

The book cover is split vertically. The left half is a solid light brown color. The right half is a light blue color with a large, circular graphic of concentric rings in shades of green, yellow, and orange, resembling a ripple or a target. The text is centered across the vertical split.

THE SHAKING  
WOMAN  
OR  
A HISTORY  
OF  
MY NERVES



SIRI HUSTVEDT

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WHEN MY FATHER DIED, I was at home in Brooklyn, but only days before I had been sitting beside his bed in a nursing home in Northfield, Minnesota. Although he was weak in body, his mind remained sharp, and I remember that we talked and even laughed, though I can't recall the content of our last conversation. I can, however, clearly see the room where he lived at the end of his life. My three sisters, my mother, and I had hung pictures on the wall and bought a pale green bedspread to make the room less stark. There was a vase of flowers on the windowsill. My father had emphysema, and we knew he would not last long. My sister Liv, who lives in Minnesota, was the only daughter with him on

the final day. His lung had collapsed for the second time, and the doctor understood that he would not survive another intervention. While he was still conscious, but unable to speak, my mother called her three daughters in New York City, one by one, so we could talk to him on the telephone. I distinctly remember that I paused to think about what I should say to him. I had the curious thought that I should not utter something stupid at such a moment, that I should choose my words carefully. I wanted to say something memorable—an absurd thought, because my father’s memory would soon be snuffed out with the rest of him. But when my mother put the telephone to his ear, all I could do was choke out the words “I love you so much.” Later, my mother told me that when he heard my voice, he smiled.

That night I dreamed that I was with him and he reached out for me, that I fell toward him for an embrace, and then, before he could put his arms around me, I woke up. My sister Liv called me the next morning to say that our father was dead. Immediately after that conversation, I stood up from the chair where I had been sitting, climbed the stairs to my study, and sat down to write his eulogy. My father had asked me to do it. Several weeks earlier, when I was sitting beside him in the nursing home, he had mentioned “three points” he wanted me to take down. He didn’t say, “I want you to include them in the text you will write for my funeral.” He didn’t have to. It was understood. When the time came, I didn’t weep. I wrote. At the funeral I delivered my speech in a strong voice, without tears.

TWO AND A HALF YEARS LATER, I gave another talk in honor of my father. I was back in my hometown, in Minnesota, standing under a blue May sky on the St. Olaf College campus, just beyond the old building that housed the Norwegian Department, where my father had been a professor for almost forty years. The department had planted a memorial pine tree with a small plaque beneath it that read, LLOYD HUSTVEDT (1922–2004). While I'd been writing this second text, I'd had a strong sensation of hearing my father's voice. He wrote excellent and often very funny speeches, and as I composed I imagined that I had caught some of his humor in my sentences. I even used the phrase "Were my father here today, he might have said . . ." Confident and armed with index cards, I looked out at the fifty or so friends and colleagues of my father's who had gathered around the memorial Norway spruce, launched into my first sentence, and began to shudder violently from the neck down. My arms flapped. My knees knocked. I shook as if I were having a seizure. Weirdly, my voice wasn't affected. It didn't change at all. Astounded by what was happening to me and terrified that I would fall over, I managed to keep my balance and continue, despite the fact that the cards in my hands were flying back and forth in front of me. When the speech ended, the shaking stopped. I looked down at my legs. They had turned a deep red with a bluish cast.

My mother and sisters were startled by the mysterious bodily transformation that had taken place within me. They had seen me speak in public many times, sometimes in

front of hundreds of people. Liv said she had wanted to go over and put her arms around me to hold me up. My mother said she had felt as if she were looking at an electrocution. It appeared that some unknown force had suddenly taken over my body and decided I needed a good, sustained jolting. Once before, during the summer of 1982, I'd felt as if some superior power picked me up and tossed me about as if I were a doll. In an art gallery in Paris, I suddenly felt my left arm jerk upward and slam me backward into the wall. The whole event lasted no more than a few seconds. Not long after that, I felt euphoric, filled with supernatural joy, and then came the violent migraine that lasted for almost a year, the year of Fiorinal, Inderal, cafergot, Elavil, Tofranil, and Mellaril, of a sleeping-drug cocktail I took in the doctor's office in hopes that I would wake up headache-free. No such luck. Finally, that same neurologist sent me to the hospital and put me on the antipsychotic drug Thorazine. Those eight stuporous days in the neurology ward with my old but surprisingly agile roommate, a stroke victim, who every night was strapped to her bed with a restraint sweetly known as a Posey, and who every night defied the nurses by escaping her fetters and fleeing down the corridor, those strange drugged days, punctuated by visits from young men in white coats who held up pencils for me to identify, asked me the day and the year and the name of the president, pricked me with little needles—Can you feel this?—and the rare wave through the door from the Headache Czar himself, Dr. C., a man who mostly ignored me and seemed irritated that I didn't cooperate and get well, have stayed

with me as a time of the blackest of all black comedies. Nobody really knew what was wrong with me. My doctor gave it a name—*vascular migraine syndrome*—but why I had become a vomiting, miserable, flattened, frightened ENORMOUS headache, a Humpty Dumpty after his fall, no one could say.

My travels in the worlds of neurology, psychiatry, and psychoanalysis began well before my stint in Mount Sinai Medical Center. I have suffered from migraines since childhood and have long been curious about my own aching head, my dizziness, my divine lifting feelings, my sparklers and black holes, and my single visual hallucination of a little pink man and a pink ox on the floor of my bedroom. I had been reading about these mysteries for many years before I had my shaking fit that afternoon in Northfield. But my investigations intensified when I decided to write a novel in which I would have to impersonate a psychiatrist and psychoanalyst, a man I came to think of as my imaginary brother, Erik Davidsen. Brought up in Minnesota by parents very much like mine, he was the boy never born to the Hustvedt family. To be Erik, I threw myself into the convolutions of psychiatric diagnoses and the innumerable mental disorders that afflict human beings. I studied pharmacology and familiarized myself with the various classes of drugs. I bought a book with sample tests for the New York State psychiatric boards and practiced taking them. I read more psychoanalysis and countless memoirs of mental illness. I found myself fascinated by neuroscience, attended a monthly lecture on brain science at the New York

Psychoanalytic Institute, and was invited to become a member of a discussion group devoted to a new field: neuropsychanalysis.

In that group, neuroscientists, neurologists, psychiatrists, and psychoanalysts sought a common ground that might bring together the insights of analysis with the most recent brain research. I bought myself a rubber brain, familiarized myself with its many parts, listened intently, and read more. In fact, I read obsessively, as my husband has told me repeatedly. He has even suggested that my rapacious reading resembles an addiction. Then I signed up as a volunteer at the Payne Whitney Psychiatric Clinic and began teaching a writing class to the patients there every week. At the hospital, I found myself close to particular human beings who suffered from complex illnesses that sometimes bore little resemblance to the descriptions cataloged in the *Diagnostic and Statistical Manual of Mental Disorders* (usually referred to as the *DSM*). By the time I shook in front of my father's tree, I had been steeped in the world of the brain/mind for years. What began with curiosity about the mysteries of my own nervous system had developed into an overriding passion. Intellectual curiosity about one's own illness is certainly born of a desire for mastery. If I couldn't cure myself, perhaps I could at least begin to understand myself.

EVERY SICKNESS HAS an alien quality, a feeling of invasion and loss of control that is evident in the language we use about it. No one says, "I am cancer" or even "I am cancerous," despite the fact that there is no intruding virus or bac-

teria; it's the body's own cells that have run amok. One *has* cancer. Neurological and psychiatric illnesses are different, however, because they often attack the very source of what one imagines is one's self. "He's an epileptic" doesn't sound strange to us. In the psychiatric clinic, the patients often say, "Well, you see, I'm bipolar" or "I'm schizophrenic." The illness and the self are fully identified in these sentences. The shaking woman felt like me and not like me at the same time. From the chin up, I was my familiar self. From the neck down, I was a shuddering stranger. Whatever had happened to me, whatever name would be assigned to my affliction, my strange seizure must have had an emotional component that was somehow connected to my father. The problem was that I hadn't *felt* emotional. I had felt entirely calm and reasonable. Something seemed to have gone terribly wrong with me, but what exactly? I decided to go in search of the shaking woman.

PHYSICIANS HAVE BEEN PUZZLING over convulsions like mine for centuries. Many diseases can make you shudder, but it's not always easy to separate one from the other. From Hippocrates onward, making a diagnosis has meant herding a cluster of symptoms under a single name. Epilepsy is the most famous of all the shaking illnesses. Had I been a patient of the Greek physician Galen, who ministered to the emperor Marcus Aurelius and whose copious writings influenced medical history for hundreds of years, he would have diagnosed me with a convulsive illness, but he would have ruled out epilepsy. For Galen, epilepsy not

only caused convulsions of the entire body, it interrupted “leading functions”—awareness and speech.<sup>1</sup> Although there were popular beliefs among the Greeks that gods and ghosts could make you shake, most physicians took a naturalist view of the phenomenon, and it wasn’t until the rise of Christianity that tremors and the supernatural were bound together with bewildering intimacy. Nature, God, and the devil could wrack your body, and medical experts struggled to distinguish among causes. How could you separate an act of nature from a divine intervention or a demonic possession? Saint Teresa of Avila’s paroxysmal agonies and blackouts, her visions and transports were mystical flights toward God, but the girls in Salem who writhed and shook were the victims of witches. In *A Modest Inquiry into the Nature of Witchcraft*, John Hale describes the fits of the tormented children and then pointedly adds that their extreme sufferings were “beyond the power of any epileptic fits or natural disease to effect.”<sup>2</sup> If my tremulous episode had occurred during the witch madness in Salem, the consequences might have been dire. Surely I would have looked like a woman possessed. But, more important, had I been steeped in the religious beliefs of the age, as I most likely would have been, the weird sensation that some external power had entered my body to cause the shudder probably would have been enough to convince me that I had indeed been hexed.

In New York City in 2006 no sane doctor would have sent me to an exorcist, and yet confusion about diagnosis is common. The frames for viewing convulsive illness may

have changed, but understanding what had happened to me would not be a simple matter. I could go to a neurologist to see if I had come down with epilepsy, although my past experience in the ward at Mount Sinai Hospital had left me wary of the doctors in charge of investigating nervous systems. I knew that in order to be diagnosed with the disease, I needed to have had at least *two* seizures. I believed I had had one genuine seizure before my intractable migraine. The second one looked suspicious to me. Uncontrollable shaking can occur in some seizures. My shaking was on both sides of my body—and I had *talked* throughout the fit. How many people *talk* through a seizure? Also, I had had no aura, no warning that some neurological event was in the making, as I often do for migraine, and it had come and gone with the speech about my dead father. Because of my history, I knew that a careful neurologist would do an EEG, an electroencephalogram. I'd have to sit with gooey electrodes clamped onto my scalp for quite a while, and my guess is that the doctor would find nothing. Of course, many people suffer from seizures that are not detected by standard tests, so the physician would have to do more tests. Unless I kept shaking, a diagnosis might not be forthcoming. I could float in the limbo of an unknown affliction.

I had puzzled for some time over my shaking when a possible answer announced itself. It didn't appear slowly but came all at once as an epiphany. I was sitting in my regular seat at the monthly neuroscience lecture, and I remembered a brief conversation I had had with a psychiatrist who had been sitting behind me at an earlier talk. I'd asked her

where she worked and what she did, and she'd told me she was on the staff in a hospital, where she saw mostly "conversion patients." "The neurologists don't know what to do with them," she'd said, "so they send them to me." *That could be it!* I thought. My fit had been *hysterical*. This ancient word has been mostly dropped from current medical discourse and replaced by *conversion disorder*, but lying beneath the newer term is the old one, haunting it like a ghost.

Nearly every time the word *hysteria* is used now in newspapers or magazines, the writer points out that the root comes from the Greek for "womb." Its origin as a purely female problem connected to reproductive organs serves to warn readers that the word itself reflects an ancient bias against women, but its history is far more complicated than misogyny. Galen believed that hysteria was an illness that beset unmarried and widowed women who were deprived of sexual intercourse but that it wasn't madness, because it didn't necessarily involve psychological impairments. Ancient doctors were well aware that epileptic fits and hysterical fits could look alike, and that it was essential to try to distinguish between the two. As it turns out, the confusion has never disappeared. The fifteenth-century physician Antonius Guainerius believed that vapors rising from the uterus caused hysteria and that hysteria could be distinguished from epilepsy because the hysterical person would remember everything that had happened during the fit.<sup>3</sup> The great seventeenth-century English doctor Thomas Willis dispensed with the uterus as the offending organ and located both hysteria and epilepsy in the brain. But Willis's

thought didn't rule the day. There were those who believed that the two were merely different forms of the same disease. The Swiss physician Samuel Auguste David Tissot (1728–1797), who has remained part of medical history mostly for his widely published treatise on the dangers of masturbation, maintained that the two illnesses were distinct, despite the fact that there were epilepsies that originated in the uterus.<sup>4</sup> From ancient times through the eighteenth century, hysteria was regarded as a convulsive illness that originated somewhere in the body—in the uterus or the brain or a limb—and the people suffering from it weren't considered insane. It is safe to say that if any one of the doctors above had witnessed my convulsive speech, he might have diagnosed me with hysteria. My higher functions weren't interrupted; I remembered everything about my fit; and, of course, I was a woman with a potentially vaporous or disturbed uterus.

It's interesting to ask when hysteria became an illness associated exclusively with the mind. In ordinary speech we use the word *hysteria* to indicate a person's excitability or excessive emotion. It conjures up a screaming out-of-control person, usually a woman. Whatever was happening to my arms, legs, and torso, my mind was all right, and I spoke calmly. I wasn't hysterical in that sense. Today, conversion disorder is classified as a psychiatric, not a neurological disorder, which explains why we connect it to mental problems. In the *DSM*, now in its fourth edition, conversion disorder is included among the *somatoform* disorders—disturbances of the body and physical sensations.<sup>5</sup> But in the last forty years,

the term for and classification of the illness has changed several times. In the first *DSM* (1952) it was called *conversion reaction*. The *DSM-II* (1968) grouped it with *dissociation* disorders and identified it as *hysterical neurosis, conversion type*. In 1968, the authors were apparently eager to reinstate the roots of the illness by bringing back the word *hysteria*. *Dissociation* is a very broad term used in different ways to indicate some form of distance from or disruption of ordinary selfhood. For example, when a person has an out-of-body experience, he is said to be in a dissociated state; someone who is plagued by a sense that he or the world isn't real would also be called dissociated. By the time the *DSM-III* (1980) came out, the word *hysterical* had vanished, and the term had been changed to *conversion disorder*, a somatoform problem, which was left unchanged in the *DSM-IV*. The current manual of the World Health Organization, the *ICD-10* (1992), however, disagrees. There it's called *dissociative (conversion) disorder*. If this sounds confusing, it is. The authors of psychiatric diagnostic texts have obviously been uncertain about what to do with hysteria.

There is some general agreement, however. Conversion symptoms often mimic neurological symptoms: paralyzes; seizures; difficulty walking, swallowing, or speaking; blindness; and deafness. But when a neurologist investigates, he won't be able to find anything that would normally cause these problems. So, for example, if some wandering neurologist had happened to give me an EEG while I was shaking in front of the tree, hysterical convulsions wouldn't have been recorded on it, but epileptic shudders might have

been. At the same time, hysterics are not malingerers. They can't help what's happening to them and aren't faking their illnesses. Also, the symptoms can and often do resolve themselves spontaneously. The big caveat is that, as the *DSM* authors note, "Caution must be exercised."<sup>6</sup> In other words, if I had gone to a psychiatrist he would have had to be careful about me. An unidentified neurological illness might have been hiding under my symptoms that wouldn't show up on any tests. He'd have to be confident that my shakes were too odd for epilepsy before he made the diagnosis. And the problem goes both ways. Carl Basil, a pharmacologist at Columbia University, tells the story of a patient who watched the place where he worked burn down and "suddenly became paralyzed on the right side as if he had a stroke."<sup>7</sup> In fact, the man had had a "conversion reaction," which vanished with his shock. The issue is further riddled by the fact that people who suffer from epilepsy are far more likely to have hysterical seizures than people who do not have the disease. In one paper I read, the authors stated that between 10 and 60 percent of people with psychogenic nonepileptic seizures (PNES) have comorbid epilepsy.<sup>8</sup> This contemporary dilemma of identification sounds a lot like the difficulties physicians have had throughout the ages separating epilepsy from hysteria. The question has always been, A woman is shaking. Why?

For years in the late twentieth century, physicians blithely threw around the phrase "no organic cause." Hysteria was a psychic illness with no *organic* cause. People found themselves paralyzed, blind, and convulsing without any organic

cause? How could that be? Unless you believed that ghosts, spirits, or demons swooped in from heaven or hell to take control of a person's body, how could it be argued that this wasn't an *organic, physical* phenomenon? Even the current *DSM* acknowledges the problem, stating that the difference between mental and physical is "a reductionistic anachronism of mind/body dualism."<sup>9</sup> That split has been with us in the West at least since Plato. The idea that we are made of two stuffs, not one, that mind isn't matter, continues to be part of many people's thinking about the world. Certainly the experience of living in my own head has a magical quality. How do I see and feel and think, and exactly what is my mind? Is my mind the same thing as my brain? How can the human experience originate in white and gray matter? What is organic and nonorganic?

Last year, I heard a man talking on the radio about life with his schizophrenic son. Like many patients, his son had trouble staying on his medicine. After hospitalizations, he would return home, stop taking the drug he had been prescribed, and collapse again. It's a story I've heard often from the patients I teach in the hospital, but with each person the reasons for going off the medicine are different. One patient got horribly fat from an antipsychotic, and it made him miserable; another felt dead inside; another was furious with her mother and stopped out of spite. The father on the radio made a point of saying, "Schizophrenia is an *organic brain disease*." I understood why he said it. No doubt his son's doctors had told him this or he had read articles about the illness that referred to it in this way, and it comforted

him, made him feel that as a father he was not responsible for his child's illness, that the boy's environment had played no role. The genetic mystery of schizophrenia may one day be solved, but for now it remains unknown. If one identical twin suffers from the disease, there's a 50 percent chance that the other will. That's high but not determining. There have to be other factors at work, environmental factors, which might be anything from poisons in the air to parental neglect. Too often, people prefer easy answers. In the current cultural climate, *organic brain disease* has a reassuring sound. My son isn't mad; he has something wrong with his brain.

But there is no quick route out of the psyche/soma trap. Peter Rudnytsky, a prominent scholar of psychoanalysis, discusses Otto Rank, a psychoanalyst in Freud's circle, who probably suffered from manic depression. He notes that because manic depression is now known to be an "organic" illness, Rank's mood swings can't be construed as a taint on his "character."<sup>10</sup> Manic depression, also known as bipolar disorder, does run in families, and the genetic component seems to be considerably higher than in schizophrenia. And yet, Rudnytsky implies that there are nonorganic states that might be attributable to character flaws. This raises a question: What is character? Isn't character the sum of our parts, and aren't those parts organic? And if not, what is psychic and what is somatic?

The problem is that the phrase *organic brain disease* doesn't mean much. There are no lesions or holes in the brain tissue of schizophrenics or manic-depressives, no

virus eating away at their cortices. There are changes in brain activity that can be detected by the new technology of brain scans. But then there are brain changes when we are sad or happy or lustful, too. All of these human states are physical. And what is a disease exactly? In *Campbell's Psychiatric Dictionary*, I found this remark from Culver and Gert's *Philosophy in Medicine*: "Illness and disease are closely related, but diseases are ontologically more robust than just an illness."<sup>11</sup> A disease, in other words, has more there there, more *being* than an illness. Not long ago, a friend of mine showed me a book called *Living Well with Migraine Disease and Headaches*. I was amazed. In my earlier travels from one neurologist to another, migraine was never referred to as a *disease*. Obviously it had gained new status, had attained a more "robust" existence since 1982. Is conversion disorder, unlike schizophrenia or manic depression, a psychic phenomenon? Is a psyche different from a brain?

Sigmund Freud was the first to use the word *conversion* in the book he published with Josef Breuer, *Studies on Hysteria* (1893): "For the sake of brevity, we adopt the term 'conversion' to designate the transformation of psychical excitement into the chronic somatic symptoms, which is so characteristic of hysteria."<sup>12</sup> What did Freud mean by this? Did he believe that psychical excitement was a nonbiological entity? Freud was a man steeped in the philosophy and science of his time. As a medical student, he pursued his degree but took additional classes in philosophy and zoology. In the summer of 1876, Freud received a grant to go to the

Zoological Experimental Station at Trieste, where he spent his time dissecting eels, studying their histological structure, and looking for testes that no one had ever been able to find. It seems that the gonadic structure of eels had been puzzling interested parties since Aristotle. Freud's results were inconclusive, but his research was part of the journey that would eventually end with an answer to the question. After three years of medical school, he settled on neurology as his main interest and spent six years studying nerve cells in the physiology laboratory of Ernst Wilhelm von Brücke. He concentrated on the visible material of the nervous system. The first book Freud published was *On Aphasia: A Critical Study*. Aphasia—the word is derived from the Greek for “speechless”—refers to language problems in patients who have brain damage. Every aspect of language can be affected. Some patients understand words but can't produce them. Some can't comprehend what is being said to them or can't register whole sentences. Others know what they want to say but can't retrieve the phonemes to utter it. Although not given great attention at the time, much of what Freud argued in that book remains valuable. He insisted that although brain processes could be localized—certain parts of the brain were responsible for different human behaviors, such as language—they were not static but were dynamic moving pathways in the brain. This is unquestionably true. His position on the connection between mind and matter was subtle. He was neither a reductionist nor a dualist: “The psychic is, therefore, a process parallel to the physiological, a dependent concomitant.”<sup>13</sup>

Freud remained a materialist all his life. He did not truck with misty notions about souls, spirits, or psyches detached from physical processes. One depended on the other. At the same time, following Kant, he did not believe that it was possible to know things-in-themselves. Our access to the world comes only through our perceptions of it, he argued. And yet, I'm always running into people who treat Freud almost as if he had been a mystic, a man whose ideas bear no relation to physical realities, a kind of monster of mirage who derailed modernity by feeding all kinds of nonsense to a gullible public until his thought was finally shattered by a new scientific psychiatry founded on the wonders of pharmacology. How did a scientist acquire this reputation?

Not long after he published *Studies on Hysteria* with Breuer, Freud embarked on what was later called his *Project for a Scientific Psychology*, an attempt to attach his insights about how the mind works to his knowledge of neurology and create a biological model founded on brain stuff—neurons. After a period of feverish writing, he realized that not enough was known about neural processes to produce such a map, and he put his *Project* aside. The father of psychoanalysis then made his fateful turn toward a purely psychological explanation of the mind, although he never abandoned the idea that sometime in the future, scientists would be able to ground his ideas in actual brain functions. In his history of psychoanalysis, *Revolution in Mind*, George Makari offers a pithy assessment of the problem Freud and many others working in neurology, psychology, and biophysics faced: “One could not glibly say a nerve

housed a word or an idea.”<sup>14</sup> Freud had thoughts about how this connection worked, but he couldn’t begin to prove he was right.

LET US SAY THAT after my imaginary visit to the neurologist turned up nothing of interest, I decided to see a psychoanalyst. Although American psychiatry was once heavily influenced by psychoanalysis, the two disciplines have grown further and further apart, especially since the 1970s. Many psychiatrists have little or no knowledge of psychoanalysis, which has become increasingly marginalized in the culture. Large numbers of American psychiatrists now leave most of the talk to social workers and stick to writing prescriptions. Pharmacology dominates. Nevertheless, there are still many psychoanalysts practicing around the world, and it’s a discipline I’ve been fascinated by since I was sixteen and first read Freud. I’ve never been in psychoanalysis, but at a couple of junctures in my life I’ve considered becoming an analyst, and in order to do that I would have to be analyzed myself. I was in psychotherapy once, briefly, and it was very helpful, but I’ve come to understand that some part of me is afraid of an analysis. That fear is difficult to articulate because I’m not sure where it comes from. I have a vague sense that there are hidden recesses of my personality that I am reluctant to penetrate. Maybe that’s the part of me that shook. The intimacy of the dialogue between analyst and patient is also rather frightening. Frankly, saying *everything* on my mind has a terrifying ring to it. My imaginary analyst is a man. I choose a man because he

would be a paternal creature, an echo of my father, who is the ghost somehow involved in my shaking.

After listening to my story, my analyst would surely want to find out about my father's death and my relationship to him. My mother would come into the dialogue as well, and no doubt my husband and daughter and sisters and all the people who are important to me. We would talk, and through the exchange the two of us would hope to discover why a speech I delivered in front of a pine tree turned me into a shivering wreck. Of course, it has to be acknowledged that talking wasn't my problem. Even while I was in the grip of the thing, I was fluent. My pathology lay somewhere else, beneath or to the side of language, depending on the spatial metaphor. The psychoanalytic word for my difficulty might be *repression*. I had repressed something, which had then burst out of my unconscious as a hysterical symptom. Indeed, my dilemma would look classic to a Freudian analyst. I would, of course, tell my phantom analyst that I had visited a neurologist and wasn't an epileptic, and from that moment on, he wouldn't spend much time worrying about my *brain*. Although Freud was fascinated by neurons, my analyst would forget about them and instead help me dig into my story, and between us we would find a way to retell it in order to cure me of my symptom. On my way to a cure, I would fall in love with my analyst. I would go through transference. Through that love, which might also turn into hate or indifference or fear, I would transfer to him the feelings I had or have for my father, my mother, or my sisters, and he, in turn, would have a countertransference, shaped

by his own personal story. We would find ourselves in the grip of ideas, as well as emotions. In the end—there is supposed to be an end—we would have a story about my pseudoseizure, and I would be cured. That is, at least, the ideal narrative of an analysis, which is a peculiar form of storytelling. Freud himself noted the oddness of the enterprise in *Studies on Hysteria*:

Like other neuropathologists, I was trained to employ local diagnoses and electro-prognosis, and it still strikes me as strange that the case histories I write should read like short stories and that, as one might say, they lack the serious stamp of science. I must console myself with the reflection that the nature of the subject is evidently responsible for this, rather than any preference of my own. The fact is that local diagnosis and electrical reactions lead nowhere in the study of hysteria, whereas a detailed description of mental processes such as we are accustomed to find in the works of imaginative writers enables me, with the use of a few psychological formulas, to obtain at least some kind of insight into the course of that affection.<sup>15</sup>

As a scientist, Freud felt a little queasy about sounding like a fiction writer. Over time, his thoughts about the psychic apparatus would both change and evolve, but he would never be able to sink his theories into the nervous system, where he knew its processes originated. Aphasia was an illness with an identified physiological ground. Damage to particular parts of the brain caused language problems.

When Freud wrote on aphasia, the French scientist Paul Broca and the German scientist Carl Wernicke had already done their groundbreaking work that localized language centers in the brain's left hemisphere. Hysteria, however, was an illness *without* brain lesions. The work of the eminent French neurologist Jean-Martin Charcot, whom Freud knew, translated, studied under, and was deeply influenced by, had made this clear. Working in the Salpêtrière Hospital in Paris, Charcot, like countless physicians before him, struggled to distinguish epileptic seizures from what he called "hystero-epilepsy." Because some genuine epilepsies could also occur without lesions in the brain, a fact discovered through autopsy, Charcot had to make the distinction between the two illnesses on clinical grounds by carefully observing his patients. He categorized diseases like hysteria, which were not caused by anatomical lesions, with the "neuroses." He considered hysteria a neurological, *organic disease*, maintained that it had a hereditary basis, and said it wasn't unique to women. Men could be hysterical, too.

Charcot became interested in the psychological dimension of hysteria when he noticed that a severe fright or powerful emotion could be linked to its symptoms. In such cases, Charcot believed, the shock created an autosuggestion, a form of self-hypnosis in the patient that remained outside his awareness. For example, one of the neurologist's patients, diagnosed with traumatic male hysteria, was a blacksmith who had suffered a burn to his hand and forearm and then weeks later developed contractures in the same part of his body. The theory was that trauma could

create an idea that acted on a person's already vulnerable nervous system to create the symptom: a fit; a paralysis; the inability to walk, hear, or see; fugues; or somnambulisms. Furthermore, a doctor could produce the same symptom by hypnotizing the patient and suggesting to him that his hand was paralyzed. Autosuggestion and hypnotic suggestion activated the same physiological areas and so were two forms of the same process. For Charcot, the very fact that a person could be hypnotized meant that he or she was a hysteric. Despite his interest in trauma, Charcot remained committed to a physiological explanation of hysteria.<sup>16</sup>

Pierre Janet, a philosopher and neurologist who was a younger colleague of Charcot's went further than his mentor in exploring the psychic aspects of hysteria. He maintained, as Charcot had, that hysteria could begin with a shock—a carriage accident, for example—and that the person need not have been physically hurt in the crash. It was enough, Janet argued, for him to have the idea that “the wheel passed over his leg” for the limb to become paralyzed.<sup>17</sup> Janet was the first to use the word *dissociation* in relation to hysteria. He defined it as a division among “systems of ideas and functions that constitute the personality.”<sup>18</sup> Ideas, for Janet, weren't disembodied thoughts but were part of psychobiological systems that included emotions, memories, sensations, and behaviors. In a series of lectures Janet delivered at Harvard in 1906, he argued that hysteria was defined by “suggestion,” which was “a too powerful idea that acts on the body in an abnormal way.”<sup>19</sup> The horrible idea of the carriage accident becomes dissociated within the person: