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Point of View

Hysteria, Belief, and Magic*

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"We cannot command nature except by obeying her" (Bacon)

First, four stories in crescendo.

(a) A courageous GP refers a boy aged eight who has 'gone off his legs' that morning. The GP says he knows it is hysterical but that he cannot stop it. The boy is brought by car. A kind psychiatrist negotiates through the window the need for the boy to mount the steps to come and talk. The boy comes. He talks about how his estranged father had promised first a trip to the cup final and then to the replay and had twice let him down. The anger, love, disappointment, and the humiliation in front of his friends took his legs from under him, turned him weak at the knees, turned his legs to jelly. He walked out of the consultation and remained well.

(b) A 14-year-old boy has a fixed flexion deformity of the right hand. Sudek's atrophy is beginning. The psychiatrist is the 11th sort of specialist to be consulted. A sudden painful inexplicable bruise on the back of the hand has been casually dealt with by a locum GP; after a sleepless night the mother and child waited in casualty for hours, finally to be told that spontaneous bruises were not treated there. The casualty department of an orthopaedic hospital, however, provided a plaster, an appointment to review in two days' time, then admitted him because of pain in plaster, an admission which had lasted for eight weeks before the psychiatrist was called. Several persuasive chats and devices were needed before the hand was able to recover fully.

(c) A very mature 13-year-old girl has twice been admitted for abdominal pain. Following the removal of a normal appendix, anaesthesia develops round the wound and gradually spreads. When encouraged to be upstanding she shows marked astasia abasia. The psychiatrist is called synchronously with a surgeon who, "not going to be caught out", orders a myelogram and a scintillation scan. The family meeting is angrily supportive of the child's right to be ill. The mother works in the medical field, the father is affable but largely absent on business and is said to have a chronic illness, a brother is described as having had an accident in which "he left most of his blood in the road but was otherwise alright", and another brother's school and university careers were ruined by 'lymphoma', which turned out to be spastic colon. Over the ensuing years, despite treatment, the girl works her way through a variety of illnesses including one from which she emerges with the sort of scar she might otherwise have derived from wrist slashing.

(d) A girl of nine vomited her lunch when her sister and boyfriend started to punch one another. The fighting stopped and she was "rushed to hospital". Later, a recurrence of vomiting led to another admission and then one lasting six weeks, needing intravenous fluids. The psychiatrist met her gently mewing into the steel bowl provided. Her trick of deliberate vomiting continued inexorably. Her mother had died of an overdose of drugs and alcohol, her father was a recidivist gaol bird. Both her brothers were in gaol for serious offences. No negotiation with her about her facility to vomit proved possible over 18 months in psychiatric care nor during a subsequent stay at another hospital. There she suffered a rupture of the oesophagus from the stomach and, following a heroic repair, she requested orange juice by mouth. When refused this she made to vomit, reopened her wound, and bled to death.

A number of young people are being presented to doctors with sicknesses of great morbidity and occasional mortality, which ape illnesses or suggest serious diseases, but which are attributed either to unknown or to arcane physical processes by the sick person or his supporters. Doctors, acting on their ordinary assumptions about physical illness, exert themselves and may exhaust themselves in their search for aetiology. In the absence of classic signs, pathognomic illness, or conventional pathological changes, the doctors may then attempt to exit from their engagement, reassuring the patient that all is well, despite the apparent sickness. This reassurance may be accepted, but it may be blocked by the patient or family if they are deeply committed to the sickness in its structural sense (Taylor, 1986; Goodyer, 1986). Even worse, diagnostic frustration or the physician's personal needs might ensnare him into formulations on which reputation is staked and so are not easily relinquished. While it is unarguable that there are yet undiscovered diseases (Slater, 1965), it has also been true throughout the recorded history of medicine that people, transiently or chronically, and for a variety of motives, lay claim to physical ailments, impairments and disorders which they do not have, and for which they are prepared at times to manufacture the evidence. As I see it, such people

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have a belief about how they are, and they are prepared to go to great lengths to make the world congruent with that belief (Robins & O'Neal, 1953; Maloney, 1980; Flechet *et al*, 1983). In children's medicine it is usual for the beliefs to be held by the family, or some part of it, or by some other system, which can include doctors (Goodyer, 1985; Byng-Hall, 1986). Doctors who are not caught up in the system have called these sicknesses deceits (Naish, 1979; Bayliss, 1984) or, more dispassionately or compassionately, hysteria.

There is nothing unreal or imaginary about these sicknesses, even though they are of the imagination, just as the novel or the play is not imaginary although it was imagined. I shall argue that they are an aspect of a defence mechanism, a mechanism which from one perspective we call hysteria but from another perspective we understand as belief, and from another as magic. The dramas of which I gave examples above are mostly chronic socialised medical versions of the hysterical mechanism, which is normally of very rapid onset and offset. I see these dramas as mobilising reactions every bit as powerful as do the more dramatic situations to which I shall later refer.

Belief

I want to draw attention to the fundamental part played in these scenarios by beliefs. Doctors' training is more directed towards what people say and how they act and is too little concerned with what they believe. In a largely godless society, there are few people who experience the power of a benign conviction with which it is easy to empathise. But the mental action of believing, of "accepting propositions as true on the grounds of the testimony of others or on the basis of facts beyond observation" (*Oxford English Dictionary*), while it clearly has survival value, is also subject to abuse. Thus, while it is necessary to have a mental mechanism that allows judgements to be made and action initiated on the basis of incomplete information, such a mechanism does allow false convictions to be arrived at either spontaneously or by the contrivance of others (Taylor, 1987). Included in the definition of beliefs are "propositions accepted on the grounds of evidence", but I do not think really that one can be said to believe in the moon, although one might believe it to be spherical or made of green cheese. Words like 'trust' and 'persuasion' come into belief. Unlike other animals, we can believe what we are told or be persuaded even by that which has not yet been seen and has not yet been directly experienced. We can entertain the notion of terror. Indeed, such a split can be produced within us that, provided we do not believe it, we seek terror for fun. This split between experiential and propositional knowledge, what is true for us against truths of a more empirical sort in the outside world, like "the most beautiful girl in the world" as compared with the height of St Paul's, may be an important component in the sense of conviction, where the individual experiences as propositional and empirical what is actually experiential.

Belief is very carefully treated in psychiatry partly for these reasons and partly because it is essential to respect beliefs, albeit they might seem alien and odd, otherwise psychiatry could claim immense and improper power. Perhaps because of this, the source, impact, and dissemination of beliefs are little studied (but see Jaspers, 1962). People can develop, sometimes quite suddenly, powerful and subsequently incorrigible beliefs (Sargant, 1973). The Christian paradigm is St Paul. These beliefs are not regarded as delusional if they are sanctioned within a relevant social network (Goldberg *et al*, 1987), but they can be damaging to health. Beliefs and normal convictions are the powerful basis of much human behaviour, including illness behaviour.

I shall argue that hysteria, as it presents clinically, arises from deep convictions, avowals, about abnormal states of health or of functioning which are maintained within a small social system about casually selected, if not entirely random, victims who are presented as sick. The characteristics of the victims and the nature of their disorder are the subject of a long debate in medicine (Roy, 1982). However, the characteristics of the victim and the physiology of the disorder may be less crucial to our understanding if we are simply dealing with a medical perspective on an aspect of normal human behaviour, which might be differently interpreted from other perspectives and at other times (Rabkin, 1964; Mayou, 1975; Hurst, 1983).

In 1961 I was house officer to William Sargant. One Saturday he admitted to our ward a teenage girl diagnosed schizophrenic on the evidence of her terrifying sensation of being the victim of systematic persecution by "dark forces" and the fact that an older sister had already been institutionalised for some years, diagnosed with a similar illness. Starting treatment seemed unwise until contact could be made with her parents. Initially, she resisted this, explaining that contact could be made only via intermediaries. As her terror diminished and her confidence grew, she agreed by late afternoon to initiate the contact. Within an hour I was telephoned by her father. He took the view that his daughter had been abducted into hospital by a witches' coven and that he would proceed through public pressure to secure her release. Her fiancé appeared. he was induced, against what he regarded as his better judgement, to reveal to me that the family were extremely secretive because they were in great danger. He instanced

occasions when his future father-in-law had explained to him the ominous significance of a coil of string in a gutter, a dab of paint on a wall, an ostensibly courteous remark by a waiter. Each was evidence of the malign plot. Armed with this key, a further interview with the patient revealed stories of black rays striking out of clear skies where her father "might have been", and of a Jaguar car hurled to destruction across the M1 which father "could have been driving" had he not, cunningly, been in a small Ford in Devon at the time. The father meanwhile had alerted most of the national press to the incident and telephoned so incessantly that the GPO had to protect the hospital number. Finally, on Monday morning he appeared with his wife, each carrying several large baskets of food and bottled water. To my civil greeting he replied, "You! You are obviously a warlock!" Fortunately, by then I had contacted other agencies who revealed to me that he suffered from schizophrenia, so there were only five and not six participants in this (*folie*) whose beliefs ranged from the delusional through the overvalued to the intense.

The construction we place upon this incident in a psychiatric ward in England, in the late 20th century, is not of a family bewitched, but of a small confined group, powerfully influenced to believe and act upon the basis of a belief held by a schizophrenic, a man suffering a serious chronic disorder of brain function. The rest were in thrall to the power of his conviction. It is a clinical example, but there are abundant political and religious examples that readily come to mind in the world today, and we have the recent history of madmen like Mr Jones, 900 of whose believers were readily persuaded to a synchronous suicide in Guyana.

Hysteria

In its most general sense in medicine, hysteria implies laying claim to, or making an avowal of, bodily dysfunction for which the typical causes are not apparent and in a manner that somehow parodies the sorts of distress produced by organ pathology (Head, 1922; Walshe, 1965). It is dangerous ground for everyone; hysteria might entail pretending by the patient on the one hand, and yet it will also subsume ignorance and error by doctors on the other (Slater, 1965). It has a long history in medicine, which encourages doctors to believe that it is a disease, tangible in some sense (Flor-Henry *et al*, 1981; Flor-Henry, 1985; Guze *et al*, 1986), rather than a description of how things stand between a doctor and his patient, and the patient and his world (Mayou, 1984). Some descriptions of hysteria continue, on the conceit of requiring long-standing claims for sickness in many systems, to portray a syndrome, but hysteria has also to encompass the transient sickness of schoolchildren on a day out. Confusion between hysteria, as that which is being experienced, and hysterics, as those who are experiencing it, has increased the problems in the discourse. Is hysteria something that only hysterics can do? A further problem concerns possible differences between the mechanisms that enable the hysterical response and those that maintain it to a clinical presentation. A conviction might be suddenly arrived at but be abandoned or become incorrigible according to circumstances. The circumstances include the intrapsychic life.

What constitutes hysteria to different doctors is determined by their personal perspective and by their locus in the health care organisation. Psychiatrists mostly see and have written about long-established cases, neurologists have been preoccupied with not allowing themselves to be deceived nor yet overlook organ pathology; both have hankered after running the great neurosis to earth in the neurone. Physicians have leant towards seeing hysteria as a moral flaw or a deceit. Paediatricians, well used to deflecting children's and parents' offers of sickness, are nevertheless sporadically overwhelmed by bravura performances, and then sometimes feel so shy they do not like to let on (Creak, 1938; Dubowitz & Hersov, 1976; Goodyer, 1981; Ernst *et al*, 1984). Almost all doctors, almost all the time, participate in the sexist plot to regard hysteria as a sickness of women, despite the efforts of physicians from as long ago as Briquet and Charcot to the contrary (Owen, 1971), while largely ignoring the massive issue of war-time hysterias.

Very important insights into the probable basis of the hysterical mechanism have come to attention through war-time casualties and through the epidemic hysterias. It is because these occasions recruit so readily from otherwise ordinary human beings that they provide us with a glimpse of possible mechanisms. The arguments about hysteria will continue until the mechanism is clarified. To separate epidemic and war hysterias from clinical cases is simply to evade the issue, at the expense of learning a useful lesson.

The literature on hysteria during and after World War I and II reveals the scale of the problem (Sargant, 1940; Sargant & Slater, 1940, 1941). Thousands of men were affected and, while battle casualties were an important core of the group, much of the hysteria was contributed by non-combatants. Despite an attentive and relatively humane method of dealing with the casualties, they were subsequently largely useless for combat (Slater *et al*, 1941). Considering the extremely detailed, persistent work of the St Louis school and its finding that the male relatives of females with Briquet's syndrome are psychopathic, it is worth noting that many hysterical

men were regarded by the military doctors as having been neurasthenic, psychopathic, and shiftless in their pre-military careers. The language of these reports is derogatory in style and condescending, patronising, in flavour. Particular attention was drawn to the model provided for Pavlov by the drowning and near-drowning of his experimental dogs in the Leningrad laboratory flood. The dogs that succumbed to the terror by losing their conditioned reflexes and becoming subsequently untrainable (which must have been annoying to Pavlov) were regarded as having what he called "weak" or "strong excitatory" central nervous systems. "Transmarginal inhibition" was the ambiguous term he applied to the state of brain into which they more easily lapsed than those Pavlov called "lively" or "calm imperturbable" types, which retained their conditioning. Similarly, the war casualties were graded in personality traits, so that groups of men, similar in character to the dogs, could be shown to have behaved similarly under varying degrees of stress. Obviously, invaliding out on psychiatric grounds had to be controlled, and the disparaging language reflects the negative military attitude to the faint of heart. But it suggests too that, for men at least, the option of going transmarginal will be associated with severe loss of esteem whatever the scale of the precipitating event (Sargant, 1973).

In war men came to accept the proposition that they might well die. Often on the evidence of their own eyes, but also on the testimony of others they had, as soldiers, accepted the possibility of death as a fact beyond observation. In other words, they came, at varying degrees of remove from the evidence, to believe they might die. The transmarginal inhibition was a defence. Pavlov believed that ultimately every human being had the capacity for it. Ross (1941), in his interesting short book on war neuroses, quotes from an earlier book by Babinski and Froment in which is a report written by a French medical officer. His report is astonishing.

> "When 'La Provence' was torpedoed we were able to study the manifestations of emotion close at hand apart from any commotional state.
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> We found that the pithiatic (hysterical) phenomena did not occur until later when the survivors were in safety. These phenomena yielded to an energetic treatment which was immediately applied, and did not recur during the week which followed the accident. Our experience was divided into four periods.
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> 1st period. On board the boat seventeen minutes between the explosion and the complete disappearance of the boat – period of pure emotion. The crew were anxious and dumb. No cries. Many were in a state of agitation. Later an officer shot himself through the head. This was followed by a small epidemic of suicide. There were however no fits, convulsions or paralyses. In seventeen minutes there was nothing left on the water but wreckage, swimmers and drowned.
>
> 2nd period. In the sea for eighteen hours. Seventeen of us clung to a raft during this period. At first there were some expressions of despair but a cheerful fellow pulled them together by saying he had often been in a much worse hold and was sure he would get out this time. One man began a religious lament which began to upset others, but the officer told him if he did not keep quiet he would throw him in the water. None of the the men died.
>
> 3rd period. After eighteen hours we were picked up by a torpedo boat and when all were on deck I inspected them. Several now showed neuropathic phenomena: quadraplegia, paraplegia, mutism, snarling, weeping, barking, shaking amounting to spasmodic movements of the upper limbs. I sent them down to the engine-room close to the engine where the temperature was very high. The number of my patients increased as new survivors arrived so that out of six hundred picked up there were about forty showing nervous disturbances.
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> The treatment was simple. They were stripped naked in an overheated room and energetically rubbed by two vigorous sailors with a hair glove soaked in alcohol. As soon as they had been warmed externally and internally with rum, I took each one separately and smacked him harder and harder until the disturbances disappeared, all the time speaking kindly to them and expressing my delight at the rapidity of their recovery. No-one resisted more than ten minutes: many were cured of contagion on witnessing the treatment of the others. The majority expressed to me their gratitude on witnessing the treatment of the others.
>
> 4th period. I was able to see my patients for a week and there were no relapses."

The report describes the traumatic event leading to pervasive stunned shock or a self-destructive alternative. Then, while peril remains but before rescue, a long period of apparent calm. Then, as seen from a medical perspective, some of the phenomena of relief from trauma and peril. Silent tears, congratulatory embraces, gales of laughter are not mentioned, only those men whose 'symptoms' might have some medical connotation, however, various they may be. It is honest about the aggressive nature of the brainwashing treatment. The difference between these symptoms and clinically presented hysterias is that they were experienced by people from a group known to be well only a while before and there are no supporters of their sick condition. Once these circumstances change, the belief, the hysteria, could take a more chronic hold.

Ross's other contribution is to note the paradox of how differently the civilian population, who had ostensibly had the cream of their manhood withdrawn from them, react to the devastation of civilian bombing, from which they can neither escape nor

make reprisals, with relatively low rates of hysteria as compared with the troops. Ross wonders whether the deliberate training of military personnel to states of near mindlessness contributes at all to their subsequent breakdown. Of course, the terror and appalling revulsion experienced as a ship is blown up or during the bombardment of soldiers in trenches can only be imagined, but there are accounts of reliving them under abreaction described by Grinker & Spiegel (quoted by Sargant, 1957). This is as near to the moment of the manifestation of the hysterical mechanism as we can get descriptively.

> "The terror exhibited . . . is electrifying to watch. The body becomes increasingly tense and rigid; the eyes widen and the pupils dilate, while the skin becomes covered with a fine perspiration. The hands move convulsively. . . . Breathing becomes incredibly rapid or shallow. The intensity of the emotion sometimes becomes more than they can bear, and frequently at the height of the reaction, there is collapse and the patient falls back in the bed and remains quiet for a few minutes. . ."

Abreaction does not require the reliving of the traumatic event that seemingly precipitated the hysterical symptoms (Shorvon & Sargant, 1947). Its therapeutic value lies in the intensity of an emotional catharsis. It seems to offer a close approximation to the physiology and psychology of the overwhelming event. Sargant (1957) sets this description against one of Wesley's congregation reacting to his hell-fire preaching, and coming to believe through crisis: truly a convert.

Friday 15 June 1739 (Wesley's Journal)

> "Some sunk down, and there remained no strength in them; others exceedingly trembled and quaked; some were torn with a kind of convulsive motion in every part of their bodies, and that so violently that often four or five persons could not hold one of them. I have seen many hysterical and many epileptic fits; but none of them were like these in many respects."

For Wesley, this process, which he called "sanctification", was instantaneous work. It is crucial to my thesis that such depth of conviction is achieved in a moment. Indeed, it is recognised for what it is by its being the work of a moment.

Now consider the mechanism which enables the hysterical response. What would be the biological and evolutionary value of such a mechanism with instantaneous onset and offset? While the response to threat in human beings through flight or fighting back is amply described in student textbooks of physiology and psychology, little is said about responses to events in which these options are both precluded. What options remain? Consider the condition of stunned shock in the bird or the mouse which the cat has caught. They are close to death and maybe, in stupor or even by self-induced death, at least avoid further pain. But there may be a fine margin of profit in playing possum. Several species feign death to deflect potential predators or mimic injury to draw predators away from helpless young. Even the alternative, the frantic, non-cognitive, headless chicken, "violent motor reaction", just *might* secure escape. These two responses were described by Kretschmer (1961) in casualties of World War I, and have been confirmed by others since in wars and disasters. They are seen, albeit at lesser states of intensity, in the classic epidemic hysterias.

The settings of epidemic hysterias, the trigger events, and the symptoms are important to understanding hysteria (McEvedy *et al*, 1966; Moss & McEvedy, 1966; Alexander & Fedoruk, 1986). So too are the nature, quality, and the stridency of the alternative explanations which are always insisted upon a section of the community (usually relatives of victims) which assist in the promotion and maintenance of symptoms (Watson, 1982; Small & Borus, 1983). In these dramas the actors and the audience are equal partners. When the sick are presented to doctors the doctors are compelled to act from their perspective just as the parents or the crowd acted from theirs. In this way the medical procedures tend to validate the sickness to the relatives in the same process which invalidates it to the doctors. Epidemic hysterias arise couched in social settings that enhance emotionality and promote the rapid "mental acceptance of propositions as true even if beyond observations". The sorts of events that produce these responses are unavoidable apparent threats that have emerged through some form of ultra-rapid group consensus. Removal of the affected individuals from the group normally allows them a rapid return to normality since the so-called threat exists much more as a function of corporate than of personal belief. The parallels in animal behaviour are in the extraordinary rapidity of communication in herd and flock behaviour. A recent epidemic of hysteria on the Israel/Arab border, however, was politically exploited, and by precluding appropriate treatment of young people the epidemic persisted longer and spread wider than usual (Hefez, 1985).

> "Thirty-four students . . . were suddenly afflicted by an attack of blindness, headache and stomachache, as well as cyanosis of the . . . limbs. . . . The doctors noticed that two girls had developed complete blindness with respiratory complications and transferred them by ambulance to Affula Central Hospital where they were admitted to the intensive care unit . . ."

Within the affected group in the hysterical epidemic there will be some who are at that moment so placed that, for them, the hysteria is psychologically opportune. This leads to recidivism, as it did in that report, especially if non-symptomatic contacts are keen to exploit the occasion to air their beliefs about aetiology. Currently non-validatable high-technology credos are favoured as bases for these epidemics: viruses, allergens, crop sprays, nuclear fallout, etc. Sadly and tragically, these credos also affect sick children presenting individually whose sicknesses, because they are sporadic, are easily initially misperceived and become even more deeply established as a result of the interventions and investigations required to invalidate medical diagnoses once they have been entertained. In order to make an investigation ethically, the doctor must entertain the same possibility as the complainant, and this reinforces the possibility and it is that which is the important element in the belief.

Magic

Bronowksi (1978) in his *Magic, Science, and Civilization* lectures traces the change in our interpretation of nature from magic to science to the period between 1500 and 1700. He defines magic as "that logic which is separate from the logic everyday life but which, given the secret key, could command nature". Only the initiates would have this power. Of all the situations where people might wish to command nature (such as during drought), sickness, especially in their children, must be the most pervasive and seductive. Since medicine has been largely technologically powerless for most of its history, it is not surprising to find its alliance with magic (Precope, 1954; Maple, 1968). Magical precepts fail, according to Bronowski, as compared with science, in that magic formulae never produce alterations in things at a distance from the magician, except seemingly through the credulity of people. Hence the peculiar fascination of Uri Geller. Where magic formulae succeed they become technology, for example, cinchona bark. According to W. Lehman (quoted by Mauss, 1950, p. 130) "magic derives from errors of perception, illusions and hallucinations, as well as acute, emotive and subconscious states of expectation, prepossession and excitability" and according to Mauss (1950, p. 142) "The magician . . . puts to work collective forces and ideas to help the individual imagination in its belief". Magical cures, then, simply reverse the process of hysterical sickness.

The 'forces' to which Mauss refers are to my view originally in the individual and derive from primitive animism, that historical, but also, and more persistently, developmental phase to which we variably readily regress, and about which we are variably embarrassed when we do. Primitive animism implies that all objects are imbued with their own spirits which have motives, and their behaviour is regulated by the interaction of these spirits, leaving man a hapless bystander, unless he can command them. It is an almost universal experience, especially when we have been let down by a machine. There is thus ample scope for deceit, conviction, and delusion to comingle and interact in manipulating these moments of distorted conviction. If the magical convictions are powerful enough, man can be persuaded to give up life itself (Beecher, 1962; Milton, 1973; Mauss, 1979):

> ". . . the expression on his face becomes horribly distorted. . . . He attempts to shriek, but the sound chokes in his throat, and all that one might see is froth at his mouth. His body begins to tremble and the muscles twist involuntarily. He sways backwards and falls to the ground, and after a short time appears to be in a swoon; but soon after he writhes as if in mortal agony, and, covering his face with his hands, begins to moan." (Basedow,1925, quoted by Cannon, 1942)

This description of death through conviction through "pointing of bones" is compelling similar to the sequence of events in sudden religious conversion, abreaction, war hysteria, and epidemic hysteria, given above. Like the "stunned shock" and "possum" reactions, recovery is immediate if the curse is lifted by the person who imposed it, even when seemingly profound physiological changes have supervened.

More common than such executions are the living deaths or the temporary deaths to which I initially referred. Some of these sicknesses are very long, troublesome and costly; they deserve our attention. They differ from serious diseases by being lived with almost triumphantly, although protestingly, while still maintaining a belief system which conventional medicine does not hold.

In 1985 a 12-year-old boy was referred for a further opinion on management. His parents' view was that he suffered numerous lifelong somatic complaints and, increasingly, behavioural problems which were due to multiple allergies. His allergy to rain had made the national press, but he was also said to be allergic to North Sea gas and a wide variety of other substances, not often thought of as allergens. Initially, he could not be brought into the building where I work because his mother could see that it was the type of building in which potential allergens abound. 'Neutralising drops', available in phials costing £25 each, were used. The touch of these under the tongue instantly enabled him to enter. Nevertheless his 'allergic' response was judged by his mother to be evidenced by his

pathetic foul-mouthed observation that she might now leave. He was born, nine years after his only sibling, to an elderly mother. Termination was considered. She suffered from high blood pressure and many 'allergies' that limited her diet. Her husband was a bizarre man of extraordinary social behaviour who had been subject to psychosis from the age of 21. He was still in regular psychiatric care. He also claimed migraine due to potato allergy. Their implacable belief was that their son exhibited lifelong allergy, as evidenced by his having had episodes of sickness and diarrhoea as a baby, his developing stomach pains, weak feelings, muzzy headedness, and his own parody of aggression from his first days at school. They could no longer afford private allergy treatment. They hoped he could be placed in a 'bubble' so that he could recover while protected from the alien world.

The boy, when separated from his parents, was just an obese, dull, unhappy child who reiterated the family beliefs. The parents initially rejected psychiatric treatment and admission to hospital but reluctantly conformed when the question of school avoidance and its legal consequence was raised. He lived for four months in hospital taking ordinary hospital diet and going swimming with the school. No evidence of any form of 'attack' was witnessed except those involving his parents and consisting of childish rudeness and slaps. These were always interpreted by them in terms of reactions to allergens. A consultant paediatrician expert in allergy found only minor traces of evidence, of marginal relevance. Initally, the boy began to settle to the fuller life and improve his impoverished education and social skills. But as pressure to remove him from home more permanently increased, he regressed in his general behaviour, and became firmer in his beliefs about his allergic state. At the same time his father's psychosis decompensated and his mother's beliefs became more fervent and frantic. It became clear that the local authority felt unable to act on behalf of the child on the basis of the available evidence of abuse, and the parents removed the child from hospital. A year later his 'unique problem' made the Sunday newspapers. He was pictured at home, indoors on a rainy summer day. He is the real prisoner of their imaginations.

Levi-Strauss (1967) recognised these sicknesses now being variously labelled by the technologists: he called them "Piteous sicknesses, the total surrender of existence in a last ditch defence of the self by total capitulation."

This capitulation by the organism, often partial, sometimes total, is being hypostatised, made into yet another illness. In hysteria there exists an alternative defence mechanism to fight or flight. It is widespread in animal species. It has an aspect of stupor and an aspect of frantic, mindless activity that is not organised flight. In animals these mechanisms are accessed through extreme terror, usually in situations that imply potential imminent demise. It is crucial that these physiological defence mechanisms unlock instantly if the situation improves. In man the mechanisms are readily accessed in situations of terror, horror, or revulsion, experienced from outside, but in man these states can also be accessed from within, as a result of beliefs. Beliefs are generated by information which is accessed from memory in a subjective (emotional) context. Beliefs differ from certain knowledge in that they are generally arrived at on the basis of partial information and can derive from experiential rather than empirical knowledge. This is not necessarily verbally encoded in memory and is hence inaccessible to verbal approaches. This has survival value but allows error. Belief and false belief are thus tied into the third defence mechanism. In groups it is in the nature of belief to be contagious. Magic plays its tricks through the mechanism of belief.

Sickness evokes aspirations to command nature. In man, through belief, through magic, a mechanism of potentially lethal power can be manipulated. But there are more chronic terrors, more persistent states of being, where neither flight nor fighting back is available. One possible diversion lies in a mechanism which is perceived as sickness, and this at times will be opportune and give rise to lengthy dramas. Unfortunately, doctors cannot guess at that before they become embroiled in them. But they can beware.

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