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Demonic Possession, Mesmerism, and Hysteria: A Social Psychological Perspective on Their Historical Interrelations

Nicholas P. Spanos and Jack Gottlieb
Carleton University, Ottawa, Canada

This article provides a social psychological interpretation of the interrelations among demonic possession, mesmerism, and hysteria. It argues that the reciprocal role relationship of mesmerist and magnetized subject in the 18th and 19th centuries involved the secularization of the role relation that had existed between exorcist and demonically possessed. The commonalities between these two sets of social roles are delineated, some of the variables leading an individual to learn and enact the possessed role are outlined, and several lines of historical evidence pertaining to the influence of the exorcist-demoniac relationship on the mesmeric relationship are outlined. The influence of the possessed role in shaping the role of the hysterical patient is also discussed. However, the use of hysteria as a modern explanatory concept in histories of possession and mesmerism is criticized.

This article deals with historical interrelation among demonic possession, mesmerism, and hysteria: three phenomena that have played critical roles in shaping modern conceptions of mental illness, many of the therapies currently used to treat such illness, and some modern theories of hypnotic behavior (Ellenberger, 1970; Sarbin, 1962). The prevailing psychiatric view concerning relation among these three historical phenomena can be outlined as follows: Before and during the 17th century, people suffering from various mental illnesses, particularly hysteria, were thought to be possessed by demons. During and after this century demonic superstitions were gradually discarded, and hysteria came to be correctly diagnosed. Many patients treated with mesmerism and later with hypnotism were suffering from hysteria and for this reason displayed symptoms that had

earlier characterized people thought to be demonically possessed (Owen, 1971; Veith, 1965).

Our position rejects such mental illness interpretations of possession, mesmeric phenomena, and hysteria and presents an alternative conceptualization of their interrelation based on modern social role and social learning formulations. We describe the reciprocal roles enacted by mesmerist and subject and argue that the mesmeric relationship secularized the role relationships that existed between exorcist and demoniac (possessed person). The components of the exorcist and demoniac roles are outlined, important commonalities between the mesmeric relation and the exorcist-demoniac relation are specified, and several lines of evidence pertaining to the influence of the exorcist-demoniac relation on the mesmeric relation are evaluated. Finally, the notion of hysteria, as it relates to the history of demonic possession and mesmerism, is evaluated within a social-psychological framework.

Before proceeding, we will attempt to clarify several potentially troublesome issues associated with the theoretical notion of social role behavior. The term *role enactment* refers to patterns of activity that are linked to and

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Jack Gottlieb is now at the University of Massachusetts—Boston.

Requests for reprints should be sent to Nicholas P. Spanos, Department of Psychology, Carleton University, Ottawa, Ontario, Canada K1S 5B6.

identified with a particular social status (e.g., physician), an informally defined social position (e.g., class clown), or a particular social value (e.g., a patriot; Biddle & Thomas, 1966, Turner, 1956). Role enactment or role playing may involve prescribed patterns of subjective experience as well as overt behavior. Moreover, this notion implies neither that enactments involve a lack of personal conviction nor that they involve a superficial going through the motions without a subjective involvement (Goffman, 1961; Sarbin & Allen, 1968). For instance, to say that individuals enact the role of hypnotized subjects does not imply that they are faking or that they do not believe themselves to be "really" hypnotized (Sarbin & Coe, 1972). Similarly, the following discussion of magnetized and demoniac roles does not imply that those who filled the roles failed to believe that they were magnetized or possessed, or that they construed their enactments as deliberate ploys aimed at achieving some surreptitious goal.

On the other hand, role playing perspectives do not preclude analysis of such phenomena as faking or disinterested enactment (Goffman, 1974). People may become highly absorbed in roles and enact them with great conviction, or alternatively they may distance themselves from certain roles and enact them in a disinterested, uninvolving fashion. In short, role theory perspectives focus attention on and attempt to account for variations in the degree of commitment with which roles are enacted. These perspectives certainly do not assume that such enactments are necessarily (or even usually) uninvolving, superficial, or faked.

Mesmerism

Toward the end of the 18th century, Mesmer (1779/1948) developed a theory of disease and its cure. Briefly put, Mesmer believed that a "subtle fluid" permeated the whole universe, including the human body. Disease resulted from an obstruction or dis-harmony of this fluid within the body, and cure of disease was effected by redistributing and harmonizing the flow of fluid. Redistribution of fluid in the sick could be brought about by the transmission of magnetic fluid from certain healthy individuals (magnetizers) to the sick.¹

By the early 19th century, the social role of the mesmerized or magnetized subject had become fairly well demarcated. Its enactment consisted of a set of rather unusual behaviors that occurred within the delimited social context of a mesmeric relationship. The most important of these behaviors included convulsions, amnesia, demonstrations of increased intelligence and clairvoyance, unusual feats (e.g., heightened sensory ability, analgesia), and the subjective experience of these behaviors as occurring without volition. By the same token, the techniques employed by the mesmerist in curing his patients also became quickly standardized and included not only specific curative procedures but, equally important, the development of a particular moral stance toward himself and his patient.

The Role of the Mesmerized Subject

The role of magnetized subject was multi-faceted. Each of its more important components will be briefly described.

Convulsions. The most visible and, at least initially, the most dramatic component of the magnetized role consisted of convulsions. The French Royal Commission that investigated mesmerism in 1784 reported that convulsions were experienced more frequently by females than by males and that when mesmerism occurred in a group setting, convulsions in one patient were followed quickly by convulsions in others. These convulsions were clearly a function of social-psychological variables. They could be initiated not only by observing fellow patients convulse, but also by the wave of the mesmerist's hand, his glance, or even by contact with inanimate objects that the patient believed had been magnetized (Franklin et al., 1785/1970).

¹ Historians of mesmerism and hypnosis have been primarily concerned with tracing the intellectual antecedents of Mesmer's theory. For instance, Mesmer's notion of an all pervasive fluid has been related to specific earlier ideas concerning universal fluids propagated by Paracelsus, Von Hartman, Mead, and others, as well as to the general intellectual climate pervading 18th century science (Darnton, 1970; Ellenberger, 1970; Pattie, 1956; Podmore, 1909; Sarbin, 1962). Less work has focused on the reasons that certain unusual behaviors coalesced into the social role of the mesmerized subject.

ury, the social role magnetized subject had assumed. Its enactment of unusual behaviors were delimited social relationships. The most famous included convulsions of increased sense, unusual feats of ability, analgesia), evidence of these beyond volition. By techniques employed by his patients also seemed and included not edures but, equally important of a particular self and his patient.

Subject

subject was multi-dimensional and important component of the experience of convulsions. The research that investigated found that convulsions frequently by females when mesmerism was used, convulsions in one study by convulsions were clearly a causal variables. They were by observing fellow subjects by the wave of glance, or even by objects that the magnetized (Franklin

and hypnosis have been concerning the intellectual. For instance, Mesmer's theory has been related to universal fluids proposed by Mead, and others, under climate pervading (Cohn, 1970; Ellenberger, 1969; Sarbin, 1962). Less well known is that certain unusual social role of the mesmer-

Mesmer and his associates believed that convulsions of this sort were therapeutic. They purportedly ended in a crisis that led to the patient's cure. Patients supposedly showed an alleviation of at least some of their symptoms following their convulsions (Binet & Fére, 1888; Mesmer, 1779/1948).² Later mesmerists like Deleuze (1825/1879) modified these opinions, and believed instead that convulsions resulted either as a symptom of the patient's disorder or from inappropriate magnetizing. Nonetheless, the occurrence of convulsions remained a fairly common feature of the mesmeric role throughout much of the 19th century.

Increased intelligence, clairvoyance, and amnesia. Since de Puysegur's (1784/1820) discovery of artificial somnambulism in 1784, mesmerism (and, later, hypnotism) has been indelibly associated with the notion of an altered state of consciousness. For the mesmerists, magnetism involved a profound alteration in experience that differed fundamentally from everyday waking consciousness. Among the most important indices of this somnambulistic state were an apparent increase in intelligence, clairvoyance, and a spontaneous and total amnesia for the events that occurred during the magnetic session (Esdaile, 1852; de Jussieu, 1784; Podmore, 1902).³ The writings of 19th century mesmerists were studded with references to the intellectual and clairvoyant powers of their subjects and to the profound amnesia that purportedly followed a magnetic session (Binet & Fére, 1888; Deleuze, 1825/1879; Haddock, 1849; Sandby, 1844). Sandby, for example, described the intellectual enhancements of somnambulism as follows:

The intellectual faculties are surprisingly increased and developed in the sleep—so much so, as to lead to the opinion that there is a general rise and exaltation of the whole moral being when under the mesmeric influence. (p. 192)

Other Transcendent Phenomena

Among the most important of the unusual feats commonly attributed to the magnetized subject were insensitivity to pain (Esdaile, 1852; Hamard, 1835; *Rapport sur le Magnétisme, par une Commission*, 1836), catalepsy (Dupau, 1826; Petetin, 1808; Ricard, 1841),

and heightened sensory abilities (Dupau, 1826; Gueritat, 1811; Thompson, 1847). It was believed by many, for example, that somnambules could see their own internal organs and read without the use of their eyes (Frapart, 1850; Storer, 1846). Furthermore, it was believed that they could accurately predict the course of their own disorder, specifying the time of their next "attack," and also the time of their eventual cure (Bell, 1792; Binet & Fére, 1888; Deleuze, 1825/1879; de Montravel, 1785; Podmore, 1902). In short, the role expectations of the magnetized subject included not only generalized convulsions and changes in cognitive functioning but also the performance of specific behaviors that were thought to transcend the capacities of non-magnetized individuals.

Experienced involuntariness. The behaviors of the magnetized subject were construed as automatic concomitants of procedures carried out by the mesmerist. Even the subject's much touted intellectual enhancements were not seen as her⁴ own attainment but instead were

² The view that convulsions were therapeutic was proffered before Mesmer by a late 17th/early 18th century school of medical thought known as "animism." The animists held a teleological view of disease and interpreted convulsions and other symptoms as an attempt on the part of the body to rid itself of irritants (Temkin, 1971).

³ The utterances of somnambules were taken to indicate not only increased intelligence but also a heightened moral and religious sensitivity (Deleuze, 1825/1879; Podmore, 1902). The theme of the lowly uneducated peasant inspired by God to religious eloquence recurs regularly in the religious tradition of Western Europe (Cohn, 1970). The somnambules of the 18th and 19th centuries, who were themselves often of humble origin, reflected one aspect of this prophetic tradition. The attitude of the Catholic church toward inspired prophecy was always guarded. While the utterances of some prophets were received as divinely inspired, it was much more common for them to be condemned as diabolical in origin (Cohn, 1970; Knox, 1950).

⁴ We refer to demoniacs and hysterics as "she" rather than as "he/she" not only to emphasize that these roles were usually filled by women but also to stress that at the time women in general were conceptualized as possessing innate deficiencies that predisposed them to these disorders (Smith-Rosenberg, 1972). We recognize that demoniacs were sometimes male and that some 19th century physicians (e.g., Charcot) spoke of male hysteria (Oesterreich, 1966; Ellenberger, 1970).

explained as temporary manifestations of some force external to the self such as magnetic fluid passing to the brain, odylic force, electricity, the unconscious, or even communication with the spirit world (Deleuze, 1825/1879; Newman, 1847; Podmore, 1902; Reichenbach, 1852). This conceptualization of the subject as a passive automaton bridged the theoretical shift that occurred when the fluid theory was replaced by the notion of hypnotic trance (e.g., Charcot, 1889). Even Bernheim (1886/1900), despite his emphasis of the importance of suggestion, viewed hypnotic behaviors as passive, automatic occurrences:

In hypnotism the subject's condition is such that the idea suggested imposes itself with greater or less force upon the mind, and induces the corresponding action by means of a kind of cerebral automatism. (p. 28)

The magnetized (and, later, hypnotized) individual was seen as one whose normal personality had been temporarily set in abeyance and who was controlled by an agency external to her "normal self."

The Role of the Mesmerist

In their initial theoretical formulations, the mesmerists viewed themselves as repositories of an impersonal fluid that could be directed into the bodies of their patients by certain mechanical actions known as *passes*. Passes usually consisted of stroking motions close to but not touching the patient's body, although occasionally the afflicted areas of the body were touched (Binet & Fétré, 1888; Deleuze, 1825/1879). Mesmerists also used objects into which they had directed magnetic fluid. For example, patients would drink magnetized water between therapy sessions or would hold a magnetized handkerchief over a painful or diseased area of the body (Deleuze, 1825/1879; Grimes, 1845).

The conception of the magnetizer as an impersonal repository and transmitter of fluid was, however, quickly modified. The magnetizer's personal characteristics were quickly seen as crucial to the treatment. De Puysegur (1784/1820) stressed the importance of the mesmerist's will and faith in effecting a cure. Passes without appropriate willing and faith were considered useless. Without the magnetizer's unquestioning faith in his procedures

and in the moral purity of his undertaking, the treatment would fail (Deleuze, 1825/1879). In some respects the magnetizer came to be seen as possessing personality characteristics opposite to those of his patient. Whereas the magnetized patient was seen as having a "weak, uncultivated, or wandering mind," the successful magnetizer had to be a "man of powerful and well cultivated intellect" (*A Practical Magnetizer*, 1843, p. 11).⁵

The mesmerists often construed their activities in moral terms. Disease was a moral evil and health a moral good. Virtue was necessary for the maintenance of health, and vice could produce disharmony and disease. Mesmerists were pledged not only to magnetize away sickness, but also to prevent injustice and promote honesty and correct conduct (Bergasse, 1785/1970; Rostan, 1825). Engaged in a moral confrontation with the evil of disease, the mesmerist would be victorious only if he first girded himself with the appropriate moral stance (Darnton, 1970; Deleuze, 1825/1879; Dupau, 1826).

Inappropriate magnetizing could produce harmful effects not only in the patient but also in the magnetizer. Thus, the magnetizer who employed incorrect techniques, or who was morally or physically unfit to magnetize, might develop symptoms of the patient's disorder (Deleuze, 1825/1879; Newman, 1847; Pearson, 1790). In fact, Deleuze warns novice magnetizers that "you may experience a feeling of pain or a difficulty in the internal organs of your body, corresponding with those which are affected in your patient" (p. 262).

Most attempts to account for the constellation of behaviors seen in the mesmeric interaction have focused on the patient and ignored the role of the magnetizer. The most common historical account held that the magnetized

⁵ The dominance-submissive aspect of the mesmeric interaction was in part a reflection of the way in which 19th century physicians tended to conceptualize the doctor-female patient relationship. These physicians commonly saw themselves as strong, intelligent, and competent, and viewed their "nervous" female patients as being innately weak, relatively unintelligent, and possessed of a childlike incompetence. The treatment of "female complaints," they believed, required benevolent but firm masculine control and guidance (Mitchell, 1877, 1888; Morantz, 1974; Smith-Rosenberg, 1972; Wood, 1974).

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subject's behaviors were automatic con- comitants of underlying physiological change. Thus, from the mesmeric and, later on, the hypnotic perspective, behaviors such as convulsions, increased sensory acuity, intellectual enhancement, and spontaneous amnesia were intercorrelated because of intrinsic changes in the nervous system that occurred when the patient entered "magnetic or hypnotic sleep" (Braid, 1843/1960; Charcot, 1889).⁶ The major difficulty with such explanations was pointed out by Bernheim (1886/1900) in his criticism of Charcot's (1889) three stages of grand hypnosis. The essence of the criticism is simply that the symptoms of magnetism or hypnosis do not necessarily intercorrelate. On the contrary, such diverse behaviors as lethargy, paralysis, and convulsions will cluster together only when expectations for their occurrence have been implicitly or explicitly suggested to the subject.

Nevertheless, this suggestion hypothesis is itself inadequate as the sole explanation for magnetic behavior, because it does not explain why magnetizers would choose to suggest such an odd assortment of behaviors to their patients. Furthermore, it fails to explain why the behaviors in question were occurring before magnetism came on the scene. Mesmer's (1779/1948) initial patients were often convulsing and exhibiting catalepsy, paralysis, and various sensory dysfunctions before he met them. During the 18th century many of these behaviors, particularly when they occurred in females, were considered symptomatic of hysteria (Cheyne, 1773; Raulin, 1758; Veith, 1965; Whytt, 1767). Rather than suggesting these behaviors to his patients, Mesmer attempted to control and regulate the timing of their occurrence and eventual disappearance. There is also little evidence to indicate that amnesia, intellectual enhancements, and purported displays of clairvoyance occurred initially because of suggestions given by the magnetizers. For instance, there is some evidence indicating that displays of amnesia occurred but went largely unnoticed around the *baquet* of Mesmer's pupils (Podmore, 1902). Similarly, de Puysegur (1784/1820), far from suggesting amnesia and intellectual enhancements to patients, appeared to be astonished

at their initial occurrence (Binet & Fére, 1888).

Another means of understanding the form taken by the social roles of magnetizer and magnetized suggests that the mesmeric interaction was patterned on an earlier form of social interaction. The remainder of this article will explore the notion that the role of the demonically possessed served as a template for magnetized behavior, and the role of an exorcist served as a model for determining the behavior and attitude of the magnetizer.⁷

Demonic Possession

The Role of the Demoniac

By and large, the phenomenon of demonic possession emerged in Western Europe as an accompaniment of Christianity.⁸ From the

⁶ Braid's (1843/1960) earliest theory was of this type. However, he revised it as he became increasingly aware of the role played by the hypnotist's expectations in guiding the subject's behavior (Braid, 1855/1970). He developed the notion of monoideism: the hypothesis that the subject's behavior was a function of the specific idea dominating the mind at the time (e.g., the idea of arm catalepsy led to stiffness in the arm). The dominant idea resulted from cues provided by the hypnotist (Bramwell, 1903/1956; Sarbin, 1962).

⁷ It is important to point out that the mesmeric relationship, like any semiformal ritual activity undergoing widespread cultural diffusion, was modified in different directions in response to various pressures. For example, because of their respective theoretical beliefs concerning the existence of magnetic fluid, Faria (1819/1906) and his followers made little use of "passes," whereas Deleuze (1825/1879) considered them extremely important and provided detailed information concerning their execution and the parts of the body over which they were made. Similarly, some magnetists regularly elicited convulsions from their patients while others did so only rarely (Deleuze, 1825/1879). Several relatively distinct schools of animal magnetism developed during the 19th century, and these were associated with somewhat different role requirements for both magnetist and patient (Dingwall, 1968). Nevertheless, these differences should not obscure the important commonalities that, by the early 19th century, helped to give mesmerism its unique identity. The more important of these commonalities included the dominance-submissive aspects of the interaction, the view of the magnetized subject as an automation, and the cognitive alterations (particularly lucidity and amnesia) that constituted somnambulism.

⁸ In recent years the assertion that pre-Christian Greeks and Romans believed in demonic possession has been called into serious question (McCasland,

earliest Christian centuries through the 17th and 18th centuries, the role behaviors enacted by demoniacs remained fairly consistent (Oesterreich, 1966).⁹ Among the most important of these were the very behaviors that later became associated with magnetism: convulsions, increased intelligence accompanied by clairvoyance and spontaneous amnesia, unusual feats and the experience of the role enactment as involuntary.¹⁰

Convulsions. The occurrence of convulsions, particularly during exorcisms soon before the expulsion of the demon, was an almost invariable accompaniment of possession (Guazzo, 1608/1970; Hartwell, 1599; Niau, 1634; Wolley, 1932). The following description of a 17th century nun possessed by the demon Asmodius provides a typical example of demonically induced convulsions:

Asmodius was not long in manifesting his supreme rage, shaking the girl backwards and forwards a number of times and making her strike like a hammer with such force that her teeth rattled and sound came out of her throat. Between these movements her face became completely unrecognizable, her glance furious, her tongue prodigiously large, long, and hanging down out of her mouth. (Aubin, 1716, p. 226)

It is important to keep in mind that the onset and termination of convulsions were frequently a function of social cues. For

1951; Smith, 1965; Temkin, 1971). The most important precursor of Christian beliefs in possession was Jewish demonology. Although Judaism had no organized demonology during the Old Testament period, an extensive demonology developed in the period between the testaments (Boyd, 1975; Gaster, 1956; Kelly, 1974; Wilson, 1955). During the 2nd and 1st centuries B.C., the Babylonian and Assyrian notion that demons could invade the human body became common among the Jews, as did the practice of exorcism (Russell, 1960; Toner, 1974). The authors of the New Testament were strongly influenced by the beliefs of sects on the fringe of Judaism that were immersed in dualistic and escatological thinking (Boyd, 1975; Kelly, 1974). As a result, the New Testament is permeated with those themes expressed through the medium of demonological imagery. In the New Testament the notion that demons can enter and take over the functioning of the body is made explicit, possession is differentiated clearly from physical illness, behavioral symptoms of this condition are specified, and numerous examples of possession and exorcism are recorded (Catherinet, 1972; McCasland, 1951). The criteria developed by the medieval church for recognizing cases of possession were based on these New Testament descriptions.

instance, in the 16th and 17th centuries it was commonly believed that demoniacs would convulse in the presence of the witch that had caused their possession (Glanvill, 1689; Mather, 1693/1914; *The Most Strange and Admirable Discovery of the Witches of Warboys*, 1593/1972). Thus, during the Salem witch trials of 1692, demoniacs convulsed whenever an accused witch looked in their direction and were relieved of their convulsions whenever they were touched by the accused (Brattle, 1692/1914; Lawson, 1693/1914).

Increased intelligence, clairvoyance, and amnesia. The importance of heightened intellectual ability and clairvoyance in recognizing possession was continually stressed by both witch hunting and exorcism manuals (Boguet, 1603/1929; Glanvill, 1689; Kramer & Sprenger, 1489/1971; *Thesaurus Exorcismorum*, 1626). For instance, the *Compendium Maleficarum* held:

An even more certain sign is when a sick man speaks in foreign tongues unknown to him, or understands in those tongues; or when, being but ignorant, the patients argue about high and difficult questions; or when they discover hidden and long-forgotten matters, or future events, or the secrets of the inner conscience, such as

⁹ As was the case for the magnetized role, some components of the demoniac role were found more consistently in some locales and times than in others. Speaking in a "demonic voice" seems to have an almost invariable accompaniment of possession in 16th and 17th century French nunneries, where Catholic exorcism procedures strongly demanded this aspect of the role performance (Bavent, 1615/1933; Mandrou, 1968). However, the demonic voice, although sometimes heard, was much less common in Protestant England where standardized exorcisms occurred infrequently (Hole, 1947; Hutchinson, 1720; Notestein, 1911; Robbins, 1959).

¹⁰ Because standard psychiatric histories frequently confuse demonic possession and witchcraft (Spanos, 1978), it is important to stress that these were very different phenomena and were rarely associated with one another before the 15th century (Brown, 1970). After this period, the demoniac was often construed as the victim of witchcraft and was encouraged to name the witch that caused her to be possessed. The accused witch was often executed on the basis of the demoniac's accusation (Spanos, 1978). In this manner demonic possession could (and often did) become an instrument for political and social persecution. The exorcist, because of the control he exercised over the demoniac, could often determine who would be denounced as a witch and thereby gained a potent weapon for controlling personal and political enemies (Robbins, 1959).

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Another common, although not invariable, manifestation of the possessed role was spontaneous amnesia for events occurring during the demon's occupation of the body (Catherinet, 1972; Oesterreich, 1966). For instance, the following possessed girl experienced long "Ludicrous Intervals" in which she appeared to be more intelligent than usual but later manifested amnesia for the events occurring during these intervals:

Her Apprehension, Understanding, and Memory, was riper than ever in her life; and yet, when she was herself, she Could Remember the other Accidents of her Afflictions but forgot almost everything that passed in these Ludicrous Intervals. (Mather, 1693/1914, p. 272)

Other Transcendent Phenomena

The demonically possessed displayed not only intellectual enhancements and amnesia but also enacted unusual behaviors that were thought to transcend normal capacities (More, 1600).¹¹ Examples of some of the more important of these follow.

Insensitivity to pain.

The insensibility of her bodie, during her extasies and furies tried by the deep prickings of long pinnes [sic], without any shew, that ever she made of feeling the same, either in the putting in of them, or in the taking out of them. (Hartwell, 1599, pp. 15-16)

Predicting the future occurrence of their own "demonic attacks."

If they asked their possessing demon how many fits they should have the next day following, and the third day, or any day that week . . . and what manner of fits they should be, whether more grievous or less, how long every fit should continue . . . it [their demon] hath told them and not failed in one point. (The Most Strange and Admirable Discovery of the Witches of Warboys, 1593/1972, p. 261)

Temporary and selective sensory-motor deficits.

Sometimes, being taken in her fit she is but deaf only. . . . Sometimes also she can hear only, and not everybody, but someone whom she liketh and chooseth out from the rest; sometimes she seeth only, and as plainly as any other, but neither heareth nor speaketh anything, her teeth being set in her head; sometimes both hearing and seeing very well, and yet not able to speak. (The Most Strange and Admirable Discovery of the Witches of Warboys, 1593/1972, p. 249)

Experienced involuntariness. Some episodes of possession did not involve amnesia. From these it is clear that demoniacs defined their possession as an event over which they could exercise no volitional control; their convulsions, contortions, blaspheming, and other behaviors were carried out in spite rather than because of their wishes (Oesterreich, 1966). For instance, Henrick Kramer and James Sprenger (1489/1971), the 15th century authors of the infamous *Malleus Maleficarum*, asked a demoniac why he did not restrain himself. The demoniac replied:

I cannot help myself at all, for he [the demon] uses my limbs and organs, my neck, my tongue, and my lungs. . . . I am altogether unable to restrain them. (pp. 131-132)

Possession was not only experienced as involuntary by the demoniac, it was defined as an involuntary occurrence by the society at large. Medieval canon law classified possession as a species of demonically induced insanity, and the possessed, like other insane, were not considered responsible for their actions (Pickett, 1952; Richter, 1959). Thus, the possessed saw themselves and were viewed by others in much the same way as magnetized subjects were later to be seen—as automatons controlled by a foreign agency that had temporarily set the normal personality in abeyance.

There are many similarities between the role behaviors enacted by demoniacs and those that eventually became associated with magnetism. In both cases patients convulsed on cue, appeared to be more intelligent and sometimes clairvoyant, reported spontaneous amnesia, engaged in behaviors that were thought to transcend normal capacities (e.g.,

¹¹ The fact that transcendent phenomena, like clairvoyance and analgesia, were part of the role definition of the demoniac and mesmerized subject does not, of course, mean that such phenomena necessarily occurred. The "tests" for these phenomena, when conducted at all, were often lax, informal, and carried out by individuals with a strong vested interest in demonstrating the reality of the phenomena in question (Dingwall, 1968; Podmore, 1902). One of these phenomena—psychologically produced analgesia—remains a controversial issue in modern hypnosis research (Barber, Spanos, & Chaves, 1974; Hilgard & Hilgard, 1975).

insensitivity to pain), specified the time course of their own disorder, and experienced their role enactments as an involuntary occurrence. Furthermore, during both exorcism and magnetism, symptoms tended to increase in severity as the treatment proceeded, reach a peak characterized by dramatic displays of convulsions, and end with an alleviation or diminution of symptoms.

Socialization into the Demoniac Role

Demonic possession was one of the causes that might be suspected when individuals suffered certain physical illnesses and/or when their behavior was socially disruptive, annoyingly idiosyncratic, and largely inexplicable within the communities' frame of reference concerning what constituted normal interpersonal behavior.¹² The components of the demoniac role were generally well known to the average person in medieval and late medieval Europe (Baroja, 1964; Nauman, 1974), and the potential demoniac's exposure to "experts" (usually clerics) served to define the subtleties of the role in great detail. For instance, the possessed girls of Salem Village initially reported an array of unusual imaginings and odd behaviors that were potentially interpretable as either diabolical or divine intervention (Boyer & Nissenbaum, 1974). However, after several weeks of close observation by and interaction with clergy and neighbors who feared the possibility of demonic influence, their symptoms became much more uniformly diabolical.

Perhaps the demoniac's single most extensive source of information concerning role expectations was the exorcism procedure. As a preliminary to the Catholic exorcism rite, the priest was required to obtain information from the demoniac concerning the number and names of the possessing demons, their reasons for possessing the individual, the exact hour they entered the body, and the length of time they intended to stay (*Manual of Exorcism*, 1720/1975; *The Roman Ritual of Exorcism*, 1614/1976; *Thesaurus Exorcismorum*, 1626; Woolley, 1932). In obtaining this and other information the exorcist addressed only the possessing demons (as opposed to the person possessed) and expected to be answered

only by the demons. In these and numerous other ways, exorcism procedures provided the demoniac with a detailed recipe of expected role enactments.

Detailed information concerning role enactments was also conveyed to the demoniac outside of the exorcism situation proper. The sources of this information sometimes included (a) explicit coaching by parties with a vested interest in the demoniac giving a convincing performance, (b) conversing in the demoniac's presence about the occurrence, timing, and termination of expected symptoms, and (c) opportunities to observe the performances of other, more practiced demoniacs (de Bergerac, 1654/1969; Harsnett, 1599, 1603; Hutchinson, 1720; Willard, 1683/1974).

A number of potent social-psychological variables converged in leading the potential demoniac to define herself as possessed (Oesterreich, 1966; Spanos & Gottlieb, 1976; Spanos, Note 1). To begin with, she shared the same cultural frame of reference as the community that labeled her and, therefore, was likely to view her own illness or behavioral deviation in the same light as her neighbors. In some cases the potential demoniac was made entirely dependent for the satisfaction of her physical and social needs on those who labeled her. The labelers continually reinterpreted her experiences in terms of pos-

¹² The regularity with which psychological disturbances were explained in terms of demonic influence has been greatly exaggerated by some psychiatric historians (e.g., Alexander & Selesnick, 1966; Zilboorg & Henry, 1941). Naturalistic explanations for such disturbances were regularly employed by both physicians and nonphysicians throughout the medieval-early modern period (Kocher, 1953; Kroll, 1973; Neugebauer, 1978; Temkin, 1971). For example, Neugenbauer studied the extant records of the English court that made determinations of mental competency. Between the 13th and 17th centuries he found a demonic explanation for insanity proffered in only a single case. The vast majority of lunacy cases were explained in naturalistic terms: head injury, grief, fever, and so on. The conditions under which demonic rather than naturalistic causes were posited to explain deviance are not altogether clear, and their determination remains an interesting problem for historical research. However, in many cases, these conditions probably had less to do with the characteristics of the behavior being labeled than with the attitudes of the labelers and the vested interests served by positing demonic explanations (e.g., Boyer & Nissenbaum, 1974).

these and numerous procedures provided the recipe of expected

concerning role enacted to the demoniac situation proper. The n sometimes included parties with a vested giving a convincing in the demoniac's irrence, timing, and symptoms, and (c) the performances of ioniacs (de Bergerac, 19, 1603; Hutchinson, 4).

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session while isolating her from anyone who might offer nondemonic interpretations of these events. When, for example, one potential demoniac slipped and fell, she was informed that her possessing demon had tripped her. Similarly, minor changes in her mood toward sadness or irritability were quickly attributed to an indwelling demon (Harsnett, 1599). Periodic denials of being possessed were expected by authorities and were routinely construed as obvious indications of a wily demon attempting to escape divine punishment (*A Manual of Exorcism*, 1720/1975). Continued refusal to enact the role properly frequently led to punishment administered in the guise of benevolently motivated attempts to free a helpless victim from demonic control (Aubin, 1716; Harsnett, 1599; Michaelis, 1613).¹³

Despite what has been said, adoption of the demoniac role was often associated with a number of advantages. The role was usually filled by socially powerless individuals who were without access to socially approved channels for changing their situation (Oesterreich, 1966). Adoption of the role frequently led to a dramatic rise in social status. On the one hand, demoniacs were seen as helpless victims of satanic influence and thereby received substantial amounts of sympathetic attention and a lightened work load. On the other, they often became awesome seers, repositories of arcane knowledge, and doers of amazing feats whose performances commanded fearful attention and respect (Aubin, 1716; Glanvill, 1689; Mather, 1693/1914; Michaelis, 1613). In some cases they even became determiners of life and death (see Footnote 9). In short, adopting the demoniac role frequently catapulted an individual from a social position of little power to one in which she was afforded a degree of respect and social privilege that would have been unattainable in any other way.¹⁴

Exorcism and Exorcists

The practice of exorcising demoniacs appears to have been widespread from the earliest Christian centuries through the 17th century (Gaster, 1956; Keller, 1974; Oesterreich, 1966; Woolley, 1932). Initially, exorcisms tended to

be relatively unstructured and unelaborate affairs that consisted mainly of "laying on of

¹³ Contemporaries who for religious or political reasons wished to discredit the reality of demonic performances or who simply wished to offer rational accounts of possession phenomena frequently argued that demoniacs were simply engaged in conscious and deliberate faking (Harsnett, 1603; Hartwell, 1599; F. Hutchinson, 1720; T. Hutchinson, 1768/1972). There is, in fact, evidence that some demoniacs acted as if possessed without actually believing this to be the case (Harsnett, 1603; Turrell, 1720/1823). On the other hand, many demoniacs appear to have believed quite firmly that their enactments resulted from the machinations of indwelling demons. A number of social psychologists have extensively discussed the variables important in the development and maintenance of such counterfactual beliefs as spirit possession (Bem, 1970; Sarbin & Allen, 1968; Sarbin & Coe, 1972).

¹⁴ Although this article does not review the cross-cultural data concerning possession, a few facts concerning these data are worthy of note. Possession phenomena occur in many cultures, but they do not occur in all cultures. Furthermore, the symptoms associated with possession differ, sometimes markedly, from one culture to another. For instance, possession is associated with convulsions or with amnesia in some cultures but not in others (Bouriguignon, 1967; Lewis, 1971). These data support the contention that the demoniac's culturally determined expectations of the role she is to play are crucial in shaping her role performance. In many respects Western European demonic possession had much in common with what anthropologists have labeled peripheral possession in "primitive" societies (Lewis, 1971). The following description of the social functions served by peripheral possession fits Western European cases of demonic possession remarkably well:

In its primary social function peripheral possession . . . emerges as an oblique aggressive strategy. The illness requires treatment which his (or her) master has to provide. In his state of possession the patient is a highly privileged person: he is allowed many liberties with those whom in other circumstances he is required to treat with respect. Moreover, however costly and inconvenient for those to whom his normal status renders him subservient, his cure is often incomplete. Lapses are likely to occur whenever difficulties develop with his superiors. Clearly, in this context, possession works to help the interests of the weak and down-trodden who have otherwise few effective means to press their claims for attention and respect. . . . The possessed person manipulates his superior without radically questioning his superiority. He ventilates his pent-up animosity without questioning the ultimate legitimacy of the status differences enshrined within the established hierarchical order. If peripheral possession is thus a gesture of defiance, it is also one of hopelessness. (Lewis, 1971, pp. 32-33)

hands" and commanding the demon to depart in the name of Jesus. In time, the procedure became both more standardized and more complex. Prayers were added, the demon was addressed in order to gain certain information, and the use of holy water and consecrated objects became common (Kelly, 1974; Woolley, 1932). By the Middle Ages the procedure had become quite elaborate and involved many prayers, adjurations, and sometimes even violent cursing of the demon by the exorcists. Exorcisms sometimes lasted months or even years. They were often performed publicly, sometimes with groups of demoniacs at once (Killigrew, 1635/1974; Mandrou, 1968).¹⁵ For example, it has been estimated that on one day as many as 7000 people attended public group exorcisms in Loudun during the 17th century (Baskin, 1974). Every exorcism represented a dramatic moral confrontation between the power of God and that of the Devil. Thus, successful exorcism served to illustrate the power of the church, to affirm its values, and to maintain its authority.¹⁶

The Role of the Exorcist

The most visible and certainly the most often cited similarity between exorcising and magnetizing was the use of "laying on of hands" by the exorcist and the "passes" and touches employed by the mesmerist (Owen, 1971; Rose, 1971). It should be noted that the exorcist's laying on of hands often involved a general rubbing or stroking of the demoniac's body (Harsnett, 1599; Law, 1894).

However, the role of the exorcist, like that of the mesmerist, also involved the development of an appropriate attitude toward himself and his procedures. Despite the fact that the exorcist's power was seen as deriving not from himself but from God, his personality and attitude were conceptualized as being crucial in effecting a cure (Harnack, 1915; *Thesaurus Exorcismorum*, 1626). Descriptions of the exorcist's attitudes sound very similar to the descriptions given earlier of the mesmerist's attitude. The exorcist, like the mesmerist, construed his activity as a moral confrontation between good and evil. In order to prevail against the demonic forces he had to (a) have strong faith in God and in his pro-

cedures, and (b) lead a moral life and cleanse himself spiritually before exorcising (*Roman Ritual of Exorcism*, 1614/1976). If the exorcist did not meet these requirements, not only might the procedure fail, but he himself might become possessed by the demon. Possession of an exorcist was, in fact, a fairly common occurrence, and it was usually explained in terms of pride on the part of the priest or his failure to gird himself with the proper degree of faith and moral purity (Aubin, 1716).

¹⁵ The causes of group possession appear to have been similar to the causes of modern "epidemics" of hysterical contagion (Kerckhoff & Back, 1968; Rosen, 1968). In both cases the epidemic often began when people residing or working in close quarters were exposed to increments in psychological stress that could not be escaped through existing social channels and against which there were no sanctioned means of protest. However, modern epidemics of hysterical contagion have usually dissipated rather quickly, often within several weeks (Kerckhoff & Back, 1968). On the other hand, some possession epidemics, like those of Loudun and Salem village, lasted months or even years (Boyer & Nissenbaum, 1974; Huxley, 1952). In the contemporary epidemics of hysterical contagion that have been studied, there were no organized segments of the community that had a vested interest in supporting manifestations of the epidemic. Thus, the sufferers may have gained some temporary relief from psychological stress by adopting the sick role, but the community did not reinforce them for the continued enactment of that role. In extended-possession epidemics, powerful segments of the community (e.g., clerics and political leaders) reaped substantial financial, political, and personal benefits from continuing the possessions. Not only were the demoniacs encouraged to continue their performances, they were not allowed to give up their role. In both the Loudun and Salem possessions at least one of the demoniacs confessed publicly that they had not been bewitched and were not possessed. At Loudun the demoniacs were informed by an ecclesiastical court that their confessions were products of the devil, and the exorcisms continued (Huxley, 1952). At Salem, the confessing girl (Mary Warren) herself became suspected of witchcraft and would have been prosecuted had she not reverted to the demoniac role (Woodward, 1864/1969).

¹⁶ Demonic role performances affirmed the religious values of a community in a variety of relatively subtle ways. For instance, demoniac French nuns often supported Catholic beliefs by contending that Calvin was their leader and that they loved the Huguenots (Michaelis, 1613). Similarly, demoniacs at Boston and Salem were able to read the sacred writings of Quakers and Catholics with ease (indicating that these writings were not, in fact, sacred). However, they were unable to read Calvinist writings (Calef, 1700/1914; Mather, 1693/1914).

moral life and cleanse before exorcising (*Roman Ritual*, 1976). If the exorcist fails, not only will he himself might become the demon. Possession of a fairly common occurrence was usually explained in terms of the priest or his failure to attain the proper degree of faith (Brockhoff, 1716).

Possessions appear to have been of modern "epidemics" of possession (Brockhoff & Back, 1968; Rosen, 1976). A possession epidemic often began when people living in close quarters were under psychological stress that could include existing social channels and lack of no sanctioned means of escape. Epidemics of hysterical possession participated rather quickly, often within days (Brockhoff & Back, 1968). On occasion epidemics, like those in France, lasted months or even years (Leventhal, 1974; Huxley, 1952). In cases of hysterical contagion there were no organized groups that had a vested interest in the continuation of the epidemic. Thus, they provided some temporary relief by adopting the sick role, but did not reinforce them for the sick role. In extended-possession epidemics of the community leaders) reaped substantial personal benefits from control. Not only were the demoniacs' performances, they were their role. In both the Loudun and Westerwold cases one of the demoniacs had not been bewitched. At Loudun the demoniacs appeared before the ecclesiastical court that their master was the devil, and the exorcist (Garrett, 1975). At Salem, the confessress herself became suspected of being a demoniac and was prosecuted had she not confessed (Woodward, 1864/1969). Both cases affirmed the religious variety of relatively subtle demoniac French nuns often contending that Calvinists loved the Huguenots more than the demoniacs at Boston and in the sacred writings of Quakers contending that these writings however, they were unable to do so (Mather, 1700/1914; Mather,

A crucial aspect of the relationship between exorcist and demoniac revolved around the dimension of authority and submission. Exorcism manuals (*Thesaurus Exorcismorum*, 1626; *Roman Ritual of Exorcism*, 1614/1976) continually reminded the exorcist that it was he, not the demoniac, who controlled the situation. Despite all of her ravings and convulsions, the demoniac, in the last analysis, remained submissive to the exorcist. The exorcist commanded, the demoniac obeyed, and the power of God over the Devil was thereby demonstrated (Oesterreich, 1966; Summers, 1956). For example, in order to impress the spectators with God's power to perform miracles, one exorcist commanded a possessed nun to change her body into iron, and immediately her "body shot out straight, and the arms thrust out; and so lay the whole body of one piece as the priest said" (Killigrew, 1635/1974, pp. 93-94).

The relationship between exorcist and demoniac was similar to the relationship between mesmerist and subject in a number of important respects. In both cases the interactions were construed as moral confrontations. Evil could be conquered in such confrontations only if the representative of good (exorcist or mesmerist) was morally purified, possessed an abundant faith in his procedures, and maintained a firm control over himself and the situation. Moral failings in the exorcist or mesmerist could lead to their developing the symptoms of their patients.

Influence of Possession on Mesmerism

The similarities between the demoniac-exorcist role relationship and the mesmerized-mesmerist role relationship do not often themselves demonstrate that the demoniac-exorcist relationship actually influenced the development and the structure of the mesmeric relationship. We will endeavor to demonstrate such a relationship by examining lines of evidence that indicate that (a) demonic possessions and exorcisms were still regular, culturally accepted activities in the 18th century and therefore could have influenced mesmeric practices, (b) clerics and mesmerists were well aware of the similarities in the effects they each produced and often reinterpreted

each other's practices in their own terms, and (c) transitional phenomena developed that involved the juxtaposition of demonic possession and magnetic cure.

Demonic Possession in the 18th Century

Although the 18th century is often described as an age of rational enlightenment and anti-religion, belief in demonology was far from dead in this period. Among lower socioeconomic classes and many of the clergy, it was common (Leventhal, 1976; Wilkins, 1974). Cases of demonic possession were frequent enough throughout the 18th and early 19th century for Esquirol (1838/1965) to classify them as a type of demonomania and devote a chapter to them in his famous *Des Maladies Mentales*. Some 18th century possession cases received a great deal of popular notoriety. Among the best known were those of Maria Renata, a German nun who was burned as a witch in 1749 for causing the possession of her sister nuns, and Catherine Cadiere, a possessed French nun who in 1731 engendered a great deal of publicity and controversy by claiming that she was seduced by her exorcist (Gaar, 1749; *Recueil des Pièces Concernant le Procès contre la Demoiselle Cadière*, 1731; Robbins, 1959).

Between 1728 and 1732 about 600 alleged miracles occurred at a Parisian cemetery (Dupau, 1826; Knox, 1950). The behavior of the participants at these miracles strongly resembled earlier reports of demonic possession and later reports of mesmerism. These behaviors included convulsions, analgesia, reported amnesia, and indications of preternatural knowledge. The participants, known as "convulsionnaires," were usually female. Huge audiences went to watch the convulsionnaires perform and participated in the procedure by stroking or hitting them in order to stop the convulsions (Garrett, 1975, in press; Jourdain, 1735). The performances of the convulsionnaires were diversely interpreted. Rationalist philosophers and a portion of the medical establishment believed they were due to hysteria and "faulty imagination" (Hecquet, 1733). However, the most popular interpretations revolved around notions of divine intervention or demonic possession (Garrett,

1975; Hecker, 1837/1970; Wilkins, 1974). In short, the syndrome that was later to be associated with mesmerism was well known to 18th century Europeans and was still associated by many with demonic influence.

By the middle of the 18th century, manifestations of possession were sometimes medically classified as hysteria, and hysteria was by this time considered by the majority of physicians to be a purely natural disorder (Diethelm, 1970; Tourney, 1972). However, medical opinion was divided, and a number of prominent physicians continued to espouse the reality of demonic possession and to believe that some diseases were caused by a combination of naturalistic and demonic influences (Diethelm, 1970).

The most famous 18th century exorcist was undoubtedly John Joseph Gassner, a Catholic priest from Swabia (Ellenberger, 1970; Rose, 1971). Gassner believed in the reality of demonic possession and had, in fact, cured himself by exorcism. In the middle of the 18th century, he exorcised thousands of people in Swabia, Switzerland, and Tyrol. Mesmer watched some of the Gassner's demonstrations and concluded that the results were due to animal magnetism (Mesmer, 1779/1948). However, De Haen, a celebrated physician and teacher of Mesmer, suggested instead that Gassner's power might be derived from the Devil (De Haen, 1778). The following quotation quite clearly illustrates the similarity between Gassner's procedure and Mesmer's. It also indicates that information concerning the symptoms of possession was widespread at the time:

The number of persons resorting to him was so considerable, that he often had ten thousand of them encamped in the neighborhood of Ratisbon. Gassner regarded faith as an essential condition to be cured . . . he almost always touched the affected part. Sometimes he rubbed his hand upon his [the patient's] waist or neck, but it was not always the case. Gassner had the power by his will, to make the pulse of his patients vary. . . . He paralyzed their limbs; caused them to weep, to laugh, soothed or agitated them simply by expressing his order in Latin, or rather, mentally. (Hartshorn, 1879, p. 304)

Demonic possession remained a well-known phenomenon in 18th century Europe. The medical profession and some intellectuals tended to interpret these phenomena in

naturalistic terms, but even among them there was ambivalence. Among the lower classes demonic superstitions remained strong. Exorcisms continued to be carried out and they were often highly popular public events.

Mesmerism Reinterpreted as Demonic Possession

One factor that suggests that the demoniac-exorcist relationship influenced the role structure of the mesmeric relationship is the ease with which these practices became identified with one another. Mesmerism was quickly identified by many clergy and laymen as a species of demonic possession, and this identification continued to be maintained throughout the 19th century (Marne, 1828; Resie, 1857).

Although some Catholic clergy defended and even practiced mesmerism, most were vehemently opposed to it and interpreted the behavior of the magnetized subject as resulting from possession (Darnton, 1970; Pailloux, 1863). The church was particularly concerned by reports of clairvoyant phenomena occurring within mesmerism. Clairvoyance, it will be recalled, had traditionally been one of the church's most rigorous tests of demonic possession. Its occurrence allowed for only two interpretations: The clairvoyant was either divinely inspired or demonically possessed. Because there was nothing about mesmerism that the church would consider divine, satanic influence remained as the only possible explanation for transcendent mesmeric phenomena (Pace, 1908). In the mid-19th century the Inquisition investigated both mesmerism and spiritism and urged bishops to suppress the practice of mesmerism in order to protect the flock of the Lord and preserve the faithful from moral corruption (Macchi, 1856/1888).

The identification of mesmerism with demonic possession was not a viewpoint restricted to the clergy. It appears to also have been a fairly common lay belief. Madam du Barry, mistress to Louis XV, described popular attitudes toward Mesmer as follows:

His lectures were attended by crowded audiences . . . many departed with the conviction that, if he were endowed with supernatural powers, he derived them from Lucifer himself. (cited in Goldsmith, 1934, p. 135)

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Similarly, Deleuze (1825/1879) cites the case of a magnetizer who was forced to stop practicing in an early 19th century French town because the populace believed that "he could not do things so extraordinary but by the influence of the devil" (p. 159). Throughout his book, Sandby (1844), who was both a mesmerist and a Protestant clergyman, frequently bemoaned the fact that mesmerism was commonly associated with diabolical powers. He believed that the clergy played a major role in propagating and reinforcing this idea and indicated that sermons damning mesmerism as a diabolical activity were common practice throughout England in the mid-19th century.

Clergy and laymen frequently associated mesmerism with diabolical activity. Within this framework, the magnetized subject was construed as being the innocent victim of diabolical influence, and the magnetizer was seen as the evil witch or sorcerer who controlled the demon's activities. This view of the magnetizer as a powerful but evil despoiler of innocent purity quickly captured the popular and literary imagination of the 19th century and led to the creation of such still memorable fictional characters as Svengali.

Although the mesmerists were often seen by their opponents as sorcerers, they tended to identify themselves with exorcists. We have already seen that Mesmer was quick to reinterpret Gassner's exorcisms as examples of magnetism. Similar reinterpretations were made by many mesmerists and, later, by hypnotists as well (Dods, 1865; Haddock, 1849; Hartshorn, 1879; Mahan, 1855; Newman, 1847; Sextus, 1893/1968). These reinterpretations typically indicated that exorcism had historically been effective because the priests who employed it unknowingly made use of mesmeric techniques. For a time, it even became fashionable to interpret biblical references to exorcism and healing as examples of magnetism at work (e.g., Dods, 1865).

The hypothesis that the mesmeric relationship was to a large extent modeled after the exorcist-demonic relationship is supported not only by the fact that both activities involved highly similar phenomena and overlapped one another during the 18th century but also by the fact that both mesmerists

and proponents of the possession doctrine quickly and easily reinterpreted the phenomena of each other's system within their own frames of reference.

Transitional Phenomena

The transition between demonic and mesmeric conceptualizations involved not only competition between these alternative frames of reference but attempts to combine and integrate them. Mesmer's conceptions of disease, cure, and magnetic fluid were, of course, purely naturalistic. Nonetheless, the notions of magnetism and somnambulism were quickly integrated into supernaturalistic frames of reference. Two such instances included the association of mesmerism and spiritism and the notion of demonico-magnetic affections.

Belief in communication with the spirit world was widespread in Paris during the second half of the 18th century. Seances and mediums were common, and mesmerism quickly became associated with the spiritism movement (Dingwall, 1968; Podmore, 1902). Somnambulism was soon conceptualized as a state that allowed for direct contact with the spirit world (Cahagnet, 1854-1862; Segouin, 1853; Thouret, 1784). Mesmerism began to be increasingly employed as a technique for divination and spirit communication, somnambules became professionalized as mediums, and before the end of the century this spiritualist form of mesmerism had spread throughout Europe (Darnton, 1970; Ellenberger, 1970).

The mesmeric relationship that emerged in the late 18th century as a secularized version of the exorcist-demonic relationship was, by the early 19th century, partially reincorporated within a supernaturalist framework. The magnetized subject, initially conceptualized as ill rather than possessed, was within a few years reconceptualized as possessed—usually by good spirits, angels, or departed relatives rather than by demons—but possessed nonetheless.

In the early 19th century, Justin Kerner (1836), a German physician and romantic poet, developed the notion of demonico-magnetic affections. Kerner believed that individuals, sometimes unbeknownst to themselves, could become possessed by demons.

His treatment of such individuals was a mixture of exorcism and magnetism. The first step involved the individual becoming aware of the fact that his affliction was demonic in nature.

Once the patient recognized the demon within him or her, its expulsion by means of a magnetic exorcism could proceed. Occasionally, as in the following case, this procedure failed:

As for the action of the magnetic passes which I only tried upon her two or three times, the demon tried to neutralize them immediately by counter passes made with the girl's hands. (Kerner, 1834, p. 40)

The development of the concept of demonico-magnetic affections illustrates two points made throughout this article: Cases of possession were not uncommon occurrences even as late as the 19th century (see Constans, 1863; Evans, 1893), and during this period physicians were not unanimous in accepting a naturalist explanation of possession phenomena. Kerner's work further illustrates the important role played by the exorcist's expectations in shaping heterogeneous physical and psychological complaints into full-blown manifestations of demonic possession.

From Possession to Hysteria

The view that manifestations of demonic possessions were really symptoms of the "disease" hysteria gained virtually complete acceptance in the medical community by the mid-19th century. It became common among physicians of this era to interpret both the behavior of magnetized subjects and the historical occurrences of demonic possession as manifestations of hysteria (Calmeil, 1845; Dupau, 1826; Richet, 1887). This point of view was, of course, epitomized by Charcot, who contended that only hysterics could manifest the signs of grand hypnotisme and who never tired of pointing out similarities between the symptoms of hysterics and the behavior of the demonically possessed of previous centuries (Bournèville, 1886-1891; Charcot & Marie, 1892; Charcot & Richer, 1887/1972). Charcot's specific ideas about hypnosis and its relationship to hysteria were discarded before the end of the 19th century. Nevertheless, many implicit conceptions of

the hypnotic subject propagated both by him and by most other 19th century investigators persisted as part of the general mythology of hypnosis well into the 20th century (e.g., the conception of the hypnotic subject as a helpless automaton). These notions, derived historically from medieval and late medieval conceptions of the exorcist-demonic relationship, became an integral, often taken for granted, part of 18th and 19th century conceptions of the mesmeric relationship and have persisted down to the present day as part of the popular public image of hypnosis.

The 19th century notion that hysteria is a disease and that historical cases of demonic possession demonstrate that this disease has manifested itself largely unchanged down through the centuries remains a popular point of view among contemporary psychiatric writers as well as some historians (Demos, 1970; Gallineck, 1962; Hansen, 1969; Holmes, 1974; Veith, 1965; Zilboorg & Henry, 1941). For example, Hansen, a historian, after noting that the possessed girls of Salem reported experiences such as temporary blindness, choking sensations, and hallucinations, concluded:

These symptoms are readily recognizable. The most cursory examination of the classic studies of hysteria . . . will demonstrate that the afflicted girls of Salem were hysterical in the scientific sense of that term. (p. 22)

Unfortunately for the proponents of the "disease theory" of hysteria, there is no universally accepted scientific "sense" in which this term is employed (see Gottlieb & Spanos, Note 2). On the contrary, the term *hysteria* is highly ambiguous and historically has referred to a vast hodgepodge of relatively unusual and dramatic but often unrelated behaviors (Chodoff, 1974; Chodoff & Lyons, 1958; Janet, 1925; Szasz, 1961; Ullman & Krasner, 1969; Ziegler & Imboden, 1962). There is certainly no evidence to support the notion that the many behaviors subsumed by this term reflect a unitary disease process or have a common aetiology (Slater, 1965).

An important corollary of the disease theory of hysteria is that the primary causes of the disorder are internal. Disease theorists have usually sought the causes of hysteria in various hypothetical repressed childhood conflicts

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but often unrelated
4; Chodoff & Lyons,
sz, 1961; Ullman &
& Imboden, 1962).
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(Slater, 1965).
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(Breuer & Freud, 1895/1956; Fenichel, 1945). In such theoretical schemes, interpersonal factors that might reinforce or maintain hysterical behavior are usually relegated to positions of secondary importance.

A disease theory is not, of course, the only way to conceptualize the behaviors traditionally subsumed under the rubric of hysteria. Instead, they may be viewed as reflecting learned, interpersonal strategies designed to communicate dissatisfactions and/or obtain various types of social reinforcement (Chodoff, 1974; Szasz, 1961; Smith-Rosenberg, 1972; Ullman & Krasner, 1969). From this perspective, the behaviors enacted by the hysteric would be expected to vary as a function of the manner in which the "sick" role came to be defined by her and by significant members of her audience (e.g., physicians). Furthermore, the variables primarily responsible for leading the individual to define herself as sick or possessed, for enabling her to acquire the components of the sick role, and for maintaining her behavior within the confines of that role definition would be conceptualized as involving the sick person's stock of knowledge concerning the role and the characteristics of the individuals occupying it, interacting with interpersonal communications and rewards received from significant others.¹⁷

A social role conceptualization applied to the history of possession, hysteria, and mesmerism acknowledges that disease theorists have been correct in pointing to behavioral similarities associated with these notions, but it also argues that interpreting these similarities as the result of a unitary disease process that was variously labeled during different historical epochs is not theoretically fruitful. Instead, a social role theory suggests that the manifestations of the demonic role were shaped to fit Judeo-Christian conceptions of demons and demonic activity. The role was maintained because the status of demoniac became associated with a number of important social functions. The demoniac notion provided a culturally consistent explanation for various physical disorders and for otherwise inexplicable violations of propriety norms. When coupled with exorcism procedures, the role provided a means of reintegrating deviants into the social community, served as a proselytizing

device, and in various ways supported the religious and moral values of the community. The role also provided a channel for allowing, while simultaneously controlling, some expressions of social and personal dissatisfaction. Finally, from the 15th to the 18th centuries, the role was increasingly exploited as a means for controlling personal, political, or ideological enemies by having the demonic label them as witches.

¹⁷ A social role theory does not exclude the possibility that some of the symptoms displayed by some hysterics may be related to physiological dysfunctions. For instance, temporal lobe dysfunctions may sometimes be associated with a host of relatively unusual sensory and perceptual experiences (Bingley, 1958; Glaser, 1975; Valenstein, 1973). However, according to a social role perspective, whether or not a person with such experiences becomes labeled a hysteric would depend on a host of psychosocial variables such as the manner in which (a) the experiences were defined to the self and described to others; (b) significant others reacted to the descriptions (e.g., dismissed them as unimportant, viewed them as interesting and non-pathological, or called a physician in alarm); (c) manifestations or descriptions of the symptoms became incorporated into an interpersonal strategy designed to communicate a particular self-presentation and/or elicit particular reactions from others (e.g., "I'm sick and helpless, save me" vs. "I feel like I lose my sense of self and become one with the universe—It's a beautiful experience"); and (d) exposure to experts (physicians) shaped such rather diffuse experiences into one component of a complex social role.

A social role theory does not exclude the possibility that certain personality factors may have enabled some individuals to enact the hysterical role more effectively than others. Nineteenth century investigators regularly described hysterics as highly imaginative, attention seeking, suggestible females with a strong flair for the dramatic (Hall, 1827; Holcombe, 1869; Janet, 1925; Owen, 1971). When stripped of pejorative connotations, such a description seems to refer to individuals who enjoy and are highly skilled at becoming absorbed in a variety of "make-believe" role-playing endeavors. Given the appropriate definition of the situation along with requisite interpersonal cuing and reinforcement, it is not surprising that such individuals would be particularly adept at enacting both the hysterical and the magnetized role. However, labeling individuals as sick because they possess and utilize flexible and convincing role-playing skills does little to advance our understanding of behavior. It is interesting to note that a substantial body of research indicates that modern "good" hypnotic subjects enjoy and are effective at dramatic role playing and are skilled at becoming absorbed in a variety of imaginative and "make-believe" activities (Hilgard, 1970; Sarbin & Coe, 1972; Spanos & Barber, 1974; Tellegen & Atkinson, 1974).

The gradual conceptual shift from possession to hysteria that occurred from the 16th through part of the 19th centuries was associated with delimited changes in patients' role performance. As patients as well as physicians began defining behavioral deviance as a purely medical issue, those components of the patients' role least compatible with notions of natural disease became less prominent (e.g., vomiting pins, blaspheming against God, speaking in a demonic voice, defining oneself as possessed). Role components that could be more easily conceptualized in terms of natural disease (e.g., convulsions, analgesia, sensory-motor disturbances, vague physical complaints) remained prominent symptoms of hysteria throughout much of the 19th century (Janet, 1925).

In many respects, individuals labeled as hysterics had a good deal in common with earlier demoniacs. They tended to be unhappy women who were socialized into viewing themselves as weak and passive, dissatisfied with their lives, socially and economically powerless, and without access to means of voicing their dissatisfactions or improving their lot outside of adopting the role of a sick person (Smith-Rosenberg, 1972; Smith-Rosenberg & Rosenberg, 1973). If one were hospitalized, the social structure of the institutions functioned to reward and thereby maintain skillful enactments of the hysterical role. A number of investigators (Guillain, 1955/1970; Hart, 1898; Janet, 1925) have clearly described the manner in which the social and bureaucratic organization of the Salpêtrière and other mid-19th century French hospitals led patients to enact the constellation of symptoms deemed by Charcot and his disciples to be characteristic of hysteria and hypnosis. These accounts indicate that the lower level staff and students at these institutions were afraid of displeasing or contradicting their supervisors. Therefore, with varying degrees of subtlety, they shaped patients to display the constellation of symptoms that they believed their supervisors wanted to see. The patients, often anxious to please and desirous of being at the center of attention, guided their role enactments on the basis of the cues provided by the staff. As Ellenberger (1970) put it, "A peculiar atmosphere of mutual suggestion developed between

Charcot, his collaborators and his patients" (p. 98).

In the late 18th and 19th centuries many patients treated with magnetism and hypnotism, both in and outside of hospitals, were defined as hysterics (Binet & Fére, 1888; Dupau, 1826; Esquirol, 1838/1965; Janet, 1925). In other words, they were individuals who were already adept at enacting many of the behaviors that, with the guidance of the mesmerist, quickly coalesced into the role of the magnetized subject.

The exorcist-demonic relationship influenced mesmerism in at least two ways. First, it overlapped in time with the mesmeric relationship and thereby provided an extant set of widely recognized cultural models for both the magnetizer and magnetized. Mesmer, of course, replaced the theory of exorcism with his own secular hypotheses. Nonetheless, the transformation from exorcist to mesmerist produced little fundamental change in the role components enacted by healer and patient. The demoniac relationship also influenced mesmerism in a second, more indirect, way. As we have seen, the secularization of the demonic role into the hysterical role began long before mesmerism came upon the scene. At least among more academically inclined physicians, this transition was largely accomplished by the time Mesmer began expounding his doctrine. This means that many female patients were in various respects behaving like earlier demoniacs but now defining themselves and being defined by their physicians as sick. It was patients of this type—unhappy women who convulsed, complained of vague aches and pains, reported sensory and motor deficits with little evidence of organic dysfunction, appeared anxious and "highly sensitive"—who were often treated by the early magnetizers (Binet & Fére, 1888; Ince, 1920; Janet, 1925; Podmore, 1902, 1909). It was the enactment of these behaviors, previously defined as demonic and now defined as sick, that was brought under the "control" of the magnetizers and shaped into the role of the magnetized subject.

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