BOOK REVIEW
Musing about Medical Muses

‘Hysteria, an illness that no longer exists... (it is)... an illness of the past’. So states the author of this book, another on hysteria. Do we really need yet another book on the subject, and written by one who is comfortable enough to confess that before writing it she had a ‘preconceived notion’, that hysterics were victims of a ‘misogynist institution lead by a tyrannical Charcot’. ‘an imperious authority figure who treated the hysterics at Salpêtrière as medical specimens’? At the outset, hysteria was viewed by Asti Hustvedt, at least partly, as an illness of ‘being a woman in an era that strictly limited female roles’, and whose symptoms apparently illustrated their actual social conditions. She could not understand the ‘spectacular forms of illness recorded by their doctors’ and she accused Charcot of transforming ‘his’ hysterics into ‘living dolls’.

I look around my bookshelves and can see delightful old texts related to the subject, such as the early English monograph by George Cheyne (1671–1743; 1733), who did not use the term ‘hysteria’ adjectively. The concept of ‘hysteria’ as a unitary diagnosis began in the 1800s. Then, there are the great French contributions of Pierre Briquet (1796–1881; 1859), Georges Gilles de la Tourette (1857–1904; 1891), and Charcot (1825–93) himself, whose contributions to the subject dominate many of the collected writings from his published lectures. These and the contributions of other English writers, such as H. Charlton Bastian (1837–1915; 1893), or later texts such as those of Harold Merskey (1995), are written by physicians with first-hand knowledge of the signs and symptoms they see and touch, and which they try to explain in everyday clinical practice on the basis of scientific knowledge.

At one time, it was customary for doctors to write about the history of their own subject, but a disarming trend emerged in the later half of the 20th century, which implied that without a degree in history, the authors had no business writing medical history, even within their own discipline. Competent books on the history of hysteria emerged from various non-medical historians, such as Ilza Veith’s Hysteria, the history of a disease (1965) or Mark Micale’s Approaching hysteria (1995). But more and more of these texts assumed a sociological perspective, repeating the mantra that hysteria had disappeared, and the feminist diatribe that, in any case, it was a disorder of females invented by men.

Tennessee Williams’ A Streetcar Named Desire, who, oppressed by their masculine surroundings end up in hospital as playthings of doctors. Famously, Axel Munthe (1857–1949), a Swedish doctor who attended the Salpêtrière, described ‘these stage performances... before the public of “tout Paris” were nothing but an absurd farce, a hopeless muddle of truth and cheating’ (p. 90).

The historian, Edward Shorter (1992) considered that Charcot alone was responsible for bringing forth ‘an epidemic of fits and sensory stigma’ (p. 200) in the late 19th century, and opined that ‘there is no more striking phenomenon than the disappearance of classic hysteria’ (p. 266).

By the mid-19th century, hysteria had become an important disorder for medical attention. The emphasis on causation had shifted from the uterus to the brain through writers such as Thomas Willis (1621–75), which implied that without a degree in history, the authors had no business writing medical history, even within their own discipline. Competent books on the history of hysteria emerged from various non-medical historians, such as Ilza Veith’s Hysteria, the history of a disease (1965) or Mark Micale’s Approaching hysteria (1995). But more and more of these texts assumed a sociological perspective, repeating the mantra that hysteria had disappeared, and the feminist diatribe that, in any case, it was a disorder of females invented by men. Blanche Whitman of Charcot’s stage, portrayed in the painting by André Brouillet (1857–1914), (the female who is about to have a seizure and fall into the arms of a nurse), becomes portrayed in the theatre in such characters as Blanche Dubois, the heroine of
psychological, or indeed swayed by the suggestible females who literally fell before him, remains a matter of debate, but he was aware that there was more to it than neurological examination alone could deduce.

There were acrimonious debates centred on the roles of suggestion (a trait that everyone possessed in varying degrees) in the provocation of symptoms, as opposed to the importance of some underlying cerebral weakness, which was congenital and related to the then popular concept of degeneration. Degeneration reflected a heredity neuropathy, giving rise to personality predispositions that, in the 19th century, were thought to underlie many neuropsychiatric conditions—hysterics as neuropaths. Hypnosis became one battleground. For Charcot, hypnotizability reflected a pathological condition, a form of neurosis linked to hysteria and characterized by recognizable physical signs, and he was hostile and critical of any misuse of it, for example, by stage hypnotists. His opponents argued that Charcot was simply dealing with suggestive people under his powerful influence, and not with neurologically based disorder.

Pierre Janet took these ideas further. A failure of psychological synthesis, amnesia and constriction of the field of consciousness were the elements of his theories. Parasitic ideas, which were subconscious, concealed in the deeper layers of the mind and related to traumatic events, acted as ‘idées fixes’, and were a target for treatment. This increased emphasis on the psychological as opposed to the neurological heralded a geographical shift from France to Austria, and a conceptual change followed with Freud’s writings on hysteria.

Following on from Charcot and Janet, Freud (1856–1939) (along with Joseph Breuer 1842–1925) flirted with hypnosis as a ‘cathartic’ method of treatment, but soon became disillusioned. Freud was influenced by Charles Darwin (1809–82), Theodore Meynert (1833–92), the sociologist Herbert Spencer (1820–1903) and John Hughlings Jackson (1835–1911). Freud’s unpublished Project for a scientific psychology was an attempt to correlate psychological events with the distribution of energy in the brain. It was based upon the properties of different types of neurons, their excitability and principles of inhibition and excitation (Pribram and Gill, 1976). The physiological was always imbedded into the psychical, reflecting a reciprocal causality.

From Hughlings Jackson, he took over the idea of ‘dissolution’ (the opposite to evolution) of the most organized cerebral structures, developing Hughlings Jackson’s principle of hierarchies of neural activity by positing a similar concept for psychological organization (id, ego and superego echoing lowest, middle and highest cerebral centres), and Freud adopted the doctrine of concomitance (a mind–brain parallelism; Freud, 1953). Like Hughlings Jackson, he rejected a strict localization of function in the brain, but accepted the ability of higher aspects of psychological function to be overwhelmed by lower ones. Jacksonian neurodynamics, thus, metamorphosed to Freudian psychodynamics (Freud, 1953; Dewhurst, 1982).

Freud’s eventual model of the human mind and its development had repression as central, with infantile sexual development and trauma forming an under-felt of the later clinical presentations of the signs and symptoms of hysteria. Neurotic symptoms and signs were explained in terms of symbols, reminiscences, defences and pathogenic ideas. However, although the concept of discharge of nervous excitation as related to unsatisfied drives or of some kind of interpersonal conflict leading to ‘catharsis’ formed the original basis of his psychoanalysis, this theoretical shift saw the clef between neurology, and a psychiatry based on psychology, widen to an unbridgeable gulf.

English neurologists, in contrast, took little interest in hysteria, and there were few articles on hysteria published in the early editions of Brain (Wilson, 1910). There were exceptions, such as the observations of Sir Benjamin Brodie (1783–1862; 1837), J Russell Reynolds (1828–96; 1869) and Charlton Bastian (1893). Kinnier Wilson (1878–1937) saw cases at the National Hospital ‘in abundance’ (p. 298), but Hughlings Jackson, who must have seen pseudoseizures (non-epileptic) galore, rarely mentions them in his writings, although apparently he did occasionally use hypnosis (Dewhurst, 1982; Reynolds, 2012).

The idea expressed by some that hysteria disappeared from medical vision with the death of Charcot is a complete myth. It is true that there was a backlash against his theories, notoriously led by Joseph Babinski (1857–1932), who sided with those taking the view that hysteria was created by suggestion; and he was one of the first to suggest abandoning the term hysteria trying to replace it with pithiatism (curable by persuasion: Babinski and Froment, 1918). Also, Freud’s ideas were literally blown apart by the huge number of soldiers in World War I who presented with medically unexplained somatic symptoms, essentially hysteria, in profusion, but now affecting males. Shell shock accounted for up to 40% of cases from the front and 80 000 cases of shell shock were in military hospitals, half of whom ended up in institutional care (Stone, 1985). A literature devoted to ‘shell shock’ emerged, and the organic/psychological theories of causation were all repeated (Trimble, 1981; Shephard, 2000).

In the 1860s and 1870s, females with somatic symptoms were admitted to the Salpétrière, and Charcot took an acute interest in them. He was concerned not only to clarify the signs and symptoms of neurological illnesses, but also to classify them (unlike Hughlings Jackson, who was less interested in the artificial dissections of neurological disorders in the fashion of gardeners classifying flowers, as opposed to the method of botanists). Charcot’s main concerns were theories of cerebral activity and how the signs and symptoms of a damaged nervous system emerged. For him, there was not only hysteria major (with convulsions) and hysteria minor, but hysterical seizures could be parsed out into different recognizable periods or segments from prodromes through to ‘attitudes passionnelles’, and the period of delusion, all of which were captured by the cameras of Paul Régnard (1850–1927), a photographer at the Salpétrière, and Charcot’s artist Paul Richer (1849–1933).

At this time, hysteria was considered within the provenance of neurology. There was no psychiatry, as developed later, and the so-called alienists were mainly interested in the psychoses, not the neuroses. Into this arena, stepped the three graces who are the ‘femme inconprise’ or the ‘femme fatale’ of Asti Hustvedt’s Medical Muse. They are Blanche Wittmann, Augustine and Geneviève. Their stories have been well-told in other texts and their images well-portrayed, since they all fell under the captivating gaze of Régnard, who convinced Charcot to publish a journal, with his images and an accompanying text written by
Desiré-Magloire Bourneville (1840–1909). The latter was an alienist, a neurologist and a journalist who became an assistant to Charcot. In addition to founding the Iconographie photographique de la Salpêtrière (1876–77), later to be succeeded by the Nouvelle iconographie de la Salpêtrière (1888–1918), he also started Progrès médical and the Revue photographique des hôpitaux de Paris.

According to Georges Didi-Huberman (2003), the camera was an instrument that framed and fashioned the signs of hysteria, the females posing for Charcot in postures that he desired, the images that became iconic of hysteria. The camera literally invented hysteria. The faces, gestures and postures of the females represented a ‘tableaux vivant’ that was fixed and memorialized for future generations. Labels were attached to their states, such as ‘ecstasy’, ‘crucifixion’, ‘eroticism’ or ‘catalepsy’, identifying the supposed affects and passions of the hysterics.

If the image of Blanche is the most recognized (because of her appearance in the Brouillet painting), it was Augustine who filled many of the illustrations. ‘…she has become Charcot’s most celebrated hysteric. Later generations have turned her into an icon: an object of desire, a victim of misogyny, or a feminist rebel…the camera loved.’

The signs and symptoms of the protagonists described in Medical Muses have a regularity that can only echo to the clinics today. Convulsions, fainting spells, paralyses and contractures, complex often florid hallucinations, mutism, sensory stigmata, eating disorders, intense religiosity, self-mutilation, somnambulism and so the list goes on. Their histories contain evidence of early separation from parents either abandoned or fostered, and sexual or physical abuse. Temper outbursts and labile moods pepper some of the anamneses.

Bourneville is about the only male participant in Medical Muses who gets credible press. A social activist, who established the first professional nursing school in France, an anti-Catholic who ousted the nuns, he took intense interest in Charcot’s patients, making notes in shorthand, and publishing their case histories. He developed a special unit for handicapped children and those with epilepsy, and his name lives on with Bourneville–Pringle disease. After the death of Charcot, his star waned and he died in poverty.

We do not know what became of two of the famous three. Augustine and Geneviève left the Salpêtrière for unknown destinations, and it is only Blanche that leaves us her tale. According to Hustvedt, after the death of Charcot in 1893, she never had any more convulsions, paralyses or deliria. She became an employee of the Salpêtrière, and eventually worked as a technician in the radiology laboratory. As a consequence of radiation exposure, she first had her fingers of one hand amputated, but then lost the whole arm, before the process started in the other limb. Her story, leading to the eventual amputation of three limbs has been novelized by Per Olov Enquist (2004), an engaging story of her relationship with Charcot and Marie Curie (1867–1934). She was interviewed later in life, and asked the inevitable question, had she simulated her attacks? This she denied and stated: ‘Simulation! Do you think it would have been easy to fool Monsieur Charcot?’

So, has hysteria disappeared as some would like to believe? Rather as Brieret had expressed it, when I was appointed to the staff of the National Hospital for Nervous Diseases in 1976, faced with so many cases of possible hysteria, I decided the best course was to study the disorder from historical and clinical perspectives. In this I was in line with many predecessors, notably Elliot Slater (1904–83) and Harold Merskey. One of the first investigations I carried out was to study the frequency of the presentation of hysteria to the hospital over three decades, 1950–70s. A decline relative to the overall number of admissions in the numbers occurred between the 1950s and 1960s (1.55–0.85%), but not between the 1960s and 1970s. Of interest was the symptom distribution. The numbers for motor symptoms declined, while the number of ‘convulsions’ increased. In retrospect, what was happening was that levodopa had been discovered, the dystonias and dyskinesias associated with it were noted, and the doctrine that all motor disorders were organically based disorders of the basal ganglia became the rule of the day. Alongside were the developments in epilepsy, and a growing recognition that many people diagnosed with epilepsy, in fact had non-epileptic or pseudoseizures.

The trend with respect to seizure disorders continued, especially with more sophisticated EEG monitoring and brain imaging, such that most neurological centres today have specialist seizure units, and in which the hysterical conditions of old are seen ‘in abundance’. Then, as if the times of Charcot rung out a century later, psychogenic dystonia was ‘re’discovered, followed by an acknowledgment that other psychogenic movement disorders migrated around movement disorder clinics. Video cameras replaced the silent ones at the Salpêtrière and the latest technology was employed to investigate cases. Charcot had the ovarian compressor and the thermometer, Freud had psychoanalysis, we have ambulatory monitoring, telemetry and functional MRI. Arguments about the underlying causes continue, almost with the same protagonists (a special neural state, suggestion, the role of compensation and malingering); and running a concomitant race, the sociological–historical perspective. But the patients continue coming. Non-epileptic seizures are considered to be present in up to 25% of patients presenting with chronic seizure disorders, whereas psychogenic dystonia accounts for 5% of those in movement disorder clinics.

Neuropsychiatry, like the term hysteria, came and went, and returned. In the 19th century, psychopathologists were neuropathologists, and their interest was with the brain and its abnormalities in the insane. But under the pressure of the split between a brain-based neurology and a psychological psychiatry that avoided flirting with neuroscience, neuropsychiatrists became seen as neither neurologists nor psychiatrists, but akin to the mythological chimera. The situation has now altered considerably. Along with behavioural neurology, neuropsychiatry as a discipline has undergone a renaissance, with the growing awareness that mind shares the brain with movements, that emotion is represented in the brain by extensive cortical and subcortical circuits, and that many patients presenting to neurological clinics with neurological symptoms do not have an underlying explanatory pathology (so-called medically unexplained symptoms: ~25%; Creed et al., 1990).

Before the great age of hysteria in France, there were dozens of names that had crept into the history of the subject (suffocation of the mother, uterine epilepsy and the vapours, to name but a few), and yet Medical Muses is another book about hysteria,
resurrecting a ghost that apparently had been exorcized. It is the case that newer nomenclatures have tried to bury history by adopting neologisms. The International Classification of Diseases (ICD) 9 included conversion hysteria, dissociative disorders and hysterical personality; but ICD 10 placed disorders previously referred to as hysteria under the penumbra of dissociative (conversion) disorders. The main offender for the internment has been the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) series. Hysteria was expunged and the terms somatoform disorders, which includes conversion and dissociative disorders, and a chronic form designated somatization disorder, was coined.

But as Aubrey Lewis (1900–75) firmly put it: ‘hysteria...tends to outlive its obiturists’ (Lewis, 1975), and even Hustvedt finally concedes ‘it is time to exonerate hysteria’. But it is also the time to acknowledge Charcot as the neuroscientist who changed our views of the brain and its functions; and who, along with Hughlings Jackson, must be viewed as a founder of today’s neuropsychiatry. The economic burden of patients with hysteria, especially those with chronic hysteria (eponymously referred to as Briquet’s syndrome–somatization disorder), is huge; this is rather odd for a disorder that has ceased to exist! Probably the best recent review of the medical aspects of the subject is given in the book by Peter W. Halligan and colleagues (2001). My own view on the subject is as follows: ‘Hysteria, a medical chimera with centuries of tradition...straddles myth, personal and societal and reality: it cannot be abolished by mere committee...’, and neither by sociologists nor historians largely ignorant of the essence of the subject they are dealing with (Trimble, 2004). Medical Muses is a great read, even if, as all history, it isfaction; as for hysteria, this remains hysterion proteron.

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