale, a minister who had testified against a woman subsequently executed, wrote abashedly that “We walked in clouds and could not see our way.”

The craze was over in Salem. It had lasted little more than a year, but twenty people had been executed and more than a hundred imprisoned. The incident was the last of its kind in colonial America and among the last anywhere in the Western world. With the emerging commitment to the natural sciences during the 18th century, the idea that devils and supernatural powers held humans in their thrall was gradually relinquished.

**S**TILL, THE replacement of a spiritual worldview with scientific positivism and empiricism hardly put an end to the human capacity for entertaining and promoting beliefs that could generate hysterical behavior. Any view of the world, under the right circumstances and in the hands of the right advocates, is capable of breeding the disorder.

In 1778, an Austrian physician named Franz Anton Mesmer burst upon the sophisticated circles of pre-revolutionary Paris armed with a conception of nature that, he claimed, illuminated the physical basis of terrestrial existence itself. It seemed that an invisible, energy-bearing fluid—Mesmer termed it “animal magnetism”—surrounded and permeated both animate and inanimate objects, affecting all of the physical phenomena—heat, light, electricity, gravity, and magnetism—under study by scientists of the time.

And sickness? This, Mesmer taught, was caused by some “block” to the flow of the energetic fluid through the human body. By massaging a patient with magnets and other metallic devices at the body’s “magnetic poles,” he claimed that he could unblock the flow. His treatments would occasionally provoke a remarkable attack or “crisis” in which the patient fainted or convulsed, but on passing through this crisis he would be restored once again to “harmony” with nature.

For close to a decade, the flamboyant Mesmer enjoyed great success in Paris, earning considerable wealth from supporters and patients alike. His reputation for remarkable powers—getting the blind to see, the deaf to hear, the voiceless to sing—went before him. At his treatment sessions, which were group affairs, patients would sit in a circle holding or leaning against iron rods that emerged from a large central vat of “magnetized,” slightly acidified water. (This contraption, as the historian and psychiatrist Henri Ellenberger points out in *The Discovery of the Unconscious*, was a crude imitation of the then-recently invented Leyden jar for storing static electricity.)

With music playing, Mesmer or one of his associates would approach the patients one by one, holding their hands and prodding their abdomens. Sitting quietly, the patients reported a variety of inner feelings—of energy, of electricity, of rushing fluids. At first singly, but then often in a wave spreading across the group, many would fall into a spell of convulsions (the “crises”) and be carried from the room by Mesmer’s burly attendants. After recovering from this experience, frequently likened by them to the old religious practice of exorcism, they claimed to feel better.

Mesmer’s patients were enraptured not only by his commanding appearance and kindly, encouraging manner but also by the physical instruments he used and the scientific-sounding explanations of his treatments. That animal magnetism was nothing more than another “spectral” proposition was not so obvious. Still, in 1784, a royal commission led by Antoine-Laurent de Lavoisier (the great French chemist and discoverer of oxygen) and Benjamin Franklin (at the time the American ambassador to France) concluded that Mesmer’s clinical powers rested not on any material or scientific foundations but on his skill at suggestion and on the vivid imagination and readiness for self-deception of his clientele.

Mesmer left Paris soon after the commission’s report came out, but that did not end the matter. His concepts of magnetism and “mesmeric heal-

ing” remained on the fringes of medicine until late into the 19th century. Even today, one meets people who believe that a few magnets in your shoes can do you good. The contemporary enthusiasm for the traditional form of Chinese medicine resuscitated by Mao Zedong and characterized by acupuncture and the “flow of chi” through the body most startlingly resembles Mesmer’s claims that sickness results from an obstacle to the flow of magnetic fluid.

Nor was Mesmer a charlatan. Instead, he was a persuasive true-believer in his “system,” a personality type well known in medicine. There seems to be a constant supply of figures claiming on the basis of their medical credentials to possess some special knowledge about how to live life better and more healthily. Today they gain devotees through television, celebrity endorsers, and advertising. Like Mesmer, they often develop their ideas from extensions of current science and/or exotic philosophies, and comfort or heal by being responsive to the worries and miseries of their followers. Like him, they are usually stronger on charm and charisma than on accomplishment. And occasionally, like him again, they start up fads that have a decidedly hysterical aspect.

**A**THIRD MINI-EPIDEMIC of hysteria emerged not from the charisma of a “healer” but from the thinking of one of the most illustrious and capable neurologists of the mid-19th century.

Jean-Martin Charcot (1825-1893) was a genius, among the first to link the symptoms and signs of neurological illness displayed in life to specific changes in brain tissues found post-mortem. Many a neurological condition owes its discovery and explanation to Charcot’s powers of observation and reasoning. Amyotrophic lateral sclerosis—the condition referred to as Lou Gehrig’s disease in the United States but identified as Charcot’s disease in most of Europe—is the best known. Other eponymous phenomena include Charcot’s triad in multiple sclerosis, Charcot’s joint in late-stage syphilis, and Charcot-Marie hereditary amyotrophic degeneration.

To the aspiring neuropsychiatric clinicians of his time, Charcot was “The Master.” Today he is recognized as the founder of the great French tradition in neurology and neuropsychiatry. As the neurologist Israel S. Wechsler once put it, “Of Charcot it may be said with truth that he entered neurology in its infancy and left it at its coming of age, largely nourished by his own contributions.”

As for the epidemic, it emerged when patients

under Charcot’s supervision at the Salpêtrière hospital in Paris began to display convulsive contortions during his rounds. Thanks to a prior administrative decision, patients with episodic emotional disturbances had been placed in the same ward with epileptics. Witnessing the epileptic seizures, and observing Charcot and his students carefully studying their effects, the emotionally disturbed patients started to display similar and even more remarkable symptoms.

In the belief that he was observing an overlooked condition, Charcot began to devote much time to investigating it. He found what he took to be distinct diagnostic signs, such as the hand positions struck during attacks, and concluded that, like the neighboring epilepsy patients, these patients too must have some physiological defect provoking their condition. He started to refer to this as hystero-epilepsy.

Over time, the numbers of patients with the symptoms grew. New constellations of spasms and convulsions developed among them, and more and more staff members became attentive to their condition. Presuming some brain source for the disorder, Charcot was not dismayed by the lack of evidence for it because, as he noted, many patients with other forms of epilepsy also showed no evidence of coarse brain pathology. He proceeded to present their cases in lecture halls open to the public, and to use them as subjects for his study of hypnosis. As his interest in them increased, their displays grew wilder.

It was one of Charcot’s most distinguished pupils, Joseph Babinski, who began to suspect that the symptoms were not caused by a brain condition but had instead been suggested to the patients by the clinical examinations repeatedly performed on them. In Babinski’s view, the patients had come to believe in their illnesses primarily because Charcot believed in them.

Eventually, and especially after Babinski won the support of Hippolyte Bernheim, a distinguished professor of internal medicine at the University of Nancy, Charcot began to pull back from his presumptions. He observed that when the patients were isolated from others with similar symptoms, and from doctors bearing suggestion, they invariably improved. But Charcot died before he could complete his reassessment. His successor, believing that the hysterical symptoms were simply counterfeit, withdrew all attention to the group. Its members ceased behaving hysterically, and the wards emptied out.

Two different investigative paths in neurology

and psychiatry emerged from Charcot's clinic. The most direct path—opened essentially by Babinski—was to view the paralyzes, seizures, and other antics of these patients as a manifestation of their self-deceptions and their vulnerability to persuasion. Babinski emphasized that the symptoms were human creations—"artifacts" produced by a contagion of mimicry among the patients and by suggestion from Charcot's examination methods. Following this line of reasoning, he tried to help the patients recover by turning his and their attention away from the hysterical symptoms, by offering realistic alternative suggestions, and by assisting them in dealing with any present distress.

Babinski's was a treatment based on what he saw going wrong. If persuasion could produce the disorders, then counter-persuasion could cure them. It seemed a sensible idea.

The other path was that followed by Sigmund Freud, who studied under Charcot from October 1885 through February 1886. Freud was fascinated by Charcot, and particularly by his interest in the use of hypnosis to draw out memories of past events. In an obituary, Freud claimed for Charcot "the glory of being the first to elucidate hysteria."

But Freud rejected any idea of a mysterious neuropathology in persons affected by hysteria. Instead, he proposed hidden psychological mechanisms at work in the patients. Back in Vienna with his fellow psychoanalyst Josef Breuer, he studied the case of Anna O., a young woman of considerable intellectual ability but with complicated and changing hysterical symptoms. Through their collaboration in this case, Freud and Breuer came to the idea that some kind of traumatic memories haunted all patients with hysteria, and that what was needed was to have these memories "swept away" by talking them through, ideally under hypnosis. "Hysterics suffer mainly from reminiscences" was the aphorism the two men advanced.

It is remarkable (even breathtaking) to realize that, despite all the changes in theory and practice that Freudian psychoanalysis underwent over the following decades, this basic idea—heal by remembering—has never been questioned. It remains today the fundamental concept behind the multiple-personality-disorder and recovered-memory crazes.

**W**HAT DO these three classical examples have in common, and how do they resemble the recent outbreaks of hysteria? The similarities are easily enumerated.

First, the subjects were all true-believers—they

believed they were bewitched, mesmerized, or seizure-prone. In just the same way, patients diagnosed with MPD believe they are "multiples."

Second, the patients' beliefs derived from conceptions of reality held by others and particularly by influential others—the doctors and divines of Salem, Mesmer and his distinguished supporters in Paris, Charcot at the Salpêtrière. In the same way, patients with MPD derive their beliefs from the conceptions of mental life held by therapists to whom they entrust themselves.

Third, the belief-generated behaviors spread among subjects and grew in intensity with each individual. The girls in Salem became more violent in their attacks and wider-ranging in their accusations; Mesmer's patients fell into waves of "crises"; the Salpêtrière patients began to enhance their behaviors in steadily more dramatic ways. All of them were learning the sorts of behavior that would draw and sustain attention from others.

And so again with MPD and recovered memory. Once a single "alter" is found, more and more can be expected to appear; eventually, hundreds may emerge. False memories of abuse begin as vague suspicions and then, being cultivated, grow into wild claims that can include victimization at the hands of satanic characters and international, trans-generational conspiracy cults.

Fourth, the more attention is paid to a behavior, the more the behavior is seen; the less attention is paid, the less it is seen. The Salem girls found the magistrates' attention rewarding; they found the neglect of the townspeople on the Ipswich bridge disconcerting and disempowering. Mesmer's patients underwent crises before his eyes and at his touch, but the crises disappeared with his departure from Paris. Charcot could elicit more behavioral displays with more examinations or public presentations; his successor ended the epidemic by refusing all attention. With MPD, more attention produces more alters; no attention leads to the disappearance of the behavior.

What then can we finally say about these recurrent epidemics of imitative physical and mental disorder? People vulnerable to hysteria are often emotionally if not chronologically immature, and during their lives have regularly and habitually exaggerated or dramatized their feelings. If they win public attention from their hysterical behavior, they may hold on to it long after the circumstances that provoked the behavior have disappeared. On the other hand, as I have seen time and again, they can often be persuaded to let go of their symptoms if trusted doctors tell them ("counter-suggest") that

they are in the “recovery” phase of their illness and that the still-present manifestations of it are but fading remnants that can be properly ignored. At that point, in a face-saving move, many patients will abandon all of their symptoms without being forced to question the validity of their original “sickness.”

This in turn tells us something crucial about how the contagion is transmitted from patient to

patient. The agency of transmission is, quite simply, words. Words channel meaning, and direct behavior. Because hysteria is a condition that depends on words, words that describe, explain, bewitch, hint, insinuate, persuade—or dissuade—we must look hard and carefully at the words we use, and at the words we misuse, if we are ever to understand this disorder and learn how best to help those afflicted by it.