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Abstract

In 2016, a case report of an Italian woman presenting with stigmata, the spontaneous manifestation of Jesus Christ’s crucifixion wounds, graced the pages of the international medical journal, Medicine. In the report, the authors, a group of Italian physicians, warned that as the woman had a “hysterical personality,” she could have easily been encouraged by family members to simulate her wounds for profit and attention. This paper offers a genealogy of the association of stigmata with the diagnosis of hysteria, tracing it from its origins in fin de siècle Paris to its appearance in contemporary medical literature with particular attention to how ‘religion’ may be constructed as ‘sick.’
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Introduction

A 42-year-old woman, originally from a small town in Calabria (South of Italy), showed, for the third consecutive year, cutaneous lesions during Easter holidays. Such lesions appeared every year on the forehead and on the dorsal surface of hands and feet… Lesions suddenly become manifest on Holy Monday and healed spontaneously within a few weeks. These alleged stigmata were made public, causing a steady flow of devotees and curious onlookers to the patient’s house, offering gifts of various kinds. The year before the local ecclesiastical and police authorities had become interested in the singular event, but legal or religious actions were not undertaken as the stigmata had rapidly disappeared some days after Easter.¹

The excerpt above comes from the pages of a 2016 case report, “Religious stigmata as malingering artifact,” published in the journal Medicine. Stigmata, the spontaneous, bodily manifestation of Jesus Christ’s Five Holy Wounds depicted in the case report, are not a new phenomenon — the origins of stigmata are generally identified with St. Francis of Assisi, who allegedly received the first stigmata after having a vision of a seraph in 1224.² Since St. Francis, several hundred people, most of whom being Catholic women,³ have laid claim to bearing the stigmata. Generally, the term stigmata denotes the Crucifixion wounds Christ received on his hands and feet, as well as the wound in the side of his chest.⁴ However, the term stigmata often includes similar spontaneous appearances of other wounds Christ received, such as the scalp wounds from the crown of thorns, as in the case of the 42-year old Italian stigmatic.⁵

The authors of the case report go on to describe the stigmatic woman during examination: she “showed a wary and absent attitude, occasionally speaking in a detached manner about her religious faith. The psychiatric consultation, which had been refused at the time of the previous episodes, described a hysterical personality with attention-seeking behavior and for approval of her family.”⁶ The authors add, “the patient’s absent attitude, as though she was living in her inner world, could also underlie a hysterical personality that could be easily exploited by her relatives… [and] was confirmed by the psychiatric consultation,”⁷ suggesting some incitement by family
members. While the authors conclude that “[s]kin lesions were probably caused by metal objects, by a mechanism of scaping… or overheating,” they add that “the use of caustic chemicals cannot be excluded” either. In light of her allegedly ‘hysterical personality,’ easily manipulated by nefarious family members, the authors maintain, “we should always consider the possibility that stigmata… could be self-inflicted for illegal and/or profit purposes.”

To me, this case report poses two urgent questions. First, how did hysteria, or a hysterical personality, come to be associated with stigmata as seen in this case report? The authors note “stigmatization is generally referred to as unconscious self-harm during hysteria, autosuggestion, and hypnotism,” evincing that a hysteria-stigmata association is not a haphazard hypothesis but one common throughout the medical literature. Second, why had hysteria, a supposedly defunct disorder, become a common lens used to interpret stigmata?

This paper represents an attempt to explore this collocation of stigmata with hysteria, following Michel Foucault’s methodology of a genealogy. That is, I analyze the discourses — the “set[s] of material and linguistic practices that work across multiple institutions” — of hysteria and stigmata to understand their historical relationship, including its continuities and transformations. This approach allows for a more nuanced reading of the various ways Catholic discourses about stigmata relate to medical and psychiatric ones regarding hysteria, rather than simply framing ‘religion’ and ‘medicine’ or ‘psychiatry’ as two discrete entities. Instead, I demonstrate how the intertwining of stigmata with hysteria is a project at once Catholic and psychiatric, one that operates to help constitute a Western conception of modernity. To do so, I draw heavily on Foucault’s series of lectures at the Collège de France between 1974 and 1975, entitled Abnormal. Foucault’s reading of psychiatry as an emergent political technology offers one critical insight to this project, as does his exploration of the discourse of confession. His claim that
hysterical convulsions are the result of the investment in the body through the increasingly penetrating Catholic discourse of confession, and his analysis of psychiatry’s inheritance of convulsion as a mutually-beneficial exchange for psychiatry and the Church, represents a critical node in this analysis.

This genealogy explores the questions raised by the case report of the Italian stigmatic. On one level, I trace the thread that links hysteria and stigmata from their initial coupling to the present, while necessarily condensing this history to render it intelligible. Rather than develop a definitive, comprehensive history of the association of stigmata and hysteria, I move towards outlining their historical relationship. This, of course, requires attention to the changing historical constructions of hysteria, a diagnosis much in flux throughout the past two centuries, as well as recent manifestations of stigmata and their attendant criticisms.

On another level, I point to the political contexts and dimensions that structure the association of stigmata with hysteria. In other words, folded into this historical excavation is an analysis of power relations between men and women, the wealthy and the destitute, urban elites and rural peoples. These empowered relations cut diagonally through both Catholic and medical authorities to designate stigmata, historically a Catholic phenomenon mostly observed in women and often from rural communities, as hysterical. In turn, those with power — generally upper-class, educated men — portrayed stigmata as hysterical in order to project their own religious practices (and by extension, their selves) as rational, intellectual, objective, and modern. These dynamics take up different forms in different historical moments, but they remain firmly entrenched in the process whereby hysteria is repeatedly brought into proximity with stigmata.

Finally, this project points towards broader theoretical and methodological considerations for studying ‘religion’ and ‘medicine’ together. Particularly, a genealogical approach allows for
attention to the flexible and often entangled discourses of ‘religion’ and ‘medicine,’ here, Catholicism and psychiatry. Moreover, this approach offers theoretical considerations regarding how an object may be constituted as ‘religious’ and subsequently marked as ‘healthy’ or ‘pathological.’ This process is knotted with questions of power — who may claim a practice as healthy or pathological, and to what end — and in my reading, the construction of a supposed Western modernity, itself a discursive invention. As Couze Venn and Mike Featherstone argue, “[i]n its making of difference, the discourse of modernity has reconstructed a view of preceding periods and a sense of its own coherence that simply does not accord with the historical reality” and “has been equally at work in the understanding of concepts of civilization, of nation, of the Orient and the ‘Other,’ and of science itself.” Making stigmata hysterical serves, in my reading, as a strategy for producing a supposedly coherent, rational modernity by pointing towards the most (ostensibly) retrograde features of Catholicism. Psychiatry and liberal ‘modern’ agents within Catholicism both cooperate to deem stigmata as a superstitious thing of the past against which Western modernity may be constructed as a stable reality. The persistence, however, of stigmata in the 21st century reveals that they remain a force to be reckoned with despite attempts to relegate them to the historical, premodern past.

In Chapter 1, I explore the historical moment at which stigmata and hysteria come together in late 19th-century French psychiatric discourse. The Parisian clinic of Salpêtrière under neurologist Jean-Martin Charcot represents the point of departure for this analysis, as it is here that hysteria is reconceptualized according to the newfound tenets of science at the moment that psychiatry seeks to solidify its reputation amongst the medical specialties. Stigmata, itself a nexus of various discourses of hysteria, eugenics, and Catholicism, represent terrain upon which psychiatry may extend the diagnosis of hysteria, often retrospectively, to bulwark its position as a
field. Political conflicts between Catholic monarchists and secular republicans, as well as a
groundswell of supernatural Catholic phenomena across Western Europe, form the backdrop for
this exchange.

In Chapter 2, the transformations of hysteria, following the death of Charcot, by
psychologists Joseph Babinski and Pierre Janet alter the manner in which stigmata are associated
with hysteria. The development of the concepts of suggestion, the idée fixe, and the état second
are explored here in the context of two famous 20th-century stigmatics, Saint Padre Pio and Therese
Neumann. Catholic and medical commentators alike frequently deemed these figures, who
inspired massive international followings for their stigmata, hysterical, in line with new
conceptions of the disorder associated with Babinski and Janet.

Finally, in Chapter 3, I attend to more recent writings on hysteria and stigmata. Particularly,
I investigate the moment where hysteria is fractured into myriad diagnoses with the American
Psychiatric Association’s third edition of the Diagnostics and Statistical Manual of Mental
Disorders in 1980. Rather than demolishing hysteria (and thus any attempt to relate it to stigmata),
I argue hysteria continues to animate various contemporary diagnoses applied to stigmata, such as
histrionic personality disorder, conversion disorder, and dissociative identity disorder. Returning
to the case report by Bonamonte et al. as well as other contemporary medical reports on stigmata,
I demonstrate how hysteria and its gendered associations persist to pathologize this religious
phenomenon, increasingly on a cellular level.

Together, these chapters provide vignettes of key historical moments where physicians and
critics associate hysteria and stigmata in changing ways. In the final analysis, however, I suggest
the outcome remains the same: of pathologizing a Catholic expression associated largely with
women in rural towns, in order for the construction of a ‘modern’ liberal order. ‘Religion’ may exist in this modernity, but only if it is ‘healthy’ — that is, rational, intellectual, and private.

Notes

2 There exists evidence that St. Francis was not the first person claiming the stigmata, though he is generally taken as the first. See Carolyn Muessig, “Signs of Salvation: The Evolution of Stigmatic Spirituality Before Francis of Assisi,” Church History 82, no. 1 (2013): 40–68.
4 The word stigmata literally means ‘marks’ or ‘spots’ in Greek, and the term is used in Galatians 6:17 by Paul to refer to the “marks corresponding to the hardship that Paul encountered serving God,” as Carolyn Muessig writes. See, “Signs of Salvation: The Evolution of Stigmatic Spirituality Before Francis of Assisi,” Church History 82, no. 1 (2013): 42.
8 Bonamonte et al., “Religious Stigmata as Malingering Artifact,” 3.
12 There is, of course, significant internal heterogeneity and change over time for the spheres denoted by Catholicism and psychiatry, and I do not mean to reify them here. Rather, I use these terms to point towards finer levels of analysis.
Chapter 1: Hysterical Stigmata at La Salpêtrière: Marks in French Psychiatric Discourse

Conducting a genealogy of hysteria and stigmata together necessitates a turn to fin de siècle France. It is there that two major developments occurred, bringing together hysteria and stigmata once and for all. First, hysteria, the “protean disorder par excellence,” became the object of a sustained effort by French psychiatrists to understand it according to newly-developed, rigorous, positivist methods of the clinic.¹ In other words, French psychiatrists in this period sought to diagnose and treat hysteria scientifically, which chiefly entailed paring down the endless list of etiologies and symptoms of hysteria to its supposed core, static features observable across all hysterics. The famed Parisian hospital La Salpêtrière, led by the esteemed neurologist Jean-Martin Charcot and his colleagues, becomes a hub of this project. Charcot and his colleagues gave the name ‘stigmata’ to these permanent, identifying marks of hysteria, borrowing from *stigmata diaboli*, the ‘witches marks’ Inquisitors used to identify women who had submitted themselves to the devil.²

Second, Charcot and his colleagues initiated several historical studies of apparent hysterics in an attempt to prove the universal appearance of hysteria across time and space, securing the indisputable reality of the disorder and the importance of psychiatry, a relatively new field within medicine, in managing the disease.³ In his 1897 treatise, *La foi qui guérit* (‘Faith That Heals’ or ‘Faith Healing’), Charcot claimed that St. Francis of Assisi and St. Thérèse of Lisieux are “des hystériques indéniables,”⁴ before turning specifically to the subject of stigmata. In describing the mysterious case of Coirin, a young woman who had inexplicable wounds that were later miraculously healed, Charcot rhetorically asked if Coirin’s wounds were a “manifestation hystérique.”⁵ He responded in the affirmative, gesturing towards two high-profile stigmatics: “Persistent skin ulcerations are not uncommon in neurosis, look at the wounds of St. Francis of Assisi and Louise Lateau.”⁶ This somewhat throwaway comment obscures its significance. Not
only did Charcot paint St. Francis of Assisi — one of the most popular Catholic saints — a
estympathetic despite nearly 700 years between them, but he also claimed recently-deceased and
immensely famous French stigmatic Louise Lateau (1850-1883) was hysterical too. Charcot thus
applied the newly-medicalized diagnosis of hysteria to cases of stigmata past and present, forging
an association that persists to the present.

The medicalization of hysteria at La Salpêtrière and its retrospective application to
prominent stigmatics of the past and present are the focus of this chapter. Here, stigmata become
hysterical as part of a broader shift in France, where psychiatry underwent a serious reorganization,
the French political order is in crisis, and the power of the Catholic Church was challenged by
Western European governments but buttressed by mystical visions and miracles. To this historical
and political context we now turn in an attempt to understand how the discursive engagement
between psychiatry and Catholicism, through the association between hysteria and stigmata,
functioned to pathologize women’s bodies and ‘superstitious’ Christian groups. Rather than seeing
Catholicism and psychiatry as discrete historical entities, I extend Michel Foucault’s argument that
psychiatric discourse inherits and extends the object of Catholic discourse (the excitable body) and
its practices (examination, observation, needling) in its examination of hysterical stigmata.

**Fin de Siècle France: French Psychiatry, Republicanism, and Secularism in the Marian Age**

Fin de siècle France was marked by various significant social and political shifts. Especially
relevant to this study are three historical currents: 1) the progressive reorganization of psychiatry
as a new medical discipline, 2) the establishment of the precarious Third Republic and contesting
monarchist movements, and 3) the rise of secularism across Western Europe coupled with a
groundswell of Catholic mystical phenomena across Western Europe. Together, these historical
currents help situate the discursive exchange between psychiatry and Catholicism through hysteria and stigmata, an exchange structured by and structuring of the political transformations of the period.

_Psychiatry: The New Discipline_

Psychiatry in the second half of the 19th century had not yet enjoyed the success and prestige other specialties of medicine had secured by this point. Historian Martha Noel Evans remarks how “[i]f, after long centuries of disrepute, medicine was attaining new prestige as a science, psychiatry was only at the beginning of its history. A fledgling discipline, it needed to establish its territory and its credentials in the medical profession.” Noel Evans and another historian of hysteria, Jan Goldstein, suggest that hysteria was precisely the territory on which psychiatry could establish its expertise and fortify its reputation amongst the specialties of medicine. A poorly-understood disease both mental and physiological and without any clear diagnostic signs, hysteria provided a fruitful site for constant psychiatric intervention, for locating the unlocatable marks of illness. As part of this project, Charcot advanced the conception of hysteria as a neurological condition, based in a ‘dynamic lesion’ of the brain, the experience of trauma, and arising often in concert with an inherited, defective nervous system.

Part of psychiatry’s claim to legitimacy was grounded in its self-styling as a progressive medicine. With the famous image of physician Philippe Pinel (1745-1826) freeing the madwomen from their chains at Bicêtre at the start of the 19th century, the inchoate field began positioning itself as a liberator of the French people from superstitious beliefs and anachronistic interventions that were violent and inhumane. Hysteria scholar Mark Micale suggests “[w]hile recent detective work on the subject [of Pinel] has to some extent qualified the nature of his achievement, the
overall effect of Pinel in bringing the humanitarian ideals of the Enlightenment to the medical worlds remains indisputable,” especially his “string of reforms including the prohibition of physical violence against patients, the termination of all bloodletting practices, the keeping of extensive case histories, and the making of daily clinical rounds.” Generally, historical accounts of Pinel assert he liberated the etiology of mental illness from superstitious Catholic views that witchcraft or demonic possession resulted in abnormal, antisocial behaviour. Herman Westerink, however, posits this is an inaccurate reading of Pinel’s work, as Pinel actually claimed that the cause of mental illness in such cases was specifically excessive religious feelings or obsessions. Pinel’s positioning of a religion-pathology nexus becomes salient later in understanding the association of hysteria with stigmata. Regardless, Pinel marks a starting point of reform in French psychiatry, away from Catholic explanations of mental illness towards scientific ones.

At the same time as Pinel undertook his reforms, hospitals themselves were changing in France. Unlike the sense of the term hospital in today’s parlance, hospitals at the end of the 18th century in France were more akin to contemporary prisons than treatment facilities. Here, socially deviant and marginalized groups were institutionalized, including prostitutes, religious heretics, political prisoners, people with advanced venereal disease, and the otherwise destitute. La Salpêtrière, the hospital critical in forging an association between stigmata and hysteria, was converted from a saltpetre factory to an internment facility in 1656 for such groups. Poor, mentally ill women were also interned here against their will, though there was poor nosological differentiation between patients with different mental illnesses. As Micale notes, there was no treatment for these mentally ill women: soeurs-officière, women religious, would prescribe work activities and daily religious practices for these women and provided food and shelter. By way of Pinel’s reforms at the start of the 19th century, national legislation in 1838 which theoretically
provided legal protections for the mentally ill, and the emergence of other government institutions that would take custody of caring for lepers, people with disabilities, prostitutes, tertiary syphilitic patients, and other formally interned groups, La Salpêtrière shifted away from being a general internment center for the socially marginal towards a medical centre in the contemporary sense of ‘hospital.’ Importantly, however, many of the patients during Charcot’s tenure still remained women who were interned there either against their will or left without family to care for them, often working class women and women with incurable mental illness. Describing the dynamics of La Salpêtrière under Charcot, Micale notes that “[f]or a majority of the residents, the Salpêtrière was a home, not a one time-institutional experience but the only society they knew.”

Charcot, appointed as the chef of medical service at La Salpêtrière in 1862, remained committed to psychiatry’s progressive and modern potential, consciously rejecting violent treatments of patients. For example, Tony Robert-Fleury’s painting *Pinel Freeing the Insane* (1876), depicting some of Pinel’s reform efforts and the liberation of madwomen, hung in the main lecture hall at La Salpêtrière during Charcot’s tenure, intimating a claim that Charcot’s work was within the Pinelian, progressive tradition of psychiatry. Sigmund Freud, a student of Charcot in 1885, even remarked after studying the image, “[t]he Salpêtrière, which had witnessed so many horrors during the Revolution, had also been the scene of this most humane of all revolutions.” Charcot’s styling of La Salpêtrière as a progressive force did not merely entail a denouncement of former, brutal psychiatric treatment and its Catholic interpretive schemes. It also entailed a political denouncement: a rejection of the Ancien Régime, the unchecked power of the Catholic Church, and superstitious, unfounded beliefs about mental disorders. In this context, stigmata, as we will later see, become hysterical marks that, according to Charcot and his colleagues, should be interpreted according to progressive, modern, secular psychiatry instead of an anachronistic,
superstitious, Catholic scheme. This interpretation also entailed political consequences — psychiatry was allied with the laicist republicans in France, while irruptions of the supernatural into daily life were read as marks of favour for the Bourbon monarchists, aligned with the Catholic Church.

*Republicanism and the Monarchists*

The end of the 19th century marked a period of governmental tumult in France. As Luca Sandoni describes, the end of the Second Empire following France’s defeat in the war against Prussia “opened a vacuum of power that was not sufficiently filled by the precarious and provisional institutions of the newborn Third Republic.”23 Divided into a faction of monarchists (further divided after the 1830 July Revolution into Légitimistes, who supported the Bourbon claim to the throne, and the Orléanistes, who supported the descendants of Louis Phillipe) and republicans, the Assemblée nationale saw a monarchist majority in the 1871 elections immediately following the Franco-Prussian War.24 Catholic devotees and clergy largely supported the Légitimistes and advocated for the claim of Henri of Artois, the only surviving male member of the Bourbon family and a conservative Catholic, to the throne.25 Henri’s birth became regarded by many Catholic monarchists as a miracle, a providential sign the Catholic, French monarchy could be restored instead of the secular republic.26 The restoration movement, as Sandoni has incisively demonstrated, drew much of its inspiration from ecstatic prophecies of contemporary mystical religious figures, including stigmatics Louise Lateau and Palma Matarelli (1825-1888).27

For example, French physician Dr. Antoine Imbert-Gourbeyre, known for staunchly defending stigmata against psychiatric evaluations of hysteria and for his historical catalogue of stigmatics, *Les stigmatisées*, visited Belgian stigmatic Lateau several times between 1868 and
1871, in part to question her about the fate of the Bourbon monarchy.28 He asked her about the restoration of Henri of Artois to the throne, taking her response as a prophecy of Henri’s inevitable return to the throne.29 Religious orders and periodicals also published letters circulating prophecies attributed to Lateau and Matarelli foretelling the return of a Bourbon to the throne.30

Towards the end of the 1870s, French republicans were also organizing to achieve their political aspirations of a democratic French republic, properly divorced from any trappings of the Ancien Régime. However, they found recourse to a different discourse to bolster their claim to legitimacy: the discourse of psychiatry. Foucault suggests that between the 1850s and the 1870s, a period a political demand for psychiatry emerges which generalizes its power and knowledge based on the “problematization of instinct.”31 In this period, Foucault argues “psychiatry is called upon to provide what could be called a discriminant, a psychiatric-political discrimination between individuals or psychiatric discrimination between individuals, groups, ideologies, and historical processes for political purposes.”32 Thus, psychiatry became used in France and in Italy to distinguish between productive and unproductive revolutions, of determining which movements should be sanctioned and which should be discredited, of identifying which components of the Ancien Régime should be salvaged.33 For example, critics of the burgeoning feminist movement in France regularly circulated photographs of ‘hysterics’ taken by the Salpêtrière medical photographer, Paul Régnard, to frame the ‘new woman’ as hysterical and discredit their calls for women’s rights.34 Moreover, psychiatry offered a language for distinguishing between the ‘normal’ and ‘healthy’ elements of Catholicism associated with the Ancien Régime, including demonic possession and stigmata, as we will see.

The interest of the physicians at Salpêtrière in reframing religious ecstasy and stigmata in terms of mental pathology thus arose partially from political motivations to challenge Catholic
monarchs. Positivist science, embodied by psychiatry, was thought by many republicans to be necessary for “a truly democratic conception of the social order,” following the Comtean notion that the theological and metaphysical would be replaced by positive science. The political dimensions, then, of course reflected French debates about the place of Catholicism and laicization.

**Secularism and the Supernatural in the Marian Age**

The political uses of psychiatry in determining ‘good’ governance and ‘good’ social movements also interfaced with ambivalent attitudes towards Catholicism in Western Europe at the time. On one hand, secularism was on the rise across Europe: the temporal power of the Vatican had all but been obliterated by the capture of the Vatican states in 1870, the Kulturkampf was taking place in Germany, French debates about the position of Catholicism in the government were ongoing, and the Paris Commune’s 1871 attacks saw Parisian churches destroyed and clergy executed. On the other hand, the doctrine of papal infallibility was approved at Vatican I in 1870 and Western Europe experienced the Marian Age, a revival of supernatural phenomena, from sightings of Mary, mystical phenomena such as stigmata, to faith healings. Mystical phenomena thus became focal points for conservative, Catholic revival movements at the same time the Church’s temporal power waned. As we have already seen with Lateau and Matarelli’s prophecies, these mystical phenomena often became both signs of an inevitable victory of the Church over growing secularism and a sense of Christian persecution, symbolically represented in the mimetic suffering of the stigmatics. Conversely, such irruptions of the supernatural into daily life became territory for psychiatrists to use in order to bolster their professional reputation and implicitly advance towards a secular, democratic nation-state.
Many French psychiatrists and republican politicians formed a political alliance in the 1870s and 80s. Salpêtrière physician Désiré-Magloire Bourneville (1840-1909), for example, was a vocal advocate for the laicization of French hospitals and staff, the latter of which began in 1878 with the first laic nursing school at Salpêtrière. Bourneville and others also attempted unsuccessfully to repeal the 1838 Law which allowed for Catholic asylums to receive funding from the government. This alliance eventually led to the creation of a chair of nervous disease at the University of Paris in 1882, filled by Charcot, a clear sanctioning of the promise of psychiatry. This chair focused less on absolute mental pathologies and more on a spectrum of neuroses, including hysteria. As Goldstein notes, this expansion of pathology increased the turf on which psychiatry could exercise its expertise.

Imbert-Gourbeyre and Salpêtrière physicians also engaged in a recurring debate about the limits of rationalism and positivism, centered around stigmata. The Salpêtrière school had engaged in a concerted effort to evaluate religious mystics, past and present, according to their newfound ‘scientific’ understanding of hysteria. As such, religious ecstasies and demonic possession became the focal point of their efforts to discredit the excesses of Catholicism, and the newly-reconstructed diagnosis of hysteria showed remarkable capacity to incorporate these religious fits and emotions in a psychiatric scheme. The Salpêtrière school’s persistent attacks on contemporary stigmatic, Louise Lateau, as well as historical stigmatics such as St. Francis of Assisi, motivated Dr. Imbert-Gourbeyre, himself a staunch defender of Lateau and the veracity of stigmata, to write a series of challenges to their ‘free-thinking’ and the dangers of excessive rationalism. The discursive association of stigmata with hysteria at La Salpêtrière, to which we now turn our attention, should be seen against the backdrop of a larger, anticlerical position of the school, embedded in an attempt to professionalize psychiatry as a specialty, debates around
republicanism and monarchist revival movements, as well as the ambivalent position of Catholicism across Europe, caught between a loss of temporal power and a groundswell of supernatural revival.

**Stigmata at La Salpêtrière: Retrospective Medicine and an Inquisitorial Return**

The discursive association between stigmata and hysteria, at first, seemed to be one borne out of necessity. As the newly appointed chief of medical service at La Salpêtrière in 1862, Charcot was not initially interested in hysteria. Rather, as Noel Evans suggests, Charcot sought out to develop a clearer nosology capable of distinguishing the epileptics and hysterics from the psychotics who shared the ward. Through this taxonomic endeavour, Charcot apparently became fascinated with the study of hysteria. The problem with hysteria, however, was twofold: it had taken on a huge number of symptoms, such that it became a ‘wastebasket’ of poorly understood illnesses, and it was a mostly unseen disorder, erupting in fits but otherwise unmarked. Sander Gilman argues that the culture of images of hysteria that develops around La Salpêtrière under Charcot emerged out of a need to see disease in 19th-century positivist medicine: “[d]isease is real only if it is universal. And it is universal only if it can be seen and the act of seeing reproduced.” The documentation of patients with photography at La Salpêtrière, the first hospital in Europe with a fulltime medical photographer, became one strategy of identifying hysteria. Charcot and his colleagues developed a universal scheme for the phases of a hysterical attack, replete with religious language such as ‘Attitudes Passionnelles,’ ‘Crucifiement,’ and ‘Extase’ that was easily identifiable in a series of photographs. In this vein, Daphne de Marneffe argues that by “carefully cataloging symptoms in sequence, Charcot was able to use documentary photographic evidence to ensure the veracity of his universal sequence of stages” of hysteria.
With photography as one strategy of identifying visually the signs of hysteria, the entry of stigmata into psychiatric discourse at La Salpêtrière became another. Stigmata, however, included a jumble of related connotations. First, stigmata referenced the *stigmata diaboli*, the so-called ‘witches marks’ used by Inquisitors to prove a women had had intercourse with the devil and was thus a witch.\(^53\) Drawing on this connotation, Charcot, as Steven Connor describes, “introduced the word ‘stigmata’ to signify the permanent and unchanging features of hysteria, as distinguished from its ‘accidents,’ or more mobile and transitory features.”\(^54\) In his treatise on hysteria, Georges Giles de la Tourette (1857-1904), a physician at La Salpêtrière, recounted this history of diabolical stigmata in witches, marked by areas of the skin with no feeling, before describing the similar clinical signs in contemporary stigmatics.\(^55\) These stigmata of hysteria, then, provided another strategy for seeing hysteria alongside photographs of transient hysterical fits. While insensitive patches of the skin itself could not be seen by the naked eye, by methodically needling the skin of a hysteric’s body, the physicians at La Salpêtrière were able to produce a zoned schematic of hysteria visually representing the disease itself (Figure 1).\(^56\)

![Figure 1. Hemianaesthesia in Giles de la Tourette’s *Traité Clinique et Thérapeutique de l’Hystérie d’Après l’Enseignement de la Salpêtrière*, in Steven Connor, “Stigmata,” 129.](image)

The second sense of stigmata operational at La Salpêtrière was that of Franciscan stigmata (my term), the stigmata exhibited by Louise Lateau and St. Francis of Assisi – the apparently
supernatural stigmata that mimicked Christ’s wounds. These stigmata, unlike the stigmata that marked insensitive skin (stigmata diaboli), were a separate class of hysterical symptoms. To these physicians, Franciscan stigmata were an extreme manifestation of the hysteric’s skin, generally prone to heat and swelling, arising out of a nervous susceptibility. These stigmata were not regularly used to identify patients with hysteria in the clinic, but rather, outside it — that is, very few patients presented at La Salpêtrière during Charcot’s tenure claiming they had received the stigmata. Instead, Charcot and his colleagues identified this feature of hysteria in women in convents, in rural towns, and in the historical past. The presence of Franciscan stigmata, as we have already seen, thus became a target for the Salpêtrière school. Charcot and Bourneville both took aim at Louise Lateau, the contemporary Belgian stigmatic, arguing forcefully her wounds were hysterical manifestations. Bourneville himself dedicated an entire study to the case of Lateau, making himself an enemy of Imbert-Gourbeyre, the conservative Catholic and defender of Lateau. The hysterical etiology of Lateau’s stigmata also became a fierce topic of debate at the Académie Royale de Médecine de Belgique in the 1870s.

The third sense of stigmata, perhaps less immediately salient but nonetheless operative, was the sense of the stigmata of degeneration — the features of the body associated with criminality, moral degeneration, and the racialized ‘Other.’ Coined by eugenicist Bénédict Morel (1809-1873) and popularized later by Cesare Lombroso (1835-1909), these stigmata were thought by eugenicists to be the physiognomic signs of degeneration, the biological evidence of moral decay. Influenced by a Lamarckian model of evolution, wherein hereditary traits accumulate as a result of behaviour, Morel argued that cities, such as Paris, produced a hereditary degeneration as a result of alcohol use, sexual promiscuity and syphilis, and other urban vices. Scholar Fay Brauer claims that Charcot’s theory of permanent hysterical stigmata grew out of this sense of
degenerative stigmata, as Charcot argued hereditary degeneration combined with trauma to produce hysterical insensitivity or the *stigmata diaboli*. Many French psychiatrists associated with Charcot thus thought hysteria itself was a consequence of a moral-biological degeneration of the French people. More broadly, Darwinian evolutionary thinking was becoming more common in France, reinforcing assumptions that women and children were closer to “inferior races” and thus biologically predisposed to not only hysteria generally, but specifically the moral shortcomings of hysteria, such as the willful deception of physicians commonly attributed to hysterics (we return to this thread of evolutionary thinking in Chapter 3). Lombroso’s later work on degenerative stigmata also developed a notion that the presence of tattoos amongst European criminals and Indigenous cultures that Darwin studied proved the physiognomic links between criminality and the supposed inferiority and primitiveness of Indigenous peoples.

The fourth sense of stigmata I suggest circulates here is one that absorbs these interrelated connotations: of witches’ marks and deviance, of hysterical, mystical religiosity, and of criminality, racial, and gendered inferiority. That is, it is at La Salpêtrière that stigmata became firmly attached to the diagnosis of hysteria, such that stigmata become hysterical henceforth in medical and popular discourse.

We now return to two discursive exchanges between psychiatry and Catholicism— the entrance of *stigmata diaboli*, the Catholic concept, into French psychiatry, and the application of hysteria, the French psychiatric concept, to Franciscan stigmata, the Catholic phenomena — to attend to the political and historical forces that produce the discursive features of hysterical stigmata in the years following.
The example at the start of this chapter, that of Charcot rereading history and inserting a diagnosis of hysteria where Franciscan stigmata appeared, requires further attention. What historical exigencies drove Charcot and his school to this interaction? For these doctors, “the retroactive rehabilitation of witches and demoniacs (and saints) functioned… as a noble extension of their scientific work and placed them in the role of champions of the downtrodden,” as freeing historical, hysterical women from a barbaric Catholic interpretive scheme with an enlightened science.\(^6\)

Noel Evans argues this framing, however, obscured the male, French psychiatrists from seeing their own exploitative, violent, inhumane treatment of patients, who were mostly poor, mentally ill, women.\(^7\) The ‘progressive’ discourse of hysteria placed in proximity with Franciscan stigmata thus served to elevate psychiatry’s position in France by producing the image of an ostensibly objective, male liberator, freeing the stigmatic from her time.

This positioning of psychiatry, of course, interfaced closely with the tumultuous political climate of fin de siècle France, where republicans and monarchists grappled for control of the political order. Louise Lateau, interpreted by many conservative Catholics across Europe and Bourbon monarchists in France as a prophetic figure ensuring eventual victory over secularist democracy, became a target for republican psychiatrists, such as Bourneville.\(^8\) To Bourneville, “[t]o insist that Louise Lateau was a *stigmatisée* instead of a hysteric was to run afoul of the great joint tradition of science and the French Revolution,”\(^9\) science that was the bedrock of a secular, enlightened, French republic. Psychiatry thus buttressed ascendant laic republicans, securing its own precarious position amongst the specialities of medicine. The fact that the laicization of hospitals (which started at La Salpêtrière with the first secular nursing school and was completed by 1883)\(^10\) and the creation of a university chair for nervous disorders in 1882, to be filled by
Charcot, took place in this period should not be overlooked either. Entwined in securing the status of the field of psychiatry was the advocacy of democracy over monarchy, of secularism over Catholicism, and the ‘hystericizing’ of stigmata.

To read the psychiatry-secularism-republicanism nexus as psychiatry (or medicine more broadly) against capital ‘R’ religion, represented here by some monolithic Catholicism, I think, would be in error. Rather, psychiatric actors here were interested in discrediting particular expressions of Catholicism, namely, demonic possession, ecstasies, and stigmata, rather than purging all expressions of ‘religion’ from the public sphere. Sander Gilman incisively notes this dynamic in Charcot’s reference to images of the Jansenists, who claimed their bodily movements were evidence of hysterical contractures: “Charcot’s citation of Jansenism as the central visual clue to the history of hysteria ties the image of the hysteric, not merely to ‘religion’ but to the religion of spiritual excess.” I suggest a similar dynamic is operative in the association of hysteria with stigmata. Rather than discredit all ‘religion,’ fin de siècle psychiatrists aimed to criticize a popular, superstitious Catholicism (ostensibly one that belonged to a former era) brimming with miracles, stigmata being a sensational case of such miracles. For the forebears of the Charcot school, like Pinel, a fanatical religious culture could result in mental illness, the cure being isolation. During Charcot’s tenure at La Salpêtrière, the Vatican ordered Palma Matarrelli, the famed Italian stigmatic, to be isolated from the countless pilgrims who came to see her to control her (inappropriate) celebrity. In the same period, we see Belgian physicians, with whom the Salpêtrière doctors engaged, call for the isolation of Lateau from a fanatical religious culture as a mode of treatment. The desire to isolate stigmatics from a superstitious, pathological culture, as a mode of condemnation and as a treatment, returns with famed 20th-century stigmatics explored in Chapter 2, both from Church and medical actors.
Pinel, Charcot’s predecessor, similarly did not seek to totally discredit the positive value of religion, but rather, identified religious ecstasies and overzealous religious attitudes as causes of mental illness.\textsuperscript{80} In Charcot’s time, it appears pastoral models were still used to treat sick patients, and a chapel with regular Protestant and Catholic services was still available on La Salpêtrière grounds.\textsuperscript{81} Some ‘religion,’ if stripped of pathogenic superstition, could thus be therapeutic for hysteria (or at the very least, not harmful).\textsuperscript{82} (Catholicism itself was not a monolith either: while many conservative Catholics regarded Lateau favourably, liberal Catholics, and the Vatican itself, did not necessarily view Lateau and other stigmatics of the period positively).\textsuperscript{83} Hysterical stigmata, the target of this retrospective medicine, I argue, became important as a focal point for constructing a modern, rationalist, secular public sphere against a supposedly premodern and superstitious one, the former capable of accommodating of liberal, modern Catholicism and mainstream Protestantism.

\textit{Stigmata Diaboli and the Excitable Flesh}

Having broached one dimension of the exchange between psychiatric and Catholic discourses in fin de siècle France, we now turn to another — the absorption of the Catholic concept of \textit{stigmata diaboli}, the witches’ marks, into the diagnosis of hysteria. \textit{Abnormal}, a collection of Michel Foucault’s 1974-5 lectures at the Collège de France provide a useful theoretical framing for this exchange. Here, he further develops his argument from \textit{History of Sexuality: The Will to Pleasure} regarding the discursive investment of the flesh through the development of Christian confession. Foucault tracks the historical development of confession as a penitential practice, one that increasingly relies through the Middle Ages on the power of the priest to mediate confession, to absolve blame of the penitent, to examine the penitent holistically and to hear confession not just
of sinful acts but of every fact of life (as the priest has the knowledge to determine what is sinful and what is not). As confession comes to incorporate a broader cross-section of life, “there is a corresponding increase both in the priest’s power (since he now gives absolution) and of his knowledge (since he now has to control what is said within the sacrament of penance, he has to question and impose the framework of his learning, his experience, and his moral and theological knowledge).” The development of spiritual direction in the second half of the 16th century, Foucault suggests, also reproduces these dynamics of examination, observation, confession, and penance.

Consonant with this increasing power/knowledge of priests and their duty to examine the penitent is a shift in the construction of sexuality: “[p]reviously, the flesh, the sin of flesh, was above all breaking the rule of union. Now the sin of flesh dwells within the body itself. One tracks down the sin of flesh by questioning the body, by questioning its different parts and its different sensory levels.” This shift from a relational conception of sexual morality, towards an instinctive, intrinsic, bodily conception based on desire and pleasure is what Foucault sees as the foundational shift towards the discursive investment of the flesh. Consequently, according to Foucault, “we pass from the old theme that the body was at the origin of every sin to the idea that there is concupiscence in every transgression” with the body now as a desiring body of flesh, sexuality enters into every sin. The upshot of this is that the discourse of desiring flesh, where the body is subject to total examination within strict power relations, is internalized and produces outbreaks of demonic possession of the 16th and 17th centuries. While the figure of the witch is a “bad Christian,” a person on the fringe of the Christianized empire, the possessed woman is “a woman of the town,” but “not just any woman of the town; she is the nun.” The shift from a witches’ body to a possessed body also reflects a shift in consent: from the “juridical” will, an agreement
of exchange between the witch and the devil, leaving the witch marked with *stigmata*, to a will “charged with all the ambiguities of desire,” where the possessed flesh resists the devil or is tempted by its excitations.  

Foucault suggests that convulsions become the mark of possession, “at once the ultimate effect and the point of reversal of the mechanisms of the corporeal investment that the new wave of Christianization organized in the sixteenth century,” a body that resists spiritual direction, and by extension, the power/knowledge of the Church.  

The Church, ill-equipped to control the effects of its own power, thus developed what Foucault calls the ‘great anticonvulsives,’ strategies to retain the efficacy of confession and spiritual direction. One of these strategies, Foucault claims, is the expulsion of the convulsive by making recourse to medicine. Ultimately, “a radical break is needed that turns convulsion into an autonomous and foreign phenomenon completely different in kind from what may take place within the mechanism of spiritual direction.” Consequently, “[w]hat the Christian pastoral organized as the flesh becomes a medical object in the eighteenth century. Medicine establishes itself in the order of sexuality for the first time by annexing the flesh offered to it by the Church itself through the phenomenon of convulsion,” interested in the same sensations and desires of the body as confession is.  

Convulsions, annexed by psychiatry as a pathology of instinct, thus becomes proximal to criminality.

Foucault thus sees the *stigmata diaboli*, the witches’ marks that prove intercourse with the devil, as arising out of the periphery of Christianization, while possession is the effect of discursive investment in the body that psychiatry annexes. The annexation of convulsion is clearly evident at
La Salpêtrière, from the language used to describe the stages of hysterical contractures to the retrospective studies of mystics in ecstasy. Yet, Foucault does not account for the return of witches’ marks, which he suggests phases out as the flesh becomes reorganized around pleasure, at La Salpêtrière in the diagnostic scheme of hysteria. For it seems that the *stigmata diaboli*, alongside the construction of the convulsive woman, quite clearly emerges as psychiatry inherits the object of Catholic discourse: the excitable flesh. The inheritance of *stigmata diaboli* even comes with an inheritance of the Inquisitorial method of needling marks for insensitivity, alongside the Catholic techniques of confession and examination (Figure 2). Foucault’s temporal scheme, which sees convulsion overtaking *stigmata diaboli* with the newfound investment in the flesh, thus ignores the superimposition of these marks in convulsive, hysterical patients and their consequences for psychiatry’s pathologizing of religiosity and femininity. The *stigmata diaboli*, the marks of a witch – “the bad Christian” – coincided with convulsions in the figure of the stigmatic. The stigmatic was often seen to have hysterical convulsions, patches of insensitive skin, and excitable skin that erupts into bleeding stigmata. Stigmatics became, at once, the bad Christian and the sick patient through this discursive inheritance.
Pathological Religiosity, Pathological Femininity

Psychiatry, Foucault argues, as a technology of abnormality joins together, newly in the 19th century, two senses of the normal/abnormal — the normal that opposes abnormal, irregular, uncommon conduct, and the normal that opposes the dysfunctional and the pathological. Thus, what is uncommon becomes sick and monstrous through the political technology of psychiatry. The hystericizing of stigmata retrospectively and contemporaneously by Charcot and his colleagues followed this logic. It took the stigmatic, an exceptional mystical figure who is often ecstatic or convulsive, both as a pathological expression of religiosity and femininity. Being predominantly women, stigmatics become subject to the (ostensibly progressive) discourse of hysteria in French psychiatry, where, as Noel Evans notes, ideas of female neuroticism, fragile constitutions, providential tendencies to weakness, and a less-evolved or degenerated nervous capacity, structure hysteria. In fact, to many fin de siècle French psychiatrists, the hysteric was the women par excellence. The association of stigmata with hysteria was thus a pathologizing of a bodily, mystical, feminine religiosity through the misogynistic construction of hysteria.

Stigmata, then, serve as ground for the production of the liberal, modern order. An ostensibly neutral, scientific, democratic space is forged in part by French psychiatrists buttressing republicanism against a conservative faction of Catholic monarchists, the latter viewing stigmata as proof of Christian persecution and evidence of the supernatural. Pathologizing stigmata by drawing it into proximity with the medical discourse of hysteria, forcefully pushed a particular expression of ‘religion’ (one that is bodily, largely feminine, and mystical) to the margins, at the same time that religious nurses are being purged from hospitals in France. This laicization of nursing was justified by a similar logic: differentiating between Christian charity and public welfare, the importance of freedom conscience, and as support for the “scientific method” over
“metaphysical spirit.” Religion that was ‘healthy’ might exist in the public sphere, but healthy religion — one that consoles the sick — was that which was intellectual and rational, (apparently) separate from political systems, and individual. In this process, psychiatry also shored up its own reputation amongst the medical specialties by offering a technology of abnormality useful to the emerging secular, republican, modern order.

Simultaneously, psychiatry’s marginalization of a mystical, conservative Catholicism obscured its inheritance of the object of Catholic confessional discourse, the excitable flesh, and some of its methods (examination, confession, surveillance, needling). While Foucault suggests convulsive women most clearly are the endpoint of this inheritance, I suggest that *stigmata diaboli* represent another inheritance in psychiatry of Catholic discourse that reveals their continuities. The political uses of witchcraft during the Inquisition to persecute religious others thus moved into the domain of psychiatry, albeit surreptitiously. Yet, the history of the hospital itself again reveals this inheritance of methods: the confinement of religious heretics in the hospitals of the 17th century transforms into a pathologizing of religious difference in the reorganized 19th-century hospitals.

Claiming the emergence of hysterical stigmata at La Salpêtrière under Charcot as an example of religion and medicine in conflict would be to overlook the significant historical, discursive, and epistemic continuities between a Catholic discourse of witchcraft and possession and emergent psychiatric discourse. Furthermore, it would be to overlook the empowered role of psychiatry in determining the forms of religiosity amenable to the secular, modern public sphere. These forms of religiosity necessarily reflected rationalist, gendered priorities cast as necessary for the functioning of French democracy. In the process, the mystical stigmata of Catholic women were discredited as superstitious and the consequences of a biological inferiority.
Notes


5 Charcot, *La foi qui guérit,* 20.

6 Charcot, *La foi qui guérit,* 20. Unless otherwise noted, all translations are my own.

7 By secularism, I refer to the definition Janet Jakobsen and Ann Pellegrini offer: “a political project that deploys the concept of the secular,” that may be expressed with or without any relation to “the empirical state of secularization.” In other words, I see the process whereby stigmata become hysterical as tied to the political and moral project of secularism, where ‘the secular’ takes on a positive valence in contrast to ‘religion.’ While empirical features of secularization, such as the differentiation of religion and the state, may also be related to this project of making stigmata hysterical, I bracket those questions for the scope of this paper. Janet R Jakobsen and Ann Pellegrini, “Times Like These,” in *Secularisms* (Durham, N.C.: Duke University Press, 2008), 7.

8 Noel Evans, *Fits and Starts,* 14.

9 Noel Evans, *Fits and Starts,* 14.


11 Noel Evans, *Fits and Starts,* 28.


19 Noel Evans, *Fits and Starts,* 20. See also Micale “The Salpêtrière in the Age of Charcot,” 708, 712 on the “application of Pinelian humanism” at La Salpêtrière.


21 Sigmund Freud, qtd. in Elizabeth Fee and Theodore M. Brown, “Freeing the Insane,” *American Journal of Public Health* 96, no. 10 (October 2006): 1743. The first portion of Freud’s comments appears to be in reference to the 1792 September Massacres during the French revolution, some of which took place at La Salpêtrière, where many interned women were killed or sexually assaulted.


26 Sandoni, “Political Mobilizations of Ecstatic Experiences in Nineteenth-Century Catholic France,” 22.

27 Sandoni, “Political Mobilizations of Ecstatic Experiences in Nineteenth-Century Catholic France,” 23-4, 28-34.


Sandoni, “Political Mobilizations of Ecstatic Experiences in Nineteenth-Century Catholic France,” 32.

Foucault, Abnormal, 139.
Foucault, Abnormal, 152
Foucault, Abnormal, 154.


Paul Bert, “Introduction,” Revues scientifiques 1 (1897):1, qtd. in Goldstein, Console and Classify, 368.

Foucault, Abnormal, 152.


Goldstein, Console and Classify, 364.


Paul Bert, “Introduction,” Revues scientifiques 1 (1897):1, qtd. in Goldstein, Console and Classify, 368.

Goldstein, Console and Classify, 364.

Goldstein, Console and Classify, 364-6.

Goldstein, Console and Classify, 368.

Goldstein, Console and Classify, 369.

Goldstein, Console and Classify, 369.


Noel Evans, Fits and Starts, 20.

Noel Evans, Fits and Starts, 20.

Mazzoni, Saint Hysteria, 2.


Mazzoni, Saint Hysteria, 24-5.

Connor, “Stigmata,” 120.


Pierre Janet, who worked under Charcot at La Salpêtrière, treated a patient who claimed they had Franciscan stigmata (see Chapter 2). Otherwise, stigmata appear to have been a rare occurrence in the hospital.

See n. 5.

See n. 44. Bourneville, Science et miracle.

See Lachappelle, “Between Miracle and Sickness,” 94-100.


Brauer, “The Stigmata of Abjection,”173. See also Noel Evans, Fits and Starts, 30, on Charcot’s positioning of heredity and hysteria.

Noel Evans, Fits and Starts, 32.


The term retrospective medicine comes from a 1869 article by French physician Emile Littré entitled “Un fragment de médecine retrospective,” Philosophie positive 5 (1869):103-20. On this see Goldstein, Console and Classify, 370.

Noel Evans, Fits and Starts, 35.
69 Noel Evans, *Fits and Starts*, 35-6.
70 Sandoni, “Political Mobilizations of Ecstatic Experiences in Nineteenth-Century Catholic France,” 34-6.
71 Goldstein, *Console and Classify*, 371.
72 Goldstein, *Console and Classify*, 364.
73 Goldstein, *Console and Classify*, 368.
75 Goldstein, *Console and Classify*, 370.
79 See, for example, Bourneville, *Science et miracle*, 9-14, where he cites physicians Warlomont, Lefebvre, and Charbonnier. See also n. 61.
80 Westerink, *Demonic Possession and the Historical Construction of Melancholy and Hysteria*, 336. See also Goldstein, *Console and Classify*, 213 on Pinel and the relationship between the types of religious experience and insanity.
83 Sandoni “Political Mobilizations of Ecstatic Experiences in Nineteenth-Century Catholic France,” 31-2. Imbert-Gourbeyre, for example, claimed the Church’s criticism of his writings on Matarelli were driven by a liberal Catholicism.
84 Foucault, *Abnormal*, 176.
85 Foucault, *Abnormal*, 176.
86 Foucault, *Abnormal*, 183-4
87 Foucault, *Abnormal*, 188-9
88 Foucault, *Abnormal*, 192
89 Foucault, *Abnormal*, 202, 204
90 Foucault, *Abnormal*, 205.
91 Foucault, *Abnormal*, 209-10
92 Foucault, *Abnormal*, 213
93 Foucault, *Abnormal*, 222
94 Foucault, *Abnormal*, 222-3
95 Foucault, *Abnormal*, 224
96 See Noel Evans, *Fits and Starts*, 26; Connor, “Stigmata,” 127-9 on this observation.
97 Foucault, *Abnormal*, 163
98 Foucault, *Abnormal*, 162.
99 See Noel Evans, *Fits and Starts*, 16-17, 30-2, 34, 50.
100 Though Charcot sought to remove the association of genitals and sex with hysteria, and he claimed men could also be hysterical, Freud reports Charcot describing hysteria to him, saying “It’s always a genital thing… always… always… always…” “On the History of the Psycho-Analytic Movement,” *Standard Edition* 14, (1914): 14. qtd. in Noel Evans, *Fits and Starts*, 27.
103 See also Goldstein, *Console and Classify*, 382-3 on Charcot’s return to consoling discourse of Pinel and Esquirol.
Chapter 2: Psychology and Hysterical Stigmata in the 20th Century

Having explored in Chapter 1 the historical moment wherein stigmata and hysteria became firmly associated at the clinic of La Salpêtrière, this chapter turns to the stigmatic ‘living saints’ of the mid-20th century. Padre Pio of Pietrelcina (1887-1968) and Therese Neumann of Konnersreuth (1898-1962) represent two of the most widely adored Catholic figures of the 20th century, both bearing the Franciscan stigmata (p.22). With throngs of pilgrims travelling to visit them not only from Europe, but all around the world, Pio and Neumann offer a point of departure for examining some of the continuities and transformations of the stigmata-hysteria nexus forged in fin de siècle France. Key developments in this era introduce new dynamics to the conception of stigmata as hysterical. A shift towards conceptualizing hysteria as a psychological disorder, rather than a neurological one, followed Charcot’s death. The emergence of hysterical symptoms amongst soldiers, mostly men, fighting in the First and Second World Wars also modified the hysteria-stigmata association forged under Charcot. Criticisms of the stigmata of Pio and Neumann, both by physicians and by prominent Catholic thinkers, developed along these new intellectual lines.

Suggestion, Fixation, and Hysterical Personalities during the Wars

Martha Noel Evans argues that following Charcot’s death in 1893, a robust backlash developed amongst physicians against the hegemonic Charcotian perspective on hysteria. These physicians resisted Charcot’s preeminent influence on the construction of the disorder, made possible through his prolific teaching and lecturing.1 Particularly, following the turn of the century, hysteria became not the result of an excitable, frail nervous system and trauma (p.13), but a psychological disorder, one defined by states of mind and one’s force of will. These two developments were interrelated, as a central critique that emerged against the Charcotian model of hysteria was that many of the
symptoms identified with hysteria by Charcot were, in fact, caused by physicians introducing them to patients. In other words, critics began to claim that Charcot and his colleagues unconsciously encouraged patients to simulate symptoms the doctors deemed hysterical. This criticism was also related to the Charcot school’s frequent use of hypnosis to introduce hysterical symptoms in patients, so that the disorder could be studied at will (we return to hysteria and hypnosis in Chapter 3). Not only did this critique pose a threat to the attempts to rehabilitate hysteria as a legitimate disease, but also “its unprecedented escalation [in symptoms] seemed to threaten the medical community itself,” especially the newfound prestige psychiatry had accumulated through describing and treating the disorder. Pruning hysteria’s symptomatology became a central effort following Charcot’s death, as did the reconceptualization of hysteria as a psychological disorder. Two of Charcot’s former students, Joseph Babinski (1857-1932) and Pierre Janet (1859-1947), played a central role in this shift.

Further developments in the study of hysteria emerged with the massive outbreak of hysteria in the trenches: male soldiers fighting in the first World War began experiencing loss of sensation, loss of mobility in the limbs, and other symptoms associated with the disorder that had formerly been assigned to women. Thus, physicians began to see hysteria as a strong diagnostic possibility in men for the first time. Additionally, the emergence of the diagnosis of a hysterical personality disorder in the 30s represented a further shift in the understanding of hysteria, separating neurological and psychological approaches to studying hysteria.
Joseph Babinski and the Birth of Pithiatism

Joseph Babinski, the famed Russian neurologist, set out in the first two decades of the 20th century towards the “dismemberment of hysteria” as developed under Charcot. Noel Evans notes the aggressive tenor of “dismemberment” may reveal the frustrations and disdain Babinski held towards Charcot, the former failing the necessary qualifying exam to occupy Charcot’s prestigious teaching chair or any other university teaching position. Regardless of motivation, Babinski sought to replace the old term ‘hysteria’ in favour of a new one that, in his view, better captured the etiology of the disorder: pithiatism. Babinski consciously fashioned this term, meaning “cureable by persuasion,” to gesture towards the psychic origin of the disease, replacing Charcot’s scheme of a traumatized nervous system. As part of his “dismemberment of hysteria,” Babinski argued that a large portion of hysterical symptoms were associated with simulator patients — patients who intentionally faked their symptoms — or suggested patients, who saw symptoms associated with hysteria and sub- or unconsciously reproduce them. To Babinski, both the suggested and simulator patients did not represent victims of any real disease, in the organic sense, but he maintained that patients suffering from hysteria were “half-simulator[s],” unconscious of their own deception.

Pithiatism thus located the etiology of hysterical symptoms in the patient’s mind, making it unreal in the organic sense. Noel Evans notes this understanding of hysteria not only to discredited hysterics for purely imagining their symptoms, but it also implied a value judgment about the sufferers of hysteria. As Babinski claimed suggestion was an inferior psychological mechanism to rational thought, the diagnosis of pithiatism positioned patients with the disorder as irrational. Conversely, persuasion, or the physician’s act of counter-suggestion, represented a rational mode of psychological action that could cure hysteria or pithiatism. While Babinski
failed to reckon with the contradiction of bifurcating patient suggestion and physician suggestion along the lines of irrational and rational, he did recognize the value judgment he made in distinguishing between simulation and suggestion as modes of psychological action. His advancement of suggestion as the basis for hysteria, he confessed, arises from “arguments of a moral kind and cannot be proven with the scientific rigour one brings to the study of organic diseases.” Babinski’s psychological typology of simulation, suggestion, and counter-suggestion which saw hysteria or pithiatism defined in terms of its ability to be reproduced by suggestion, such as hypnosis, and cured by counter-suggestion, markedly differed from Charcot’s conceptions of hysteria, which emphasized a catalogue of symptoms with neurological origins.

In a 1918 treatise on pithiatism, written with Jules Froment towards the end of the First World War, Babinski explicitly positioned pithiatism as the “modern conception of hysteria,” evincing a similar desire to Charcot to marshal psychiatry as a progressive, inexorable force against the antiquated. In this vein, Froment and Babinski claimed while “[c]omplete agreement on all questions related to hysteria has not even yet been reached… on certain points of primary importance the old views have been abandoned by all neurologists, and the new ideas have been generally adopted,” pointing towards the new, post-Charcotian conception of hysteria. Here, Babinski and Froment argued that neurologists are unanimous in understanding hysteria as pithiatism, to be treated by counter-suggestion. Further, they cautioned physicians and nurses to keep morale high in the ward and avoid unwittingly suggesting symptoms to patients. Writing in the aftermath of the First World War, Babinski and Froment described the importance of separating the organic causes of reflex disorders (that is, the neurological causes) from the hysterical causes (the illegitimate, manufactured ones), as hysterical symptoms were not considered a valid reason
for discharging soldiers from duty.\textsuperscript{17} We return briefly to the influence of the war on the conception of hysteria later.

Babinski’s caution against the influence of doctors and nurses on suggestable patients echoed his earlier writing, where he claimed “that hysterical or pithiatic phenomena must have the property of essentially depending, in their appearance, their duration, their form, their disappearance, on the psychic environment where the suggestable subjects live, whose sickly and sensitive predisposition is put into play by such and such sight, such and such conversation.”\textsuperscript{18} For patients not in the hospital, which Babinski suggested was a place where hysteria may spread like contagion, suggestion could still occur: “for hysterics who are cared for by their families, the sometimes very long duration of the troubles that they present is due, in many cases, to the unfortunate effect that excessive solitudes exercises on their mind that we surround them with, and the worries of those close to them.”\textsuperscript{19} Consequently, “a change of surroundings, isolation, persuasion, and psychotherapy are means which, applied to such patients, works wonders.”\textsuperscript{20} This theme of isolation and change of settings as a means for combatting the suggestion that structures hysteria returns frequently in later discourses around stigmata.

One critical departure in pithiatism from the former scheme of hysteria was the rejection of the \textit{stigmata diaboli} that marked the permanent features of the disorder. No longer an organic disease rooted in the nervous system, hysteria, renamed as pithiatism, could have no identifying marks (patches of insensitive skin, for example) beyond a cure by counter-suggestion. Babinski thus demolished the connotation of stigmata as Charcot had used it, for pithiatism had no organic, neurological core.\textsuperscript{21} Curiously, Babinski still advocated for the poking and pricking of the insensitive marks of skin, Charcot’s \textit{stigmata diaboli}.\textsuperscript{22}
Babinski’s fashioning of pithiatism, which transformed hysteria from the disorder marked by stigmata under Charcot, to a disease with no real essence, appears to form a critical node in the discourse of hysterical stigmata, in two ways. First, criticisms of stigmata in the period following emphasized the role of suggestion, of spiritual directors, family members, or zealous locals of introducing or perpetuating the physical, bleeding manifestations on the hands and feet, described earlier. Conversely, isolation from these surroundings, became increasingly offered as a therapeutic by interrupting the flow of suggestive ideas. Second, the location of hysteria in the mind offered a prototype for later discourses that position stigmata as the expression of psychosomatic disorders. Emerging consonant with other developments in the psychology of hysteria, hysterical stigmata became the product of the mind, of an inferior capacity to reason or an emotional fixation. While Babinski expressly denied the possibility of cutaneous or vasomotor diseases to arise from suggestion, his theory of suggestion seems to offer a prototype for later critics of stigmata who see the mind as the possible of creating deceptive cutaneous symptoms.

Unwittingly, Babinski and those that support his conception of pithiatism grasped the force of psychiatric discourse (itself emerging out of Catholic discourses of confession) on the body, how the investment in the flesh through examination, confession, and observation may produce or incite sensations in the body. Two of Foucault’s claims — that the investment in the flesh by Medieval Catholic discourses of confession produced the possessed, convulsive body, and that psychiatric discourse inherited this Catholic domain — thus is corroborated by Babinski, who understood hysteria or pithiatism as a product of suggestion from medical actors, such as Charcot. While pithiatism remained somewhat marginal within broader understandings of hysteria, it left an important impression on later criticisms of stigmata. Pierre Janet’s work on hysteria and the *idée fixe*, on the other hand, became much more influential on the study of hysteria.
Pierre Janet, the Idée Fixe, and the État Sécond

Pierre Janet, another student of Charcot, similarly conceptualized hysteria as a psychological disorder, rather than a neurological one. As Noel Evans describes, “[w]hat interested [Janet] was not the physiological and visible aspects of symptoms [of hysteria], but the mental conditions underlying them.”25 Janet’s 1894 thesis, *L’État mentale des hystériques* (The Mental State of Hysterics), advanced the concept of “les stigmates mentaux” — the mental stigmata — those permanent marks of the mind that could be used to identify hysteria.26 One of these mental marks was the *idée fixe*, “psychological phenomena that develop in the mind in an automatic fashion, outside of the personal will or perception of the sick person, but that, instead of being like experimentally-provoked suggestion, forms naturally under the influence of natural causes.”27 Critically, Janet distinguished the *idée fixe* that marks hysteria from other psychiatric disorders by claiming that the hysterical *idée fixe* was subconscious: the hysteric was unaware of their own mental obsession, though a trained clinician could glean it in its manifestations in hysterical attacks, speech, action, and other symptoms.28 It is this expressiveness of a mental fixation that haunts later psychopathological assessments of stigmata.

Further, Janet claimed these *idées fixes* could dissociate from the hysteric’s primary personality, forming an unconscious, second personality of the patient, an *état second*.29 Here, then, re-appeared the image of the possessed, convulsive women Foucault describes, transcribed in the discourse of psychology — the estranged, second personality takes on a consciousness of its own, not unlike the demon inhabiting a body, wreaking all manner of havoc. Foucault’s description of the possessed body echoes Janet’s notion of the *état second*: “[w]e can say that the possessed endlessly fragments and divides the witch’s body. Previously, taking the schema of witchcraft in its simple form, the witch’s body was a somatic singularity for which the problem of
division did not arise… The body of the possessed is a multiple body that is somehow volatized and pulverized into a multiplicity of powers that confront each other, a multiplicity of forces and sensations that beset it and pass through it.”

Moreover, Janet’s claim of the unconscious emergence of the état second seemed to justify an expansion of the psychologist’s observation and intervention, a role formerly held by the priest or spiritual director in the case of possessed nuns.

The logic of the état second implied that the hysterical, like the possessed, could not identify the fixation within themselves that has come to life, and thus required the psychologist’s or psychiatrist’s intervention to expel it.

Like Babinski, Janet saw the origin of hysteria in the hysteric’s surroundings. Advocating for isolation as one modality for treating hysteria, Janet claimed, “[i]t is in [the hysteric’s] family, in the presence of certain people, in conversations, that the origin of their fixed idea is located. These fixed ideas are constantly awakened and nourished by the facts of everyday life and can only grow in the environment where they originate.”

Janet also cited a case study Charcot described, where several young children developed hysterical symptoms, partially caused by the family’s participation in séances. In this case study, Charcot described how the case “clearly indicates all the danger, especially for predisposed subjects, superstitious practices — those which unfortunately have such a large appeal to them.”

Again there is a return to the claim that hysteria can largely be caused or worsened by an unsuitable environment, especially one with ‘superstitious’ elements. Consequently, isolation offered a means of severing the environmental influences on the hysteric’s mind.

In a later 1926 treatise, De l’angoisse a l’extase, Janet provided a comprehensive case study of a patient, Madeleine, who experienced ecstasies, extreme fits of anguish, visions of angels, and of particular interest here, Franciscan stigmata. As part of this work, Janet described some of the
pathological dimensions of religious belief: that is, belief that was “exaggerated, brutal, and without nuance or critique,” tied to ecstasies or torturous fits experienced by mystics and by Madeleine.\textsuperscript{34} Janet deemed these features of thought, associated with mystics, pathological for their irrational qualities and their lack of nuance or criticism. However, they were not uniquely a religious pathology — Janet thus cited the words of his patient Martial, a pseudonym for French author Raymond Roussel, who described glory in a way Janet thought akin to “how mystics speak of God.”\textsuperscript{35} The “very little logic” inherent in this secular pursuit of glory, Janet claimed, evinced a similar pathology of belief that marked the stigmatic Madeleine and other mystics.\textsuperscript{36}

It is worthwhile noting that Janet did not describe Madeleine’s Franciscan stigmata in terms of hysteria, as Charcot and his colleagues had. Instead, he framed Madeleine’s illness, and the cause of her stigmata, as a ‘psychasthenia.’ Janet distinguished hysteria from psychasthenia, Henri Ellenberger notes, by describing the former as a narrowing of consciousness, and the latter as an inability to distinguish between the real and unreal.\textsuperscript{37} Thus Janet associated Madeleine’s stigmata with the force of her imagination, as well as with her ecstatic fits, her menstrual cycle, her violent emotions, and a potential circulatory disorder that may have affected her skin.\textsuperscript{38}

Of the confluence of factors Janet identified as a possible cause for Madeleine’s stigmata, several are obviously gendered — Madeleine’s menstrual cycle and extreme emotions especially — reifying an older pathological link between women and stigmata despite a new diagnostic term. Moreover, the shift Janet accomplished in his conception of hysteria, towards a mental pathology with a fixed idea, becomes central in later criticisms of stigmata, regardless of Janet’s linking of stigmata with psychasthenia.
Global Conflict and the Hysterical Personality

Two other significant developments in the understanding of hysteria, relevant to this analysis, emerged in the period following Charcot’s death. The first was a function of a World War I and the proliferation of hysteria-like symptoms in male soldiers, which saw a material degendering of the diagnosis of hysteria. The second was the separation of hysteria as a physical or psychic disorder from a character or personality disorder under Henry Ey in the 1930s.

Regarding the first development, Noel Evans writes, “the incidence of war traumas challenged the pejorative associations thereby clinging to hysteria and provoked a reevaluation of Babinski’s theory of suggestion.” As she claims, Babinski’s advancement of hysteria as simulated or suggested left an impression that hysteria was not a genuine disorder. For example, hysterical symptoms such as motor disturbances were not given consideration the same way organic reflex disorders when discharging military patients, for example. However, this discrediting of soldiers, who had fought at great cost to defend France, apparently made many physicians uneasy. Thus emerges, Noel Evans claims, the deceptive hysterics and the sincere hysterics, the former coded as feminine, seductive, deceptive, and the latter coded as masculine, virile, and genuine. In this way, the virtuous image of the male soldier could be preserved alongside the clinical assessments of hysterical women from years past. The emergence of the diagnosis of mythomania, “a perverse will to deceive” around the same time, also reified the association of hysteria with a criminal deception, in part due to women’s apparently inferior morals, neurology, or place on the evolutionary scale. Broadly speaking, however, the war resulted in a degendering of who was diagnosed with hysteria, such that men could be diagnosed in a much greater frequency than under Charcot. The associations of hysteria with femininity, however, largely remained in place, as we will explore in Chapter 3.
The second development, whereby hysteria-as-disease and hysteria-as-personality-disorder became separated, took place under French psychiatrist Henri Ey. Representing, in part, the divisions between the earlier neurological model of hysteria developed under Charcot and the psychological model of hysteria, this bifurcation split off a physiological understanding of hysteria, based in nervous lesions and fits, from other, more minor features of hysteria. As a personality disorder, hysterical character disorder represented a “distorted but global style of responding to the world,” including symptoms that “rea[rd] like a compendium of traditional female stereotypes: excessive emotionality, an exaggerated need to be loved, lack of psychic equilibrium, impulsivity, heightened suggestibility, and compulsive lying.”

Noel Evans points out that this construction of a character disorder simply reproduced a binary of normal and abnormal behaviour for women, based in the social codes of the time, taking male normality as the yardstick against which pathological behaviour could be measured. Thus the territory controlled by psychiatry and psychology expanded again. No longer was hysteria a disorder exclusively of convulsions and contractures, but it also became a disorder of emotion and ‘bad’ behaviour. Though this splitting off of the hysterical personality disorder from the physiological model of hysteria was not central to the criticisms of Padre Pio or Therese Neumann, as we will see in Chapter 3, it become important in challenges to 21st-century stigmatics, who are often associated with histrionic personality disorder.

Having reviewed the key developments in the understanding of hysteria following Charcot’s death — the emergence of suggestion and pithiatism, the idée fixe, hysterical character disorder, as well as the degendering of hysteria through the First World War — an analysis of Padre Pio and Therese Neumann’s detractors, who draw on a stigmata-hysteria association, becomes possible. I will briefly summarize their lives and contexts before turning to the significant
criticism levelled at them, from both medical and Church quarters, which used the language of hysteria.

**Stigmatic ‘Saints’ of the 20th Century: Padre Pio and Therese Neumann**

Padre Pio of Pietrelcina and Therese Neumann of Konnersreuth represent two of the most well-known, if not the most well-known, stigmatics of the 20th century. Born around the turn of the century, they lived through two World Wars and the emergence of Cold War tensions, amassing huge international followings. While both were regarded as ‘living saints’ by throngs of devotees, only Pio has been canonized, the Vatican officially recognizing him as a saint in 2002. A cause for beatification was recently opened for Neumann in 2005, though its status is unclear.44

Michael Di Giovine, an ethnographer of Pio’s cult, argues that Pio’s movement should be regarded as a religious revitalization movement taking shape in an unprecedented, modern era marked by global armed conflict and the rise of state secularism.45 Neumann’s and Pio’s followings, which at their peak saw thousands of pilgrims travelling to their tiny villages every day, emerged in the latter half of the Marian century, a period of supernatural revival spurred on both Marian apparitions across Europe.46 Tensions within Catholicism itself, between conservative and liberal, ‘modern’ factions, also ran high in this period, with Catholic reformers seeking to update Catholic doctrine and liturgy.47 The Second Vatican Council, taking place between 1962 and 1965, represented a key transformation of the Church in light of modern, global conditions.48 Implicit in the conflict between liberal and conservative Catholic factions was also a divide between a supposedly ‘modern,’ rational Catholicism and a supernatural, conservative Catholicism, the latter being especially popular in small rural towns across Western Europe, such
as those where Pio and Neumann lived. These social conditions represent the background of Pio and Neumann’s movements, including detractors who took aim at their stigmata.

Pio, born in Pietrelcina, Italy in 1887, had visions of Jesus and Mary as well as experiences of ecstasy and demonic possession from a very young age. In 1903, Pio entered the Capuchin Order in Morcone as a novice and began to experience a mysterious, undiagnosable illness that repeatedly brought him close to death. In 1910, Pio was ordained as a priest, Di Giovine notes, possibly as he was thought to die imminently due to his mysterious condition. Around the same time, Pio received a vision of Jesus and Mary, resulting in an ‘invisible’ stigmatization that left small, red sores on his hands, feet, and side. He continued to experience bouts of mysterious illness, as well as ecstasies observed by physician Nicola Lombardi, who verified them as ‘real’ religious ecstasies. However, with the advent of the Great War, Pio was conscripted for duty in military hospitals as a cleric-soldier, serving in Caserta and later Naples. Discharged for a year because of a spell of illness, Pio then returned to service in 1917, before finally leaving service once and for all and returning to the Capuchin monastery in San Giovanni Rotondo.

Around this time, Pio began to view his suffering and inexplicable illness as a means for redeeming society and ending the war. Finally, in September of 1918, Pio, praying in a local church, had another vision of Christ and experienced a piercing of his hands, feet, and side by beams of light (not unlike St. Francis), and received the stigmata proper — bleeding lesions on his hands, feet, and side. Of Pio’s stigmata, Di Giovine writes, “[i]t is clear from his cathartic reaction that Pio’s stigmata was the culmination of his long-standing, ever-increasing desire to suffer — in a Christological, Franciscan way.” Pio’s intense desire to suffer becomes one of the targets of his detractors for its clear similarity to Babinski’s mechanism of suggestion and Janet’s idée fixe. Pio’s irregular military service also drew contemporaneous criticisms parallel to that of
other ‘hysterical’ soldiers who simulated illness to escape service. This criticism was made especially salient by his status as a priest given rising anti-clerical sentiments across Italy.\textsuperscript{60}

Following his stigmatization, Pio was subjected to a series of investigations by members of the Holy Office, such as Father Joseph Lemuis and Raffaele Carlo Rossi,\textsuperscript{61} as well as by various physicians, including Roman physician Dr. Giorgio Festa,\textsuperscript{62} Dr. Luigi Romanelli, the chief surgeon at a public Italian hospital,\textsuperscript{63} renowned professor of pathology Dr. Amico Bignami,\textsuperscript{64} and Dr. Giuseppe Bastianelli, Pope Benedict XV’s physician.\textsuperscript{65} Father Agostino Gemelli, the famed Jesuit psychologist, also visited Pio in this time and wrote harshly against the possibility of his stigmata.

With the ever-increasing number of pilgrims visiting Pio in San Giovanni Rotondo and the development of an organized, commercialized, cult, the Vatican orchestrated two suppressions against Pio in the 20s and 60s, amongst other things, limiting his ability to perform mass or confession, prohibiting contact with his spiritual director, and unilaterally seizing assets of the cult.\textsuperscript{66} The 1920s also marked attempts to move and isolate Pio from San Giovanni Rotondo, in an effort to limit his contact with his close circle of followers, especially his pie donne (pious women), the pejorative name for an inner ring of devoted women who were viewed with suspicion by many.\textsuperscript{67} Regardless of these attempts to suppress Pio’s cult, it developed a massive international following and remains one of the largest Catholic cults in the world.

Neumann, born in 1898 in the small village of Konnersreuth, Germany, similarly developed a debilitating illness before the appearance of the stigmata. Following a back injury in 1918, her health began to deteriorate such that she became increasingly paralyzed, and eventually, unconscious.\textsuperscript{68} In 1923, four days after the beatification of Neumann’s namesake, Thérèse Lisieux, Neumann’s father prayed to Lisieux, resulting in Neumann’s miraculous awakening.\textsuperscript{69} Two years later, the day of Lisieux’s canonization, Neumann entered into a trance and heard God’s voice,
who told her she would be able to walk again.\textsuperscript{70} The visions and voices returned several times that year, accompanying the appearance of a wound in her side. Finally, she had a vision of Jesus’ passion, which coincided with the appearance of the stigmata on hands and feet, as well as a wound ostensibly mirroring Jesus’ forehead injuries from the crown of thorns.\textsuperscript{71} Neumann’s stigmata bled every Friday until her death and attracted massive crowds.\textsuperscript{72} Similar to Pio, Neumann’s stigmata became the subject of a medical investigation by the local bishopric. Several members of the local Church hierarchy were present, as were several professors of medicine.\textsuperscript{73} They seemed unconvinced of the veracity of her wounds, as they reported the wounds would only freshly bleed after all the observers had vacated the room.\textsuperscript{74} Neumann was also closely watched by the Gestapo of the Third Reich, who were wary of the potential threat she posed to their political authority.\textsuperscript{75} Not unlike Lateau and Materelli of the previous century, prophecies attributed to Neumann also circulated widely in German newspapers.\textsuperscript{76} Though almost as popular as Pio, Neumann, as I have noted, has not been as successful in progressing along the path towards becoming a saint.

Criticisms of both Pio and Neumann were widespread during their lives and continue to this day. While not entirely directed at their stigmata, many of the criticisms are directed at their wounds, which, depending on one’s point of view, signify a certain sanctity, or conversely, a pathological propensity for deception and desire for attention.

\textbf{20\textsuperscript{th}-Century Stigmata Critics}

Criticism of Pio’s and Neumann’s stigmata did not come only from physicians, but also from the hierarchy of the Catholic Church. Parallel to the discrediting of stigmata under Charcot, Pio’s and Neumann’s stigmata were utilized to police particular expressions of religiosity, in light of internal pressures to modernize the Church away from its supernatural past, as well as to respond to the
external pressures of secularism. Two of these prominent stigmata critics, Agostino Gemelli (1878-1959) and Herbert Thurston (1856-1939), wrote prolifically against the possibility of stigmata, levelling significant public criticism against Pio and Neumann despite (or perhaps, because) themselves being members of the same Catholic faith. As we will see, their criticisms borrow, sometimes explicitly, sometimes implicitly, from previous discourses of hysteria articulated by Charcot, Babinski, and Janet. Similar criticisms of Pio’s and Neumann’s stigmata also developed in the medical literature of the period.

Catholic Critics: Agostino Gemelli and Herbert Thurston

Agostino Gemelli, the famed Jesuit psychologist and public advocate, Sergio Luzzatto describes, grew up in a strongly secular environment and studied medicine in his youth. After reading The Life of St. Francis, a biography of St. Francis that used positivist historiographical methods, Gemelli converted to Catholicism and became a central advocate for Catholic modernism, which, among other things, including “questioning aspects of the faith that were hard to reconcile with science and progress, especially faith based on icons, relics, and dramatic miracles.” In 1906, Gemelli exchanged a series of letters with the author of The Life of St. Francis, the Protestant Minister Paul Sabatier, who urged Gemelli to study Franciscan stigmata from a medical point of view. Nearly 15 years later, Gemelli would have his chance, examining Pio in April of 1920.

Unsolicited by the Vatican, Gemelli took it upon himself to visit Pio and investigate his stigmata. Gemelli did not conduct any histological or neurological examination. Instead, he carried out a psychiatric evaluation of Pio. In a letter to the Church, Gemelli warned against the “superstitious practices” spreading as a result of propaganda about Pio, as well as the “atmosphere of suggestion” around Pio, which included his spiritual advisor and his devotees. Thus Gemelli
advocated to the Church for Pio’s isolation from the environment of suggestion which allegedly produced his stigmata: [t]he case is one of suggestion unconsciously planted by Father Benedetto in the weak mind of Padre Pio, producing those characteristic manifestations of psittacism that are intrinsic to the hysteric mind.” Gemelli’s emphasis on suggestion echoed that of Babinski, who as we have seen, highlighted the role of the hysteric’s environment in the development of hysterical symptoms. Gemelli also identified isolation as a means for further investigating of Pio’s stigmata, not unlike Babinski, Charcot, and Janet’s claims that an uncontrolled, superstitious environment may lead to the development of hysterical symptoms. The call for isolation here represents an overlap in Catholic and psychological discourses and methods. The isolation of suspect religious persons, generally and in the case of stigmata, is an oft-used strategic move for the Catholic Church to interrupt religious celebrity, as with Palma Matarelli. However, isolation here emerges also as a medical intervention interrupting a chain of suggestion, in addition to being a strategy for controlling Pio’s charisma.

Moreover, the “Southern problem,” the apparent backwardness, superstition, and ignorance of Catholic theology exhibited especially by women in Southern Italy, animated many of the implicit dynamics in the critical assessment of Pio’s wounds: his stigmata seemed to be caused, in part, by the irrational religious proclivities of the zealous women around him who may have suggested the stigmata to him. Again, we see the criticism of stigmata being used to discredit a particular religious expression, here, a Southern, rural, and popular conception of Catholicism.

It is also worthwhile noting the psychological emphasis of this diagnosis. To Gemelli, Pio’s (hysterical) stigmata were the outcome of psychological suggestion, rather than an inherited deficit of the nervous system or a dynamic lesion of the brain. Further, the appearance of hysteria in male soldiers during World War I — on which Gemelli himself wrote a book — made it much
more common for hysteria to be identified in men. Recalling the dichotomy Noel Evans describes of the shell shocked soldier and the convulsive women, it appears that Gemelli identified Pio closer to that of the hysterical women with his ‘weak mind,’ a charge that recalls the frail, susceptible nervous system of Charcot’s patients. Gemelli later described Pio’s “simulation of holiness,” apparently borrowing vocabulary from Babinski to articulate Pio’s false wounds in light of hysteria, especially the connotations of intentional deception (see also p.23). 87

Moreover, Luzzatto argues that Gemelli’s modernist orientation drove him, at least partially, to discredit Pio’s wounds as signs of the outdated, irrational Catholicism that belonged to an era past. 88 This dynamic found its expression in his description of stigmata more generally. While Gemelli held that St. Francis’ stigmata were genuine, he claimed all stigmata since are false. 89 To this end, Gemelli developed a hierarchy of mystics, with those experiencing the “interior manifestations of exceptional spiritual grace” above the exterior mystical signs, the latter including stigmata. 90 These outward signs of mysticism, he claimed, merit the association of neurosis (as Charcot and others claimed), not the inward signs. 91 Gemelli thus posited a scheme of ‘healthy’ (i.e., not pathological) mysticism that is interior, moral, and intellectual, rather than external and bodily. This dynamic is not unlike Charcot and his colleagues’ criticisms of superstitious, zealous religion. Gemelli’s concerns about suggestion of stigmata by Pio’s overzealous followers, the pie donne, appears to similarly reify this dichotomy of healthy/pathological Catholicism.

Herbert Thurston, a prominent English Jesuit generally interested in supernatural phenomena, also took interest in the cases of Pio and Neumann. Thurston, reviewing the medical reports of Bignami, one of the physicians who assessed Pio, noted that he found them likely to be
“attributable to unconscious suggestion.”\textsuperscript{92} Anticipating objections some of his readers could raise, Thurston wrote:

You surely will not suggest, some of my readers may exclaim, that such phenomena are of hysterical origin… Padre Pio is always exceptionally calm and composed. There is no family history. He himself, with a candid simplicity which evidently made a profound impression upon the rationalist Professor [Bignami], declared that he had never suffered from any nervous malady. He had never been subject to fainting fits or convulsions or tremors. He sleeps well and is not trouble with dreams… I am not in a position to challenge these statements, and indeed there is no strict need to challenge them. What is realized by comparatively few persons outside the medical profession is the fact that a new, and as it seems, a much more exact conception of the neurosis still commonly called hysteria has come to prevail within the last thirty years… many neurologists have urged that a new name should be found for it. “Suggestion Neurosis” being inconveniently cumbersome, the term “Pithiatism” (i.e., a state curable by persuasion), which is used by Babinski… seems likely in time to win acceptance.\textsuperscript{93}

Here, Thurston explicitly cited Pio’s general lack of hysterical symptoms alongside Babinski’s notion of pithiatism to show that his stigmata may still be evidence of pathology. He also noted scientific consensus that “suggestibility, manifesting itself on occasion through such disorders as aphasia, nervous anæsthesias, palsies, inhibitions of hearing and vision, etc., frequently occur in subjects who are in no way unbalanced and have never had a fit of hysteric in their lives.”\textsuperscript{94} Thurston thus sought to provide an irrefutable argument that Pio was hysterical — even though Pio seemed sound of mind, the very existence of stigmata were evidence of unconscious suggestion. Thurston finally concluded that it was not denigrating to posit mystical manifestations may be attributed to pithiatism, as heroic virtue is the chief criterion for sainthood, rather than the mystical graces such as stigmata.\textsuperscript{95} This argument, in effect, replicated Gemelli’s regarding the hierarchy of mysticism: sanctity, recognized officially by the Church through canonization, relies primarily on human qualities, rather than supernatural occurrences.

Thurston’s analysis of Therese Neumann’s stigmata also evinced a methodological similarity to the retrospective medicine of the fin de siècle school of La Salpêtrière (p. 24): “to obtain a just view we cannot possibly discuss Theresa Neumann’s stigmata as if they were the only
Thurston argued that Neumann’s stigmatization may arise from a ‘crucifixion complex,’ associated with suggestibility and the symptoms of hysteria. The variation in the position of the stigmata across historical cases further supports a mechanism of suggestion, Thurston posited, as the stigmata depend on the environment and suggestion of the idea rather than a divine, unitary cause (this argument resurfaces in Chapter 3). Next, citing the large gender disparity in the appearance of stigmata, Thurston claimed “what predisposes [one] to the reception of the stigmata is not unusual virtue, but some form of nervous susceptibility, more often met with in women than in men,” resurrecting Charcot’s neurological framing of hysteria (p. 13). Thurston also invoked Janet’s concept of the état second: “I venture to lay some stress upon the resemblance between Theresa Neumann’s different phases of consciousness and those cases of multiple personality which recent study of abnormal psychology has made familiar… I can see no reason to suppose that the spoken words uttered by Theresa in the state of exalted repose come from any other source than a dissociated personality of Theresa herself.” Janet’s état second, a medical transcription of the discourse of demonic possession, thus re-emerged again.

**Stigmata and Hysteria in Mid-20th Century Medical Literature**

Medical literature contemporaneous with Pio and Neumann’s life also demonstrated a tendency to frame stigmata in light of hysteria parallel to Gemelli and Thurston. Joseph Klauder’s 1938 article, “Stigmatization,” in the *Archives of Dermatology and Syphililogy*, began, “a revival of study of the stigmas [sic] is pertinent, since there is a present day stigmatist, Thérèse Neumann, of Konnersreuth, Germany. Examination of her stigmas motivated me to write this report.” Klauder reviewed much of the German medical literature on Neumann, noting the debate over whether or
not she exhibited hysterical signs. Klauder rejected the claims that stigmata were simply the result of wounding during ecstatic fits, and instead maintained they represented the pathological force of the mind expressed on the skin. Other relevant factors, he added, could contribute to an understanding of the etiology of stigmata, including, “the various cutaneous lesions produced by suggestion or hypnosis… the peculiar lability of the vasomotor apparatus in psychopathic persons manifested in disorders of the peripheral circulation… the possibility that asceticism and mental training of a religious or nonreligious kind… arouse certain latent powers… [and] somatic representation of psychic events.” His reference to hypnosis and suggestion evokes the work of Babinski regarding hysteria, and the reference to vasomotor dysfunction also recalls Janet’s explanation of Madeleine stigmata, which Klauder also cited. The reference to the somatic representation of psychic events also recalls Janet’s idée fixe and its manifestation in symptoms. While Klauder seemed more open to the genuine possibility of stigmata outside the language of pathology in his reference to latent powers, he still fit firmly within Charcot’s tradition of discrediting the stigmata. Klauder’s comment that Neumann, “did not exploit or talk about herself or her stigmas… she was reticent and showed them reluctantly” is advanced implicitly as evidence Neumann was not simulating the stigmata for attention or fame, which itself reifies the notion that elsewhere, stigmata were simulated to attract attention.

An entry for “Stigmatization” in the Medical Annual, authored by Macdonald Critchley in 1947, similarly probed the link between the mind and the skin. Regarding the cause of stigmata, “only two possibilities arise for discussion – namely that the marks are produced by a process of suggestion, or that they are self-inflicted.” Critchley criticized, however, claims that suggestion certainly produces dermatological symptoms, citing Babinski. Quoting neurologist Jean Lhermitte, Critchley reminded readers that “[h]ysteria is the mother of all dissimulation… for her
to simulate tears or sweats of blood, to produce symbolic lesions, is easy in proportion as she has a clear picture in her mind of what she desires to copy.” Critchley concluded by reintroducing the issue of consciousness in simulation and whether or not hysterics (and by extension, stigmatics) intend to simulate their wounds. It appears that this debate about consciousness, which also develops along the lines of the *idée fixe* (which in hysteria is often unconscious according to Janet), reflected the binary Noel Evans describes between the perverse, deceptive, female hysteric and the strong, innocent (by virtue of their unconscious suggestion) male soldier. Together, these entries also demonstrate that by this moment, ideas linking hysteria and stigmata had entered mainstream medical discourse, such that they were included in prominent medical journals and encyclopedias.

**A Modern and Healthy Catholicism**

In this chapter, I have explored the development of the conception of hysteria following the death of Charcot. The development of hysteria as a psychological disorder, articulated especially by Joseph Babinski and Pierre Janet, strongly influenced later interpretations of stigmata, including those of Padre Pio of Pietrelcina and Therese Neumann. Suggestion, as a mechanism of inferior psychological action operating especially in ‘weak’ minds, emerged in the early 20th century as one of the key frames for understanding stigmata. The *idée fixe*, an often-unconscious obsession that finds its expression in somatic symptoms, also entered into critical discourses of stigmata in this period. As we have seen, identifying stigmata as hysterical continued to function as a discriminant of ‘healthy’ religion, here, along the lines of an intellectual-moral Catholic modernism against a conservative, rural Catholicism. In the next chapter, we turn to contemporary developments in the medical conception of hysteria and its bearings on the
medical framing of stigmata, returning finally to the contemporary case report of ‘malingering’ stigmata introduced at the start of this essay.

Notes

2 Noel Evans, *Fits and Starts*, 53. Noel Evans notes this development occurs not only following Charcot’s death, but also towards the end of his life by the work of the Bernheim school.
3 Noel Evans, *Fits and Starts*, 41-2.
4 Noel Evans, *Fits and Starts*, 53.
6 Noel Evans, *Fits and Starts*, 54
8 Babinski, *Démembrement de l’hystérie traditionnelle*.
13 Babinski and Froment, *Hysteria, or Pithiatism, and Reflex Nervous Disorders in the Neurology of War*, 8. Babinski, however, is explicit in this piece in valuing the contributions of Charcot to the development of hysteria. “The most enthusiastic adherents of the modern school are the first to recognise the value of a part of the work of their predecessors,” 8.
18 Babinski, *Démembrement de l’hystérie traditionnelle*.
19 Babinski, *Démembrement de l’hystérie traditionnelle*.
20 Babinski, *Démembrement de l’hystérie traditionnelle*.
25 Noel Evans, *Fits and Starts*, 58.
29 Noel Evans, *Fits and Starts*, 57.
30 Foucault, *Abnormal*, 207.
35 Janet, *De l’angoisse à l’extase*, 49.
36 Janet, *De l’angoisse à l’extase*, 49.
39 Noel Evans, *fits and starts*, 83.
40 Noel Evans, *fits and starts*, 85.
42 Noel Evans, *fits and starts*, 89-90.
43 Noel Evans, *fits and starts*, 90.
48 Casanova, “Global Catholicism and the Politics of Civil Society.”
49 See Di Giovine, “Making Saints, (Re-)Making Lives,” 180-1 regarding these dynamics in the Italian context; O’Sullivan, *Disruptive Power*, 55-6, 67-8 for the German context.
73 Wilson, *The Bleeding Mind*, 51.
74 Wilson, *The Bleeding Mind*, 53.
76 O’Sullivan, *Disruptive Power*, 122, 228.
Luzzatto, *Padre Pio*, 59. Psittacism was ostensibly a feature of hysteria, where a person would speak meaningless phrases without thought.
Chapter 3: Stigmata in Contemporary Medical Discourse: Hysteria R.I.P. or Hysteria’s Revenge?

In this chapter, we turn to hysteria’s recent history as a psychiatric concept and its bearing on contemporary medical discourses of stigmata. Not unlike some of the stigmata-critical literature of the early 20th century, explored in Chapter 2, Babinski’s suggestion and Janet’s idée fixe remain influential on recent explorations of stigmata as illness. Moreover, the fracturing of hysteria into a myriad of disorders in the second half of the 20th century also markedly alters the trajectory of contemporary medical discourses on stigmata. To better appreciate its articulation in cases of contemporary stigmata, we turn now to this fracturing of hysteria.

Hysteria ‘Asunder’: A Second Dismemberment

Hysteria R.I.P.?

It appears, at first glance, that hysteria has altogether disappeared today. Who would imagine entering a doctor’s office and receiving the official diagnosis of hysteria? Pronouncements by physicians throughout the 70s and 80s declared the end of hysteria,1 twinning with the relegation of “hysterical neurosis” to parentheses following “conversion reaction” in the 1980 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), and its complete elimination in the revised third edition in 1987 (DSM-III-R).2 In a 1978 article entitled “Hysteria Split Asunder,” published in the American Journal of Psychiatry, physicians Steven E. Hyler and Robert L. Spitzer describe the nosological changes in the forthcoming DSM-III: “[t]he proposed draft of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-III) presents a new classification for the diagnosis of disorders that suggest physical illness but in which psychological factors are judged to be of importance in the initiation, exacerbation, or maintenance of the disturbance.”3 While “[i]n [the] DSM-II many of these disorders were
classified among the neuroses (e.g., hysterical, hypochondriacal, neurasthenic) or psychophysiologic disorder,” these conditions “are dissected and redefined according to certain fundamental distinctions” in the hope “that this will result in more reliable and valid diagnostic categories, not merely new theoretical explanations.” The emphasis on mental states of hysteria, promulgated through the work of Babinski, Janet, and Freud (p.35-46) is evident here in the description of hysteria as a neurosis which largely depends on “psychological factors.”

Moreover, Hyler and Spitzer portend a reorganization of hysteria into a series of new diagnoses. This effort recalls, in some small part, Babinski’s ‘dismemberment’ of hysteria. The DSM-III, however, represents not a mutilation of hysteria or its complete disintegration, but rather, a rending into new, self-contained diagnoses. Hysteria, Hyler and Spitzer write, is torn asunder, apportioned into new diagnoses that largely remain in effect today: somatoform, factitious, and histrionic personality disorders. The DSM-III also divides “hysterical neurosis, dissociative type” into psychogenic amnesia, psychogenic fugue, sleepwalking disorder, and multiple personality disorder. Importantly, Janet’s work on dissociation is largely recognized as the basis for the class of dissociative disorders.

The introduction of the DSM-III, combined with Hyler and Spitzer’s comment about “more reliable and valid diagnostic categories, not merely new theoretical explanations,” points towards a critical transformation in American psychiatry: a shift away from Freudian psychoanalysis. Thus the introduction of the DSM-III includes a section entitled “Neurotic Disorders,” which reads, “[t]hroughout the development of DSM-III the omission of the DSM-II diagnostic class of Neuroses has been a matter of great concern to many clinicians, and requires an explanation.” It continues, “Freud used the term [neurosis] both descriptively (to indicate a painful symptom in an individual with intact reality testing) and to indicate the etiological process (unconscious conflict
arousing anxiety and leading to the mal-adaptive use of defensive mechanisms that result in symptom formation.”10 Given this dual and ambiguous sense of the term neurosis, the authors of the DSM-III explicitly frame their use of neurosis as descriptive. This is part of the broader transformation between the DSM-II and III, the latter taking an explicitly atheoretical, descriptive approach to describing mental disorders, rather than attempting to explain etiology of illness, which formerly had taken place using Freudian psychoanalysis.11

Historian Andrew Scull argues that the rejection of psychoanalysis in American psychiatry also twinned with the ascendancy of psychopharmacology, which increasingly couched mental disorders in chemical and physiological terms.12 Scull adds, “[t]he re-biologization of psychiatry has been accompanied by what Mark Micale has wittily called the ‘exorcism’ of hysteria from psychiatry —a systematic effort to root out the last lingering residues of psychiatry’s Freudian misadventure.”13 Hysteria, the disorder once necessary for the legitimacy of the fledgling discipline of psychiatry, a discursive object figured to expand the territory of the field over what was formerly called possession in Catholic discourse (pg.28), itself becomes ‘exorcised.’ Ill-defined and amorphous, hysteria is cast out of psychiatric discourse. Psychiatry, evidenced by the trajectory of hysteria, thus swung from neurology to psychology, and partially back to neurology again. Upon psychiatry’s return to a physiological emphasis, hysteria is exorcized, but it still haunts the field in the resultant diagnoses of somatoform, histrionic, factitious, and dissociative disorders.

Mark Micale echoes this point in his essay, “On The ‘Disappearance’ of Hysteria,” which evaluates the discursive transformations of hysteria through Babinski’s concept of pithiatism, Janet’s concept of neurasthenia, and Freud’s concept of anxiety neurosis, alongside other historical developments.14 Though writing regarding the early 20th century, Micale points towards a similar
conclusion: that the transformation of the classification of mental disorders and their symptoms in the early 20th century produces the ‘disappearance’ of hysteria in the mid-20th century. Moreover, the emergence of psychosomatic medicine, which better describes the endocrine system’s role in linking mental and somatic states, contributes to a delayed reformulation of hysteria. I recall also the Henry Ey’s work on hysterical personality disorder, mentioned in Chapter 2, as a precursor to histrionic personality disorder, which offers one of the many new diagnoses emerging out of hysteria’s demise.

_Hysteria’s Fragments_

Hysteria, we can conclude, has mostly disappeared as an operative psychiatric diagnosis, fractured into various novel diagnoses and shaped by the intellectual contributions of Babinski, Janet, and Freud. The discursive residue of hysteria, however, remains, albeit apportioned off into separate diagnoses, as evidenced by the DSM-III. The dissociative disorders, for example, are marked by “a sudden, temporary alteration in the normally integrative functions of consciousness, identity, or motor behavior,” recalling Janet’s idea of the _état second_ — the estranged personality. It seems the discursive imprint of demonic possession that Foucault describes, where a secondary personality ostensibly coexists with another person, persists in the splintering of one portion of hysteria into dissociative disorders. Furthermore, dissociative disorders — particularly, multiple personality disorder (now dissociative identity disorder) — offer one contemporary interpretation of the ecstasies of stigmata, as we will see later.

Another residue hysteria bequeaths to the disorders that emerge from it is the fundamental link articulated between a mental state and the somatic expression of symptoms. Babinski described this mental process as suggestion, where a patient’s surroundings play a critical role in
the production of hysteria or pithiatism. Thus, he advocated for an isolation of patients from their ostensibly unhealthy surroundings or more care from nurses and physicians not to ‘suggest’ hysterical ideas to patients (p.38). Janet’s subconscious *idée fixe*, an obsessive idea that expresses itself in the symptoms of a hysteric (p.41), offers another mechanism for mind-body interactions in hysteria, as does Freud’s notion of conversion, the manifestation of psychic conflict in the body.¹⁹ The DSM-III’s description of “Conversion Disorder (Hysterical Neurosis)” emphasizes these features: “[t]he predominant disturbance is a loss or alteration in physical functioning,” recalling, in part, the war patients Babinski worked with as well as the hysteric at La Salpêtrière; “a temporal relationship between an environmental stimulus that is apparently related to a psychological conflict or need and the initiation or exacerbation of the symptom,” evoking a Freudian mental conflict and a Babinskian environmental influence; “the symptom enables the individual to avoid some activity” or conversely, “to get support from the environment that otherwise might not be forthcoming,” suggesting Freudian defense mechanisms but also wartime suspicions held by Babinski regarding patients simulating illness; and finally, “the symptom is not under voluntary control,” in line with all three theorists’ conception of hysteria as subconscious.²⁰ I do not claim that these theorists definitively produced each element of this diagnostic scheme. Rather, I intend to point out the discursive continuities between the earlier periods of studying hysteria and the remarkable contiguities in surviving diagnoses, such as conversion disorder. As we will see, the residue hysteria leaves on these diagnoses reproduces a similar contemporary treatment of stigmata as the past. The general notion of conversion disorder, which persists today, is important in stigmata diagnosis, where stigmatics are often thought to unconsciously replicate on their bodies images of crucifixion around them.
Hysteria also survives, perhaps most starkly its gendered associations, in histrionic personality disorder. While the DSM-III notes it shifted the language for this diagnosis from ‘hysterical’ to ‘histrionic,’ given that “[t]he term ‘hysterical’ has many irrelevant historical connotations and suggests a relationship to conversion symptoms,” the association with pathological femininity remains. The disorder, “apparently common” and “diagnosed far more frequently in females than in males,” manifests in “emotional excitability, such as irrational, angry outbursts or tantrums.” Moreover, “[i]ndividuals with this disorder are lively and dramatic and are always drawing attention to themselves… and often act out a role, such as the ‘victim’ or the ‘princess.’” If the DSM-III sought to remove ‘irrelevant historical connotations’ by changing hysterical to histrionic, it certainly did not succeed in eliminating the gendered connotations of hysteria. The DSM-III adds that people with histrionic personality disorder “show little interest in intellectual achievement and careful, analytic thinking, though they are often creative and imaginative.” In men, the disorder is “sometimes associated with a homosexual arousal pattern,” itself having only recently been removed as a disorder in the DSM in 1973. Thus, histrionic personality disorder retains all the classic links between hysteria and a pathological femininity: complete irrationality, excessive emotionality, and a desire for attention. In men, this pathological femininity is apparently expressed as homosexuality. The words of French psychiatrist Charles Briquet, who laid the foundation for Charcot’s re-interpretation of hysteria, still ring true in the 1980 construction of histrionic personality disorder: “Woman is made for feeling, and feeling is almost hysteria.” Moreover, while the DSM-III also sought to clarify a difference between conversion disorder and histrionic personality disorder by changing the name to ‘histrionic,’ “histrionic traits are common” in conversion disorder. The model, then, of a uniquely female
susceptibility to conversion disorder, which takes on many of the somatic features of the classical notion of hysteria, still remained in 1980.

Finally, the sense of hysteria as intentionally simulated by a deceptive woman persists, surviving in factitious disorder and the notion of malingering. Both represent voluntary symptom production and differ only in motive: “[i]n Malingering, the ‘patient’ is also in voluntary control of the symptoms, but it is for a goal that is obviously recognizable with a knowledge of the environmental circumstances… [i]n contrast, in a Factitious Disorder there is no apparent goal other than to assume the patient role.” 27 The 2016 case report of a stigmata first introduced in this paper (p. 5) suggests malingering as the cause of stigmata, claiming a desire for attention or profit motivated the production of symptoms. We return to that example at the end of this chapter, but we see again Noel Evan’s simulation/suggestion distinction introduced in Chapter 2 (p. 44), that of hysterical women and suggested war veterans. The intentionally simulated symptoms fall under factitious disorder and malingering; the unintentionally suggested symptoms are classed as conversion disorder. The former imply an intentional duplicity on the part of the patients, while the latter inspires a more paternalistic, pitying approach — the (often-histrionic) patient needs psychiatric counter-suggestion, hypnosis, or removal from their surroundings. Both logics, of course, are deeply entwined with patriarchal constructions of the ideal, normal woman on one hand, and the pathological, abnormal woman on the other.

Having tracked the major transformation in medical thinking about hysteria in the second half of the 20th century — particularly, hysteria’s ‘dismemberment’ into myriad disorders — we turn now to two sources that interpret stigmata using these fragments of hysteria. The first is Ian Wilson’s 1988 book *The Bleeding Mind*, a key, oft-cited synthesis of historical and medical inquiries into the phenomenon of stigmata. The second is a selection of articles from contemporary
medical literature on stigmata from the 2010s. Together, these sources reveal the haunting of hysteria in contemporary medical categories applied to Franciscan stigmata. While they reveal a dynamic similar to that of previous centuries in the use of medical and psychiatric discourse to police particular religious expressions, they may also, at times, represent, new modes of defending stigmata and mystical, bodily expressions of Catholicism.

**Hysteria’s Revenge in Wilson’s *The Bleeding Mind***

Ian Wilson’s 1988 *The Bleeding Mind* recalls, in many ways, the projects of Imbert-Gourbeyre of the 19th century and Herbert Thurston in the early 20th century. Namely, Wilson provides a historical account of stigmata and their manifestations across centuries. Thus he contextualizes stigmatizations from St. Francis of Assisi, Padre Pio, Therese Neumann, up to the more recent English stigmatic, Jane Hunt. Wilson appears much more equivocal on the subject than Thurston and Imbert-Gourbeyre, and he perhaps is closest to Agostino Gemelli in his assessment of stigmata: “[a] saint – such as St Francis was very justifiably acclaimed – may be a stigmatic, but a stigmatic is by no means necessarily a saint,” especially, as he notes earlier, that “many stigmatics have been notable more for their neuroses than their sanctity.”

“Stigmata,” he claims, “whatever their origination, deserve to be taken seriously. If they are as spontaneous and particularised as they seem, they are one of the most baffling and intriguing of medical and scientific mysteries. If they are as far-reaching in their effects as we have shown, they demand a fundamental reappraisal of our understanding of the laws of nature.” Finally, he adds, “[m]ost important of all, if the inner power that seems to generate them truly exists and can be better understood and harnessed, they perhaps promise opportunities for the cure of diseases that so far defeated the best efforts of modern medicine.”

This final point wagers the value of stigmata not necessarily in their
ineffability or expression of a divine grace, but in their potential to be “harnessed” for medical ends.

While Wilson’s speculations about the veracity of stigmata are useful in understanding his broader argument, it is his particular references to hysteria and the disorders that emerge from it that are of interest here. Broadly, Wilson suggests that the physical illnesses of stigmatics St Maria Maddalena de’ Pazzi, Domenica Lazzari, Therese Neumann, and others “could have been what psychiatrists term ‘hysterical.’” Moreover, he adds, Soeur Jeanne des Anges’ famous possession by a demon could also be classified as ‘hysterical.’ In doing so, he unwittingly reforges the association between hysteria, possession, convulsion, and stigmata described in Chapter 1 (p. 26-9). Warning against environmental forces that give rise to hysteria, he claims, “[g]iven that hysteria can be as communicable to others as any biological infection, it is easy to understand how in the thirteenth century the Dominican convent of Adelshausen at Freiburg-im-Breisgau produced no less than six stigmatics.” This again recalls Babinski’s warning about the hysteria contagion in hospital wards via suggestion. Wilson, however, somewhat recants this argument of stigmatics as hysterical, when he adds that describing “stigmatics as hysterical, however justifiable, does little more than attach another label to them. We still need to understand what is happening. This leads in turn to the question of whether there is any recognised psychiatric condition in which similar features can be observed.” Wilson thus lands on multiple personality disorder (now dissociative identity disorder) as a contender for explaining the etiology of stigmata.

One feature common to most stigmatics that Wilson identifies with multiple personality disorder is a precipitating episode of “severe stress,” evoking Charcot’s identification of trauma with hysteria (p. 13). Somatic symptoms of rashes in patients with multiple personality disorder appear akin to stigmata, he claims, and distinct mental states in stigmatics could be seen as unique
‘personalities,’ as in the case of Therese Neumann and other stigmatics. The latter point also evokes Janet’s analysis of the stigmatic Madeleine, where he describes the distinct attitudes she experiences.37 “If for ‘multiple personality’ we substitute the older term ‘possession,’ then it is evident that stigmatic after stigmatic has experienced this in some form or another,” Wilson writes.38 On some level, then, Wilson recognizes the centrality of possession as a historical concept in the understanding of stigmata, and like Charcot, seeks to elevate new psychiatric understandings over superstitious ones. Even Padre Pio’s experiences of possession as a child Wilson finds as evidence towards the diagnosis of multiple personality disorder.39

All of this conjecture, at first glance, brings Wilson no closer to the central problem of stigmata: how somatic manifestations emerge from mental pathologies. Wilson, however, contends that another link between multiple personality disorder and stigmata will prove an underlying unity between the two. Hypnosis, Wilson argues, represents both a cure for multiple personality disorder and a mode of somatic symptoms seen in St. Francis and Padre Pio (Wilson mentions hypnosis may induce anaesthesia, echoing Charcot’s stigmata diaboli).40 If hypnosis acts equally on a dissociative disorder and the somatic symptoms of stigmatics, perhaps, he wagers, there is a common mechanism that underlies them. Further, Wilson claims, there are some cases where stigmata have been induced or cured by hypnosis.41 Wilson points to a series of experiments conducted by psychiatrist Alfred Lechler, who managed to reproduce stigmata in a patient via hypnosis, as evidence of this link.42 While of course, not all stigmatics could have been literally hypnotized, “[they seem] to be… in a mental and physical state effectively indistinguishable from hypnosis” whilst bleeding.43 Furthermore, the visual images upon which stigmatics meditated could act via quasi-suggestion found in hypnosis. Wilson uses examples of stigmatics meditating on an image or idea as evidence of this suggestion leading to stigmatization: “all the meditations
on the more lurid aspects of Jesus’s Passion on the part of St Francis of Assisi… [or] the bloody crucifix before which Padre Pio worshipped.”⁴⁴ To Wilson, “the flesh can and does change according to visual or verbal inputs… willed upon the flesh by something beyond the normal consciousness of the stigmatic, without there being any justification for regarding that something as divine.”⁴⁵ Wilson also emphasizes “the extraordinary precision of the mechanism’s conformity to the visualisations that triggered it. Stigmata have been precisely positioned to conform with the wounds of a stigmatic’s favourite cross.”⁴⁶ Babinski’s work on unconscious environmental suggestion looms large here, as does Janet’s idée fixe — an unconscious, obsessive idea — as well as Freud’s work on the somatic expression of mental states. The references to hypnosis, too, hearken back to the use of hypnotism by Charcot and his colleagues to induce hysterical symptoms (p.36).

The final argument Wilson makes, of relevance here, is with respect to evolutionary biology. Noting the developmental link between the nervous system and the skin in humans, both derived from the ectoderm and apparently evinced in the case of stigmata, Wilson speculates about cases of humans with webbed feet or reptilian skin reportedly being cured with hypnosis.⁴⁷ Wilson asks “what about circumstances of stress, when perhaps the whole species is threatened by some terrifying, hysteria-inducing newcomer, or other danger from without? Could there then be triggered some inner power, or underlying survival mechanism which permits the development of a new characteristic to tip the scale in favour of survival?” He answers himself, writing “it seems to me that the stigmatic/multiple personality mechanism just might offer a plausible key: an inner mechanism, activating only in circumstances of stress, capable of significant changes to the outward form according to whatever may be visualised.”⁴⁸ He suggests this mechanism may underly butterfly evolution and stick and leaf insects resembling their surroundings. Despite the
wild and largely unfounded speculation about evolutionary biology, Wilson appears to unwittingly resurrect the conceptions of hysteria from Charcot’s time. The notion of hysteria as something innate to women as a result of being less-evolved than men, and the sense of hysteria as being a degeneration and return to primitiveness (emerging in France at a time of colonial expansion and the production of racialized Others) (p.22-3), seems partially resurrected here by Wilson in drawing a link between a primitive mechanism from an evolutionary past that underlies stigmata. Wilson’s claim that stigmatics have a “characteristic simplistic quality of their mentality” seems to echo consonant claims about an inherent irrationality (and thus inferiority) of stigmatics, who are predominantly women.49

Wilson, in providing a useful historical survey of various cases of stigmata, uses the diagnosis of hysteria, or its proxy in multiple personality disorder, to posit an etiology of stigmata. While he does not discredit their genuine possibility in the sharp language of Charcot and his colleagues, he does point in the same direction: towards mental inferiority (of women) and traumatic experiences as a potential cause. Moreover, he draws implicitly on the logics of Babinski, Janet, and Freud to articulate a link between a stigmatic’s environments and the development of their wounds. His speculation about the predominance of rural stigmatics suggests also an environment-illness relationship. He asks rhetorically, “[a]re rustic populations more credulous? Or is it that city life, with its materialism and world weariness, dulls the faculty that becomes activated in the stigmatic?”50 Here, Wilson produces two possibilities for explaining the preponderance of rural stigmatics — either urban life separates people from their primitive, natural, ‘premodern’ capacities that ostensibly flourish in rural communities, or ‘rustic’ populations are more gullible and perhaps, superstitious. In the context of criticisms of Pio’s pie donne, Neumann’s family, and those surrounding Lateau and Matarelli, this appears to be part of
a broader current of positioning stigmata as a superstitious, ‘premodern,’ primitive, religious expression as against urban, modern, and intellectual expressions. *The Bleeding Mind*, then, pathologizes stigmata by drawing on discursive elements borrowed from Charcot, Gemelli, Thurston, and others.

**Hysterical Stigmata in Contemporary Medical Literature**

Articles on the etiology of stigmata have also been well-represented in more formal avenues of medical discourse throughout the second half of the 20th century. Generally, they revolve around hysteria or the disorders that emerged from it as a possible cause, though some also offer viral explanations for the illness (herpes simplex virus was identified as a possibility pathological agent) or models for how mental states contribute to skin pathology. F.A. Whitlock and J.V. Hynes, in a 1978 historical and literature review of stigmata for *Psychological Medicine*, provide a sweeping survey of these hypotheses. They make similar claims to Wilson regarding the parallels between a stigmatic’s mental conception of the Crucifix and stigmata location, writing “it does appear that stigmatists’ own preformed notions of the details of the Crucifixion were a very powerful influence on the sites and forms of the wounds they exhibited.”

This articulation of the influence of the mind on the body, as I have mentioned, echoes the work of Babinski, Janet, and Freud.

While recognizing the significance of ‘hysteria’ as a diagnosis largely associated with stigmata, they write, again like Wilson, “calling a phenomenon hysterical is no explanation but merely replacing one diagnostic label with another. In fact, the only ‘explanation’ is conscious or unconscious simulation.” The ejection or ‘exorcism,’ as Micale calls it, of hysteria is apparently underway here, only a couple years before the publication of the DSM-III in 1980. Whitlock and Hynes rail against an exchange of labels without an explanation of pathological mechanism, but
this is precisely what occurs in the years that follow. As I have described, the various disorders that emerge when hysteria is ‘split asunder’ in 1980 retain the residues and associations of hysteria past. Moreover, the atheoretical position that the DSM takes offers little etiological explanation of stigmata — the DSM III is descriptive and diagnostic, rather than explanatory. Later attempts to make sense of stigmata in medical literature often replace hysteria with a disease proxy, discounting the wounds without offering much insight while also discarding hysteria, “a term which implies scorn and belief.”\textsuperscript{55} The material difference between labelling a stigmatic hysterical or labelling them with histrionic personality disorder seems altogether small. If anything, the elision of hysteria in favour of the diseases it fractured into obscures their problematic, gendered history.

Two other claims made by Whitlock and Hynes are worth exploring here. First, they cite Herbert Thurston’s reservation about spiritual directors, whom Thurston saw as potentially motivating or inciting stigmata, consciously or unconsciously. Echoing Thurston, they claim “[i]ndeed, it is often difficult for the detached observer to refrain from regarding some of these sincerely motivated priests as aiders and abettors of the phenomenon [stigmata] and the theory of their miraculous origin.”\textsuperscript{56} Again an almost Foucauldian acknowledgment of the technique of confession and spiritual direction materializes, where the investment in the flesh ostensibly produces convulsions and stigmata (p.26). Of course, this framing also positions spiritual directors as pathological figures, ones that induce illness. Second, Whitlock and Hynes’ article evinces the shift towards a biological perspective on illness. As if Charcot was speaking through them, they write “if there is a psychophysiology of the skin lesions, one is surely justified in assuming that trance states, raptures, ecstasies, etc. must have some basis in brain functions.”\textsuperscript{57} While mental and emotional states remain important in their survey, the gesture toward ‘brain functions’ clearly
evokes a neurobiological level of analysis, of neurotransmitters and electrochemical signals. This also entails a shift to the cellular level — references to the immune system and cells and viral pathology abound — part of the arc of psychiatry back towards biology.

They conclude by returning to the case of ‘Mrs H.’, a stigmatic patient they had come across as part of their medical practice:

Everyone who had any dealings with Mrs H. was satisfied that her bleeding was not due to artefact, **but there can be no doubt that she showed obvious psychological abnormalities, so that even the officiating priest, when she cried aloud during a service, asked the congregation to disregard her on account of her mental state.** Possibly, in a less secular age than ours, more attention would have been given to her psychological and spiritual needs and the phenomena she exhibited would have fitted more readily into the accepted tradition of the times. **As is so often the case, it was the ordinary people who came to look and wonder and to take away as treasured relics the handkerchiefs stained with Mrs H.'s tears; and understandably, official attitudes were less enthusiastic about the whole business** (emphasis added).

Here, the priest aligns with the physician — in their official capacities, structured by their unique claims to knowledge not accessible to “the ordinary people,” they may discern between genuinely miraculous happenings and their counterfeits. The reference to a “less secular age” of the past further evinces an implicit secularization thesis that life ‘today’ is more secular — that is, less ‘religious’ — than the past, where such stigmata would “have fitted more readily into the accepted tradition.” Of course, this ignores the long history of the Catholic Church (in many ways, the arbiter of Catholic ‘tradition’) closely controlling manifestations of stigmata in ‘the past’ and thus hardly fitting in to tradition, as well as significant sociological debate over the actual disappearance of ‘religion.’ Nonetheless, they proceed in a quasi-Charcotian vein, seeking to clear away the religious superstition clouding medical diagnoses to make way for a secular, modern medicine.

These discursive features appear also in more recent medical literature on stigmata. A 2018 review of medical literature on stigmata by Kechichian et al., published in the *International Journal of Dermatology*, offers a survey of the historical features of stigmata and their
dermatological and psychiatric presentations. Their review reveals the abiding salience of hysteria for contemporary understandings of stigmata — they make reference to hypnosis-induced stigmata and the link between the skin and the nervous system (not unlike Wilson, p.70); psychosomatic disorders (including psychogenic purpura or auto-erythrocyte sensitization); the importance of trauma in etiology; the presence of ‘histrionic’ personality traits and patient suggestibility; the possibility of simulation (or malingering) or factitious disorder; conversion disorder (which they explicitly link to the history of hysteria, and before it, demonic possession); and the presence of dissociation and depersonalization (albeit only tangentially). Their review of potential stigmata etiologies, which reads almost as a list of disorders that hysteria has fractured into, points towards the continued relevance of hysteria in understanding stigmata. Certainly, they avoid the explicit diagnosis of ‘hysteria’ in their review. Regardless, recent historical discourses of hysteria clearly animate their project. The nature of a literature review makes this most evident — by bringing together all the recent medical literature on stigmata, they unwittingly demonstrate that despite the various diagnoses attached to stigmata today, most directly descend from hysteria, and as I have shown, carry its historical associations. Kechichian et al. even offer a diagnostic algorithm for cases of stigmata (Figure 3), which includes:

- a complete history taking with a psychosocial assessment and an identification of potential physical, emotional, psychological, and social triggers. The episodes must be clearly described (onset, duration, frequency, attenuating factors, treatment taken, and the presence of witnesses). Then, the extravasated liquid must be assessed (if possible) to detect the presence of red blood cells. According to the affected site, the patient should be referred to an ear-nose-throat specialist in the case of nasal or oral mucosal bleeding, an ophthalmologist in the case of hemolacria, and a gynecologist when an extragenital menstruation is suspected (occurring at regular intervals). Biopsies should be taken early in the onset of symptoms. A psychiatric consult is usually warranted. If all the workup is negative and isolated hematidrosis is suspected, beta-blockers and anxiolytics can be prescribed to control the symptoms.

Most striking here is perhaps the systematization of response to stigmata, of the depth and breadth of examination, the reliance on various professional expertises (ear-nose-throat, ophthalmologist,
gynecologist, pathology), and the treatment option of anxiolytic drugs. The techniques of examination, of a “complete history taking” evokes, at least in structure, the techniques of confession from which psychiatry descends. Further, the recording of witnesses seems to hint towards the possibility of performance or the need for an external, objective record of events to counter the deceptive patient. Finally, the analysis of pathology via a biopsy evinces a new level of penetration of examination, down to the interstitial spaces between cells, an even more granular intrusion of medical discourse into stigmata.

This turn to the cellular level in the medical assessment of stigmata is not unique to Kechichian et al. The technique originates with Manonukul et al.’s 2008 case report in the American Journal of Dermatopathology, where the authors use biopsy and “[h]istopathological examination and immunoperoxidase study and electron microscopic study” to evaluate a case of hematidrosis, or bloody sweat. This shift towards the cellular and molecular level is also evinced in a retrospective project that, in some ways, echoes the work at La Salpêtrière, and in others, diverges from it. Burkhard Rolf, Birgit Bayer, and Katja Anslinger’s investigation of Therese Neumann’s compresses, which covered the stigmata on her hands, using contemporary biotechnology such as

Figure 3 Stigmata diagnostic algorithm, Kechichian et al. 2018
polymerase chain reaction techniques, is perhaps the starkest example of the incursion of medical
discourse into stigmata. Published in the *International Journal of Legal Medicine*, their analysis
of the mitochondrial DNA present on the compresses and letters sent by Neumann proved the
blood on the compresses belonged to one woman, thus dispelling rumours that the blood of family
members or animals were used to simulate the appearance of bleeding. Notably this report was
commissioned by the diocese where Neumann died, as part of an investigation into her sanctity.
This retrospective project thus aimed to corroborate, rather than discredit, stigmata with cutting
edge medical science, recalling Imbert-Gourbeyre’s defense of stigmata using his medical training.

Returning finally, then, to the 2016 stigmata case report by Bonamonte et al. that is this
paper’s point of departure, the references to hysteria and hysterical personalities, as well as the
description of the stigmata as ‘malingering’ for attention, are put into context. While the authors
posit that generally, stigmata result from “unconscious self-harm during hysteria, autosuggestion,
and hypnotism…. associated with ‘mystical delirium,’” they warn the reader to “always consider
the possibility that they could be self-inflicted for illegal and/or profit purposes.” The image of
the simulating, attention-seeking hysteric fuses here with the degenerate, stigmatic criminal (p.22-3).
The stigmatic usually has a hysterical personality and thus is discredited from the outset for an
excessive, pathological femininity, one that quite literally erupts from the body in sores.
Bonamonte et al., in the retrospective tradition of physicians writing on stigmata before them,
make reference to stigmatics-past as part of their analysis: Louise Lateau, Therese Neumann, and
Padre Pio are all mentioned, and though not explicitly deemed hysterical, their inclusion implies
that they, too, are hysterical. Confidently, Bonamonte et al. conclude, “religious stigmata are
progressively shifting from medieval mysteries to distinct psychiatric and psychosomatic
disorders,” heralding, like Whitlock and Hynes, a secular age, one emptied of the superstitions of
the past with the progressive march of medicine. Moreover, they note (correctly) that the Catholic Church “does not allow for mandatory association between stigmata and sanctity, declining the conventional belief that stigmata represent a supernatural event, and are granted by God as a sign of piety,” again reminding readers of a hierarchy of mysticism, of personal virtue over supernatural graces (p.52-3).

The interest of Bonamonte et al. in stigmata is not anti-Religion, in the capital ‘R’ sense. They do not seek directly to challenge the existence of God or the authority of the Catholic Church. Conversely, they are vindicated by its authority, almost given permission to pathologize stigmata into an ‘unhealthy’ expression of Catholicism. This dynamic animates Charcot and his colleague’s work at La Salpêtrière, as well as Thurston and Gemelli’s criticisms of Pio and Neumann. The problem these critics identify is not ‘Religion’ or even Catholicism, but a faulty expression of it — variously, a ‘premodern’ Catholicism allied with the French monarchy against a secular Republic, a conservative Catholicism that resists modernization efforts, a Catholicism that is (predominantly) feminine, ineffable, and bodily. These expressions of Catholicism are not simply untenable politically, theologically, or socially, but become unhealthy, pathological on the level of psychology or biology. These expressions are illness disguised as stigmata. Foucault’s claim about the fusing of the abnormal in psychiatry — the linking of the uncommon or marginal with the pathological — rings true in this marginalizing of stigmata.

**Stigmata: Still Hysterical**

As I have shown, despite the official fracturing of hysteria in 1980 with the DSM-III, historical conceptions of hysteria continue to underwrite the various diagnoses that emerged following hysteria’s demise, such as dissociative identity disorder, conversion disorder, histrionic personality
disorder, and factitious disorder. Moreover, the hysteria-stigmata link remains in Wilson’s *The Bleeding Mind*, where Wilson posits stigmata as a symptom of multiple personality disorder, and in the medical literature, where ideas of suggestion remain prominent. Contemporary case reports of stigmata thus exist within a tradition where stigmata is associated with hysteria. As I have shown, these reports also evince assumptions about the inevitability of secularization and the foregone conclusion stigmata belong to an era past. These represent implicit attempts to reify the boundaries of ‘healthy,’ modern religious expressions, and ‘sick,’ anachronistic ones. To a further exploration of these dynamics we now turn.

**Notes**

3 Steven E. Hyler and Robert L. Spitzer, “Hysteria Split Asunder,” *American Journal of Psychiatry* 135, no. 12 (December 1978): 1500. Spitzer was also the Chairperson overseeing the organizing of the DSM-III.
4 Hyler and Spitzer, “Hysteria Split Asunder,” 1500.
5 Given the scope of this paper, I did not provide a summary of Freud’s conception of hysteria as it was not as immediately relevant as Babinski and Janet’s work. Future genealogies of stigmata and hysteria should more materially include the bearing of Freud’s thought on stigmata.
9 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed. 9.
20 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed, 247.
22 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed, 313.
23 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed, 313.
26 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed, 244.
29 Wilson, *The Bleeding Mind*, 83.
30 Wilson, *The Bleeding Mind*, 129.
31 Wilson, *The Bleeding Mind*, 130.
32 Wilson, *The Bleeding Mind*, 83.
33 Foucault uses Soeur Jeanne des Anges as an example in his argument about demonic possession as an effect of the technique of confession. *Abnormal*, 210-2.
34 Wilson, *The Bleeding Mind*, 83.
35 Wilson, *The Bleeding Mind*, 83.
36 Wilson, *The Bleeding Mind*, 84.
37 Wilson, *The Bleeding Mind*, 87.
38 Wilson, *The Bleeding Mind*, 87.
40 Wilson, *The Bleeding Mind*, 89-90.
41 Wilson, *The Bleeding Mind*, 91.
42 Wilson, *The Bleeding Mind*, 94-5.
43 Wilson, *The Bleeding Mind*, 97.
46 Wilson, *The Bleeding Mind*, 126.
47 Wilson, *The Bleeding Mind*, 126.
48 Wilson, *The Bleeding Mind*, 127-8. See also Scull 336-7 for a discussion of Canadian historian Edward Shorter, who makes a similar argument about a core of hysteria expressed in culturally specific ways.
49 Wilson, *The Bleeding Mind*, 122.
50 Wilson, *The Bleeding Mind*, 128.
52 See Whitlock and Hynes, “Religious Stigmatization.” See also Ratnoff and Agle, “Psychogenic Purpura,” on autoerythrocyte sensitization.
59 See for example, the classic article, Rodney Stark, “Secularization, RIP,” *Sociology of Religion* 60, no. 3 (Autumn 1999): 249–73.


65 Rolf, Bayer, and Anslinger, “Wonder or Fake,” 105. On another example of the uses of medical discourse to defend earlier stigmata, see Alberto Festa, “Stigmate,” Padre Pio La Grande Luce, accessed October 24, 2019, http://www.padrepiolagrandeluce.it/stigmate.html. This is a digital archive of Padre Pio’s medical records, curated by the great-grandson of Dr. Giorgio Festa, ostensible medical ‘proof’ that Pio’s stigmata were genuine.

66 It is worthwhile noting that the diagnosis of histrionic personality disorder makes reference both to anorexia and masochism as common features of the disorder. Anorexia and masochism map closely to many stigmatic’s claims of surviving only on communion wafers (called ‘holy anorexia’) and a tendency to desire suffering. This perhaps reveals another reason histrionic personality disorder is regularly associated with stigmata.


70 Bonamonte et al., “Religious Stigmata as Malingering Artifact,” 3.
Conclusion

The association of hysteria with stigmata, as I have shown, was no historical accident. Rather, stigmata first became hysterical at La Salpêtrière under the tenure of Jean Martin Charcot and his colleagues, who sought a new, rigorous definition of hysteria. In an effort to secure the legitimacy of psychiatry, Charcot and his colleagues undertook a project of discrediting various historical saints and mystics with psychiatric diagnoses. Stigmata, borne by St. Francis of Assisi as well as the contemporary mystic Louise Lateau, became one focus of this retrospective, medical gaze.

With the turn of the century and the death of Charcot, his students played a key role in transforming the diagnosis of hysteria once more. Together, Joseph Babinski’s notion of suggestion and Janet’s ideas of the idée fixe and the état second, shifted hysteria from a physiological, hereditary disease to a psychological one. The influence of these ideas is apparent in the criticisms of Padre Pio and Therese Neumann. Importantly, these criticisms come not just from secularist physicians (as in the previous century), but also Catholic writers articulating a new direction for the Church. Those espousing a modernist, rational conception of Catholicism had no issue discarding superstitious and distasteful elements, from inappropriate devotion to saints to the supernatural stigmata.

With the dismemberment of hysteria in 1980, hysteria splintered apart into an array of psychiatric disorders, including dissociative identity disorders, conversion disorder, histrionic personality disorder, and factitious disorder, retaining the myriad associations ascribed to hysteria. The link between stigmata and hysteria thus persisted, albeit under different names, in various contemporary sources and was increasingly explored at the cellular level. Here, stigmata remain cast as a premodern, superstitious phenomenon destined to disappear with the inevitable triumph of a scientific, secular future.
Just as convulsions, as Foucault suggests, were transcribed into psychiatric discourse at the behest of the Catholic Church in an attempt to corral an individual’s resistance to techniques of confession, so, too, has stigmata slowly been translated into psychiatric and medical discourse. Stigmata, many physicians seem to agree, emerge from a mechanism of suggestion, itself analogous to the investment in the flesh by spiritual directors. Perhaps then, similar to the threat that convulsions posed to the authority of confession, stigmata present a threat to the authority of the Church. The investment in the flesh and focused meditation on Christ’s crucifixion, both physicians and Catholic writers seem to agree, lead to the eruption of stigmata on the skin. Parallel to the challenge to the direction of the confessor that convulsions present, stigmata represent a personal relationship with Christ, evinced in the facsimile of his wounds. Coupled with the clear appeal of stigmata to Catholics across the world, stigmata represent a challenge to the institutionalized power of the Catholic Church.

The transference of stigmata to medical discourse, on many levels, emerges as a strategy akin to what Foucault calls the ‘great anticonvulsives (p.28): the Church bulwarks itself from criticism by employing medical investigators to see if stigmata are feigned or not (for example, the investigation into Neumann’s compresses, p.76-7), but maintains its authority in determining the authenticity of miracles or graces. The expulsion of stigmata into medical discourse protects the authority of the Church while also expanding the territory over which medicine may operate. Furthermore the Catholic technology of confession, the investment in the body, of examining feelings and thoughts has perhaps only persisted and extended in its scope and penetration of the flesh — clinical investigations now also include the molecular and the biochemical as new levels for discursive intervention.
In the final analysis, the association of hysteria with stigmata is about power: power over the stigmatic body (generally a woman’s body), and power over the ‘sick’ expressions of ‘religion’ (and thus the inverse, the ‘healthy’ expressions of religion). In *Between Heaven and Earth*, Robert Orsi describes how European religious studies helped construct the discourse of ‘religion’ and ‘religions’ to exert power over colonized peoples.¹ Orsi notes that of the many moral distinctions religious scholars made about ‘religion,’ almost all function to the effect of deeming the ‘religion’ of the Other as ‘bad,’ while maintain the ‘religion’ of the classifier ‘good.’² Folded into this distinction, he maintains, is also a distinction between pathological and healthy religion, between ‘primitive’ and modern practices.³ This classification scheme, in my view and Orsi’s, is certainly not limited to religious studies, but extends into various other discourses, including medicine.⁴ In my view, recurrent criticisms of stigmata as hysterical present an example of how ‘religious’ expressions of the Other became deemed sick as a proxy for ‘bad.’

That stigmata are so widely and persistently detailed in the medical literature represents the first order of pathologizing particular ‘religions’ — seeking to explain stigmata according to a medical paradigm immediately reads pathology into them. The specific association of hysteria with stigmata offers a particular character of pathologizing certain ‘religions,’ borne out of an anticlerical movement amongst French psychiatrists and intimately related to the expansion of psychiatric knowledge over poor women at La Salpêtrière. Of course, pathology and ‘religion’ may coexist — I am not claiming that one may not orient themselves within a discourse of religion and also experience mental illness. Instead, I am trying to gesture towards how deeming a certain ‘religion’ or ‘religious’ practice as sick is not an innocent move, but one enmeshed with political intentions. This strategic move — of deeming a particular expression of ‘religion’ as sick — is by no means limited to the official arbiters of medical discourse, namely physicians. As I have shown,
actors who also identify within a particular ‘religion’ may borrow such language to pathologize certain practices they find untenable, as in the case of Agostino Gemelli and Herbert Thurston.

This paper, then, intervenes to surface the power dynamics of pathologizing religion. Not explored here, but relevant also to this discussion, is how some expressions of ‘religion’ or ‘spirituality’ receive the identification of ‘healthy.’ One must look no further than the *Journal of Religion and Health* to see how particular ‘religious’ practices are framed as resources for well-being. Prayer, fasting, meditation, and yoga, for example, are lauded and removed from their cultural contexts and framed as neutral, health interventions. The discourse of ‘religion’ often interfaces with the discourse of medicine and psychiatry, the latter functioning as Foucault claims as a discriminant of healthy/unhealthy or normal/abnormal.

The vast investment in studying stigmata over the past two centuries, in light of the diagnosis of hysteria, is thus not a neutral nor objective endeavour. It is structured by medical and psychiatric discourses, but also empowered Catholic discourses over those considered marginal. The operation of power, in the linking of stigmata to hysteria in an attempt to pathologize it, seeks to reproduce the domination of rationality over irrationality, masculinity over femininity, intellectual or private ‘religion’ over somatic and spectacular expression.

Further, these developments should not be seen as separate from the emergence of modernity and secular modern states, but rather, in tandem with them. The first chapter of this paper draws attention to the political function of stigmata in legitimating certain political orders (conservative Catholic monarchists over republicans) and the response of psychiatrists by pathologizing them. The push towards Catholic modernism in the mid-20th century, which entailed increasing skepticism of the cult of saints and supernatural phenomena, raised questions about the construction of a ‘modern,’ global Catholicism and entailed a disavowal of stigmata by many. The
self-presentation of a ‘modern’ or ‘secular’ age from which stigmata can be properly rescued, compared to the superstitious and ‘medieval’ understandings of the past in contemporary medical literature, reifies stigmata as an object upon which modernity may constantly be reconstituted over the ‘premodern’ and the ‘irrational.’ This endeavour relies on empowered medical and also religious actors, to delimit the bounds of healthy and normal religion that is compatible with the modern order. Stigmata thus become useful in maintaining the construction of Western modernity Venn and Featherstone describe, of the inexorable progress of medicine and its triumph over the (religious) past. The historical process whereby stigmata became associated with hysteria, once interrogated, reveals much more about those classifying stigmata as hysterical and ‘sick’ than the mysterious phenomenon itself.

Notes

2 Orsi, Between Heaven and Earth, 183.
4 See Orsi, Between Heaven and Earth, 187 on the role of American psychologists in maintain a sick/healthy distinction in the expressions of ‘religion.’
5 I think especially of Galen Watts, “‘Of’ and ‘For’: Studying Spirituality and the Problems Therein,” Journal for the Study of Spirituality 7, no. 1 (2017): 64–71, where Watts articulates the frequent study ‘for’ spirituality in terms of its use, including as a health intervention.
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