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Conversion Reactions

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The term *conversion reactions* (*conversion disorders*) refers to any condition characterized primarily by physical symptoms of loss or disorder of a bodily function for which no evidence of an organic basis is found and for which there is evidence to support psychogenic etiology. Conversion reactions involve functions subserved by the special senses and the somatosensory nervous system. Conversion symptoms may include blindness, deafness, weakness or paralysis, tremor, and disorders of sensation such as numbness, tingling, and pain. Objective signs, which one would expect to accompany organically produced disorder of function, are absent.

Conversion reactions are distinguished from psychophysiologic reactions by the fact that symptoms of the latter are related to certain physiologic alterations which in turn are caused, at least partially, by emotional factors. In migraine headache, for example, the pain itself is probably related to vasodilatation, which in turn is part of a physiologic sequence thought to be triggered in most cases by emotional factors. Thus, the pain of a migraine attack would be considered not a conversion reaction but rather the symptomatic manifestation of a psychophysiologic vascular reaction, and the temporal or occipital pain of the common tension headache, secondary to prolonged muscular tension, would be considered part of a psychophysiologic musculoskeletal reaction. Conversely, a headache would be considered conversion if the pain, as described by the patient, obviously is not related to any known physiologic mechanism, eg, pain described as feeling as if it were due to a nail being driven into the skull. Since the subjective sensation, such as pain, of conversion reaction has no peripheral physiologic basis, it may be considered a type of hallucination. A patient may have psychophysiologic and conversion symptoms at the same time or at different times.

Briquet's syndrome refers to a chronic or recurrent neurotic condition that occurs predominantly in females, begins often in adolescence, and is characterized by a variety of conversion and psychophysiologic symptoms. Patients with Briquet's syndrome typically have complicated medical histories, are sometimes under the care of several specialists, each of whom has prescribed medication, and have often undergone a variety of surgical procedures. These patients may have periods of overt anxiety or depression.

BASIC CONCEPTS

The term *conversion* was first used by Freud in 1894 to refer to a process in which an "unbearable idea is rendered innocuous by the quantity of excitation attached to it being transmuted to some bodily form of expression" (1). Later, Freud regarded this quantity of excitation as energy derived from instinctual drive, particularly sexual drive or

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libido. In essence, Freud hypothesized that the patient represses a forbidden sexual impulse in order to avoid the anxiety which would accompany its coming into awareness, and the repressed impulse is converted into a physical symptom. The formation of the symptom, according to this theory, would thus reflect both the expression and the denial of the repressed instinctual drive.

The libido theory has come under attack. Some students of human behavior, particularly psychoanalysts, still consider it to be essential in constructing a theory to explain normal and pathologic behavior. Others feel that the validity of the libido theory has not yet been established scientifically, that it is not necessary for an understanding of human behavior, and that it can therefore be discarded (2).

Even if one does not agree with the Freudian theory of transmutation of instinctual (drive) energy, the term *conversion* can still be used to denote that process by which the patient avoids some intensely unpleasant affect by substituting a physical source of discomfort for an emotional one (3, 4). In a metaphoric sense, the patient can thus be said to have converted his emotional problems into physical symptoms. The conversion symptoms distract him from unacceptable emotional problems and at the same time afford him an acceptable reason for seeking help. Furthermore, when the patient seeks help, he is in a relatively passive position of being treated for an illness, rather than having to cope with a problem he would rather not face.

CLINICAL CHARACTERISTICS

The patient with conversion reaction typically presents himself to others as someone who considers himself to be afflicted with an organic illness. The particular symptoms unconsciously chosen by him are determined by several factors, among which is the patient's conception of the illness which he is unconsciously simulating (3).

Obviously, a physician, nurse, medical student, medical secretary, or doctor's wife is likely to have a fairly accurate conception of various organic syndromes. (By accurate, one means that the person's concept of a given syndrome is close to or identical with that of an informed physician.) A lay person who happens to have had experience with particular illnesses himself or in friends or relatives is also likely to have rather accurate conceptions of these illnesses. Therefore, the more knowledgeable the patient is, the more closely will he be able to unconsciously simulate an organic syndrome and thus present a difficult diagnostic problem.

Knowledge of medical disorders has become more widespread in our time than it was at the turn of the century. This may explain why the obvious classic forms of conversion reaction, which are relatively easy to diagnose, are probably not as common today as they were in the 19th century or in the early part of this century. For this reason, perhaps, conversion hysteria has been thought by some to be decreasing in incidence or even disappearing. Ziegler et al, however, found that approximately 13% of patients seen in 4 years of psychiatric consultative experience in a medical service were diagnosed as having conversion reactions, as compared with an estimated 3% in the psychiatric outpatient department of the same hospital (3). It therefore seems likely that conversion reactions are not decreasing in incidence but simply have become less obvious in form. These figures also indicate that these patients tend to be seen by the internist and general practitioner more frequently than by the psychiatrist.

Another important factor in the unconscious selection of conversion symptoms is the suitability of the symptoms to symbolically express some important aspect of the underlying emotional conflict.

An illustration of the way in which the patient's conception of disease and the symbolic requirements of the unconscious conflict are interwoven is afforded by a young woman who was followed for several years in a neurologic outpatient clinic. At first she was thought to have multiple sclerosis. After several years of observation, however, it was apparent that her fluctuating bouts of hypesthesias, paresthesias, and weakness were never accompanied by objective signs of neurologic lesions nor by evidence of progressive disability, and conversion hysteria was felt to be a more likely diagnosis. It was further determined that she had a realistic conception of the various symptoms and clinical fluctuations of multiple sclerosis, knowledge she had obtained in a neurologist's office where she worked for a number of years.

The patient was in the throes of a severe marital conflict, and separation or divorce seemed imminent. In view of this, as well as of her desire to be unencumbered by more children, she consciously desired to avoid another pregnancy and clearly communicated this to her physician. She became pregnant nonetheless; when she was confronted with this fact, she denied her previous wish not to become pregnant and in fact seemed to have forgotten that she once had felt that way. She now professed to be glad that she was pregnant but said she had developed a marked weakness in her hands which would prevent her from holding and caring

for her baby. Needless to say, the patient perceived this new symptom as part of her supposed affliction with multiple sclerosis. The symptoms reflected, in "body language," her now forgotten or repressed wish to avoid having to hold and care for another baby; at the same time, these symptoms reflected her own unconscious desire to regress to an infantile position.

The relative ease with which she repressed her earlier thoughts or wishes is characteristic of many patients who are prone to conversion hysteria. In addition, this patient was observed to be relatively unconcerned by the development of her latest physical symptoms. This feature, "la belle indifference," is also a common, although by no means an invariable, feature of conversion hysteria. In this case, it should be noted that the patient not only was indifferent to her physical symptoms but also was strikingly indifferent to being pregnant, the possibility of which had previously concerned her greatly.

Another factor which sometimes determines the choice of specific symptoms in conversion reaction is that of identification with another person who actually had some or all of the symptoms now present in the patient. This principle was dramatically illustrated by a middle-aged, married woman who entered the medical service for diagnostic evaluation. She had been afflicted with severe abdominal pain for 2 years. During this time the patient, normally a conscientious housekeeper and mother, had become progressively more distraught with abdominal discomfort and fatigue and had become inclined to spend her days in bed. She felt depressed but attributed this to the secondary effect of her unremitting illness.

A thorough medical evaluation revealed neither evidence of organic disease nor evidence of a functional gastrointestinal disorder to explain the abdominal pain. In an interview with the patient, a psychiatrist learned that her symptoms had begun shortly after the death of her father, with whom she had had a close, dependent, and probably ambivalent relationship. The patient did not know the name of her father's fatal illness, but in describing his symptoms she used adjectives and gestures which were strikingly similar to those she had used in describing her own symptoms. It was further noted that the patient's father was described as being a rather outspoken, forthright person who did not hesitate to give her advice and to take sides in family quarrels. By contrast, her husband was a quiet, indecisive man who tended to be a fencesitter and tried to remain neutral and fair in disputes between the patient and her mother.

When this situation was discussed with the referring physician, he took it upon himself to engage the patient in a discussion of her family affairs and to respond to her in a way not unlike that of her late father, ie, directive, advice-giving, and forceful. Within several days, the patient's abdominal pain had disappeared, her strength and energy had returned, and she was discharged from the hospital. Several months later, she wrote the physician a letter stating that she had remained well and thanking him fervently. It was apparent that he had become a very important figure in her life. The psychoanalyst would call this a *transference cure*, ie, she had transferred feelings and dependency from her late father to her physician, and the unconscious identification with her father, as manifested by her conversion symptoms, was needed no longer.

ASSOCIATED EMOTIONAL DISORDERS

In the preceding example, the conversion syndrome appeared to be related to associated depression. This is suggested by the fact that the patient's illness began shortly after the death of her father, was associated with depression and chronic fatigue, and was apparently alleviated when the physician served as a partial, symbolic substitute for the lost person.

Ziegler et al, in their study of patients with conversion disorders, observed depressive features to be commonly present, especially in patients who were middle-aged or older. In these patients, pain was frequently the major conversion symptom. Conversion symptoms may be associated with a variety of other emotional states such as schizophrenic illness or neurotic anxiety (3).

DIAGNOSIS

The diagnostic problem posed by the patient with a possible conversion reaction is particularly challenging because the physician must proceed with the clinical evaluation in such a way that the patient will be prepared to accept his findings (5). Because of the very nature of conversion reactions, this is a difficult goal to achieve. Even though the conversion patient verbalizes his wish for an accurate diagnosis and effective treatment, the physician must bear in mind that the patient also needs to see himself as being physically ill. In many instances, the patient will have been to other clinics and other doctors, seeking an organic diagnosis, and will be disappointed when the physician informs him that there is nothing wrong. If insufficiently prepared,

the patient will simply reject this verdict and will move on to another physician or another clinic.

In order to avoid this outcome, it is essential that the physician foster the patient's confidence and trust in him. He should listen with patience and respect to the description of the patient's symptoms. He should encourage the patient to relate the development of the present illness in as clear and detailed a fashion as possible and should be alert to any incidental associations to these symptoms. If the physician suspects a conversion reaction, it may be helpful to encourage the patient to reveal his fantasies about the physical symptoms by such questions as: What does the pain (tingling, numbness) really feel like? Do you have any idea about what is causing your symptoms? Do you have a fear that your symptoms may be caused by any particular disease? Has your illness seemed to cause complications in your life, for example, in doing your work or in your relationship with your spouse? From these and similar inquiries, the physician may gain an understanding of the patient's fantasies, theories, and fears that are associated with his symptoms as well as the way in which his illness is interrelated with his everyday life.

It is important that the patient be convinced that the physician is approaching the diagnostic workup with an open mind. There is no easier way to lose a patient's confidence than to give the impression of having jumped to a diagnostic conclusion before the workup has been completed.

This point is vividly illustrated by a woman who was admitted to the neurologic service of a large medical center for a diagnostic evaluation of back pain of several years' duration. She had been to numerous other physicians and clinics and had not been satisfied by the diagnosis or the treatment. Her examining physician, after quickly obtaining a history and doing a brief physical and neurologic examination, came to the conclusion that the patient was suffering from a conversion reaction and that the ensuing workup would not reveal any organic basis for her complaints. He did not reveal this quickly gained diagnostic impression directly to the patient, but he did so indirectly by immediately requesting a psychiatric consultation. The patient was convinced that he had jumped to a conclusion about her and that he had not proceeded with the remainder of the diagnostic workup with an open mind. She communicated this impression to the psychiatric consultant and stated that she had nothing more to say to him. Any opportunity for gaining her acceptance of the diagnosis, so vital for further therapy, had been lost in the initial phase of the diagnostic investigation.

In arriving at the diagnosis of conversion reaction, the physician must rule out organic disease and must also find data that positively support the psychologic nature of the illness. He seeks to rule out organic disease by searching for those clinical and laboratory signs of illness which cannot be willfully (consciously or unconsciously) produced by the patient. In addition, he must be alert to features of the patient's syndrome which are inconsistent with anatomic or physiologic principles.

When the conversion reaction has resulted in anesthesia or paralysis, it is usually possible to ascertain that the characteristics of the functional deficit do not conform to the syndromes produced by organic lesions. Commonplace examples include paralysis of the limbs in the presence of normal reflexes, inability to walk in spite of normal motor strength and intact sensation when lying in bed, and areas of anesthesia or hypesthesia which do not conform to those produced by peripheral or central lesions of the nervous system. In the patient with cutaneous anesthesia due to conversion hysteria, it is often observed that the boundaries of the anesthesia may shift markedly if the patient is examined with his eyes closed.

In patients with hysteroepilepsy, the seizures are usually not characterized by tongue biting or incontinence, and although the motor activity during the seizure may be repetitive and purposeless, it is not tonic and clonic. However, it is possible for a patient who is thoroughly acquainted with epileptic seizures to mimic them rather closely; in such cases, an electroencephalogram is useful.

It is, of course, important to remember that conversion hysteria does not confer immunity from organic disease. Indeed, it is not uncommon to find that there is a nucleus of symptoms which appear to be related to some organic problem and which have been hysterically exaggerated or considerably modified. In a study of patients with recent histories of acute infectious illnesses, it was found that some patients prolonged symptoms far beyond the period of actual infection. This tendency was correlated with psychologic test data suggestive of emotional problems, which were obtained before the acute illness (6).

In seeking data to support his supposition that the patient's symptoms are hysteric, the physician should reconstruct the life situation in which the illness began or had its most recent exacerbation. It is also helpful to evaluate the overall character structure of the patient in terms of level of maturity and tendency toward dependency vs ability to cope with the problems of life. No one personality type is exclusively associated with the development of con-

version hysteria, but many patients tend to be somewhat dependent, suggestible, and histrionic. A history of previous probable conversion symptoms may be present. Psychologic tests, including the Minnesota Multiphasic Personality Inventory (MMPI), may be useful. It is to be stressed that the diagnosis of conversion disorder is in part based on exclusion of organic disease and should not be made entirely on evidence of psychologic vulnerability.

MANAGEMENT

The physician faces the dual diagnostic challenge of not only ascertaining the true nature of the patient's condition but also proceeding to do so in a way that will prepare the patient to accept his conclusions. Thus, the treatment of this condition begins with the diagnostic evaluation.

It is not uncommon for the development of an acute conversion reaction (which may be quite a dramatic event) to so alter the interpersonal setting in which it occurred that its continued existence is not necessary to the patient. This fact may explain the relative ease with which many acute conversion symptoms yield to such simple measures as hospitalization, careful diagnostic evaluation, and suggestion. In these instances further treatment may or may not be indicated.

Unfortunately, however, a substantial number of conversion reactions persist beyond the acute phase. In these cases, careful psychiatric evaluation and psychotherapy are strongly indicated. The primary goal of psychotherapy is to enable the patient to become more clearly aware of underlying conflicts and feelings and to deal with them verbally and with appropriate coping behavior rather than in the nonverbal body language of conversion symptoms. When the patient's symptoms continue to elicit substantial gratification of dependency needs (secondary gain), it is essential that corrective environmental changes be instituted if possible. In this latter situation, behavior modification techniques in which progressive return of healthy functioning is systematically reinforced may be useful (7, 8).

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