THE NATURE OF CONVERSION

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AIM—AND HISTORICAL REVIEW

In addressing ourselves to a study of the nature of the conversion process, we are focusing upon a psychic phenomenon which is of interest from several distinct points of view. (i) This process has enjoyed a unique historical role in that it has served as a fulcrum around which both psychoanalytic theory and technique have evolved and have had their origins, and upon which the psychoanalytic method was first tested and assayed. Not only did Freud's earliest cases of hysteria provide him mainly with the symptoms of conversion (5), but even in the forerunners of these historic contributions, in the cases studied by Charcot and his school (49), it was the grand conversion, then rampant throughout Europe, which served as the raw material from which was fashioned the crucial concept that bodily disease can be caused by ideas. (ii) The process of conversion, not only historically but still at present, serves as a model for psychopathology and for the theory of neurosis. While characteristically and traditionally hysteria has served from the very beginnings as such a model, within the hysterical syndrome itself, conversion, along with phobia, has stood as a central phenomenon for observation and study. (iii) In spite of this central role, there has been a noteworthy lack of development of our concepts of conversion, and a failure to elaborate upon them and to integrate them with


For the published report of this panel, see Fox (14). Several of the other papers presented at this panel (and referred to in this paper) were subsequently published in The Mysterious Leap from the Mind to the Body, ed. F. Deutsch. New York: International Universities Press, 1959.
the subsequent extensions of our theoretical framework into such areas as pregenitality, the study of borderline states, and the developments in ego psychology in general. Freud himself considered “the formation of symptoms in conversion hysteria ... a peculiarly obscure thing” and found this “a good reason for quitting such an unproductive field of inquiry” (20, p. 60). Now, however, that we are in an era of retrospective review of basic phenomena, it is most appropriate that this central activity with its widespread ramifications be subjected to further thought and review.

Perhaps in unconscious deference to the historic importance and primacy of the early contributions referred to above, a certain narrowing, restriction and limitation, has been perpetuated with regard to our understanding of these concepts. Thus, for example, in spite of a few notable exceptions to the contrary, which will be mentioned in due course, there has lingered on the general automatic association of conversion with hysteria, so that the two have become indissolubly linked. Tell an analyst “conversion,” and he adds “hysteria.” This conceptual linkage need hardly be documented by single or isolated references, since it is present almost ubiquitously in analytic writing, especially in the clinical literature, where the presence or demonstration of conversion phenomena leads almost invariably to the search for explanations, which are usually found in terms of hysterical processes and dynamics. While historically important, I believe, as I will attempt to show at length below, that this automatic association has long since outlived its usefulness and even longer its accuracy. I believe that a re-evaluation of the concept of conversion is most in order, in which on the one hand the borders of this phenomenon must be more accurately delimited and on the other its scope widened, to have it concur more consistently with both empirically observed clinical data as well as with relevant, more recently acquired theoretical considerations. It is to this end that this contribution will be mainly directed.

As a starting point, let us first take note of Freud’s original definition, offered in connection with his early case material in the *Studies in Hysteria*, in which “we choose to designate the term ‘conversion’ as the transformation of psychic excitement into chronic physical symptoms, which characterizes hysteria” (5, p. 61). Similarly and at about the same time, in “The Defence Neuro-Psychoses” (16), he states, “In hysteria the unbearable idea is rendered innocuous by the quantity of excitation attached to it being transmuted into some bodily form of expression, a process for which I should like to propose the name of *conversion*.” Traversing then through many successive stages of subsequent developments in metapsychology, in the theory of instincts, and the structural point of view, we may quote as reflective of the generally accepted, most recent view the descriptive definition offered by Otto Fenichel, which is seen to be not too far different from the original, that “in conversion, symptomatic changes of physical functions occur which, unconsciously and in a distorted form, give expression to instinctual impulses that previously had been repressed” (11, p. 216). Moreover, the conversion symptoms, he continues, are “very specific representations of thoughts which can be retranslated from their ‘somatic language’ into the original word language.”

While these characterizations serve as a generic description, Fenichel then proceeds to follow Freud’s earliest concepts and goes on to characterize conversion as in its very essence a hysterical process with all that this term implies, i.e., a phallic orientation rooted in conflicts around the oedipal phase and centered around the problem of castration anxiety. While it is acknowledged that many constructions, such as daydreams, seem to exist which bear a pregenital stamp, or which seem to arise from any erogenous zone or any partial instinct, these are regarded as intermediary links between oedipus complex and final symptom. While not unimportant from a practical point of view, and while in fact these intermediate constructions may pose some of the most vexing technical problems in the therapeutic procedure, they are nevertheless considered to be typically and for the most part pregenital expressions of predominantly genital wishes.

To enlarge and round out somewhat our sphere of interest, it is not possible to survey this subject without also concerning ourselves with the relationship between this process of conversion and all other processes of somatization which are contiguous to it. Thus, it will be expedient and appropriate for us, during the
course of this exploration, to reflect also on the classification of perhaps all psychosomatic reactions and their mutual interrelationships. In this connection, noting again the more or less standard résumé of this subject by Fenichel, the latter divides this category of symptoms into the following groupings. (i) There are conversion symptoms proper, considered, as described above, as a center of the hysterical syndrome. (ii) There are “organ-neurotic” symptoms, brought about essentially by disorders of function in which the resulting somatic disturbances have no specific psychic meaning of their own, i.e., do not speak in body language and are not translations of specific fantasies or impulses into somatic terms. The organic changes here are rather brought about either by long-standing unconscious instinctual attitudes or behavior patterns, or by toxic or chemical changes due to the dammed-up state, or else may represent or be a result of chronic affect equivalents (11, pp. 236-237). (iii) In addition, however, it is most pertinent and germane to our present discussion that Fenichel, in recognition of an existing gap both in theory and in data, adds a grouping of “pregenital conversions” (11, p. 311) in which he gives expression to the existence of certain syndromes in which the process of conversion occurs in otherwise pregenitally oriented individuals.

With regard to this latter division, however, one has the distinct impression that (a) the application of this term “pregenital conversion” is rather limited, and applies almost predominantly to the three specific syndromes enumerated in that chapter, i.e., stuttering, tics, and asthma; and (b) that what really takes place is that a still hysterical type of mechanism, i.e., conversion, occurs in individuals otherwise pregenital. In keeping with the ideas previously expressed about conversion proper, no real change is implied in the pathogenesis of the conversion process itself. The chapter labeled “Conversion” (i.e., “Proper”) is devoted to conversion hysteria, while this subgroup is offered as rather exceptional, secondary and deviant. Moreover, the role of the pregenital fixation is considered to be limited frequently to the selection of the organ that becomes the seat of the symptom. In his paper on “So-called Psychosomatic Phenomena” (12), Fenichel again emphasizes the rather restricted meaning of the term “conver-

sion,” placing it at one end of the band of psychosomatic disease and limiting it to conversion hysterias.

**THESIS**

To advance at this point the view which is being propounded in this communication, its center is that the process of conversion must perforce be divorced from the concept of hysteria, enabled to stand on its own, and assessed more clearly and from a wider vantage point with regard to its basic mechanisms, functions and borders. To this end it is necessary to select first what are to be considered its essential ingredients, the *sine qua non*, and to discard the accidental and fortuitous adhering phenomena. Accordingly, it is our belief that the essential ingredients which are both most useful and most theoretically valid would be the concept that the essence of conversion is the shifting or displacement of psychic energy from the cathexis of mental processes to that of somatic innervations in order for the latter to express in a distorted way the derivatives of repressed forbidden impulses. These somatic changes, in keeping with the original definition and description offered by Fenichel, speak symbolically, and via body language express a combination both of the forbidden instinctual impulses as well as the defensive forces which bring about the distortions. It is proposed that these be the steadfast and exclusive criteria to connote a conversion process, a formulation which incidentally retains in its essence the central meaning of the term as originally intended by Freud.

The major contention is then offered, however, and this is seen to be parallel with the first, that while hysteria may be one of the manifestations which the conversion process is utilized to fulfill, it is by no means the only one, but rather that conversion is employed to express repressed forbidden wishes throughout the entire gamut of psychopathological symptomatology. The association of conversion with hysteria, as originally conceived and since then excessively united, has been a fortuitous historical one, applicable at the beginning and based on the nature of the early case material, but no longer valid. Moreover, in retrospect, many of the early cases upon which this concept was based historically
as stated above, with the idea of "pregenital conversions" suggested by Fenichel, upon which it is an elaboration and a further generalization. "Conversion" is to be regarded as the broader term, with hysterical phallic or pregenital as subordinate descriptions. This view was similarly supported in a psychiatric and statistical article by Chodoff and Lyons (6), who studied all the conversion reactions diagnosed in the V.A. Hospital in Washington, D.C. over a two-year period. These authors found no correlation to exist between conversion reactions and the hysterical personality type, but rather found conversion to occur along the entire gamut of the most diverse pathological personality types. Similar opinions were expressed by Kretschmer (32), by Bowlby (4), and by Noble (40). Thus far too this widening of the concept of conversion coincides with the views held by Felix Deutsch and his co-workers of the Boston workshop which are being presented at this panel (9).

That this has not been the generally accepted and recognized view, however, is evident by the automatic assumption in the bulk of the related literature, even up to the present date, of the equation between the conversion reaction and the hysterical state. Thus this issue was anything but sharply drawn in the writings which comprise the Boston Symposium on The Psychosomatic Concept in Psychoanalysis in 1952, led also by Felix Deutsch (8), which did for the psychosomatic concept what I hope the present symposium will do for conversion. Thus Margolin (36), for example, in a most perceptive article regarding pathophysiological processes in general, in which he emphasizes functions rather than psychosomatic disease entities, speaks of "diseases which affect the voluntary functions ... and are generally classified as conversion hysterias." Immediately following, however, Margolin comes closer to our view when he states that "here too it is advantageous to apply the principle of correlating the syndrome with the developmental level manifested in the psychological and physiological regression," and points out that "hysterical symptoms occur in psychoses and in regrettively fixated characters in whom the second phase (i.e., voluntary and [italics mine] involuntary) of tissue damage is often marked." Other contributors to this previous symposium, however, generally fail to make a distinc-
tion between conversion and hysteria and more or less automatically speak of the two together. Similarly Alexander (1) and also Grinker and Robbins (29, p. 74) not only link conversion with hysteria but also restrict the term to involvement of “the voluntary neuromuscular or sensory-perceptive systems” (1, p. 42). It follows therefore with these latter authors that conversion reactions have largely disappeared (28, p. 50).

**Clinical Considerations**

Thus, the conversion mechanism is seen to be a process which can be pressed into operation at any or all phases of conflictual pressure. To turn to explore the clinical considerations relevant to this main thesis, the criteria to be pursued in seeking our data are to adhere to phenomena which fulfill solely the requirements noted above. Thus, for example, the criteria of the displacement of energy from psychic to somatic innervation, and the utilization of the latter for symbolic expression, can be fulfilled at any level of both libidinal fixation and ego development, with a continuous line from the most primitive to more highly developed levels of organization. As an example, while a symptom of “stiff neck” can, via its hypercathedected voluntary musculature, symbolically represent a forbidden erection based upon incestuous wishes and thus fulfill the requirements of a hysterical process, the similarly rigid muscular posture of the catatonc can subsume the same basic function of symbolically expressing repressed instinctual impulses, although with distinct differences in levels and in the nature of the underlying unconscious motivational drives. No less accurately a conversion process, the somatic expression in catatonia may symbolically represent, on an archaic and primitive level of functioning, a sustained aggressive discharge toward the outer world, or, equally, a rigid holding back and pulling inward toward the self. In this psychotic rather than hysterical mechanism the soma is similarly used to give a distorted expression in a compromise way to a repressed unconscious wish complex, although the latter arises not from the phallic organization of development but rather from a very much more primitive and archaic oral-aggressive one. This process of conversion from a psychic to a somatic mode of expression can operate similarly at an anal or at any other level, as, for example, in a psychogenic constipation, which can represent the same basic process fulfilling repressed anal wishes. The process utilized is thus independent of the content which it subsumes, as noted also by Frosch (21), and the two are to be clearly distinguished.3

The required criteria can thus be fulfilled in a wide range of presenting clinical syndromes, from very archaic primitive levels to the more highly differentiated ones. Frequently, moreover, the individual case is overdetermined, and is hierarchically layered with dynamic mechanisms stemming from multiple points of fixation and regression. Incidentally, this broadening of the spectrum of etiologic streams converging into the phenomenon of conversion is in keeping with many recent studies emphasizing the pregenital nuclei of syndromes hitherto regarded as primarily oedipal and phallic in origin. Such studies include the work of Lewin (33) who points to the wider pregenital façade behind phobia formation, two recent papers by Greenson (26) and by Wangh (48) in the same direction with regard to phobias, and Marmor’s description of orality in general hysterical states (37). In similar vein, the studies of Greenacre (24) enlarge upon the predisposing early pregenital disturbances behind the symptom of fetishism, particularly in relation to faulty development of the body image, while Bak (3) emphasizes the part played by pregenitality, most especially the role of pregenital, preoedipal aggression, in the formation of perversions in general.4 Inciden-

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3 Frosch elaborates further on this important distinction in a personal communication, in which he points out, quite correctly, that the crucial question for study, not only with regard to the process of conversion, but similarly with all defense mechanisms, is whether or not the particular process or mechanism can be correlated with any specific stage of ego and/or libidinal development. The content subsequently dealt with does not necessarily of itself label the origin and primitivity of the particular mechanism being studied. The latter must certainly be considered, from the standpoint of a complete metapsychological investigation in all its aspects, quite independently of the impulses with which it eventually comes to deal. This is taken up in greater detail in the theoretical section later in this paper.

4 These views are concurred in by Schur, who stresses the pregenital elements in the state of anxiety, and in “so-called-anxiety neuroses” (43, p. 89), as well as more recently in phobias (45). In a personal communication, Schur expresses the necessity, in view of all these facts, for “an eventual revision of the whole hysteria concept” (46).
tally, it is worth remembering, as I have pointed out elsewhere (41), that our increasing knowledge of specific diagnostic syndromes, and a resulting extension of the accompanying psychopathology into broader areas, does not necessarily mean that these states thereby become borderline ones, nor the processes more malignant. Because we know more does not mean that the patients are sicker.

To give a clinical instance demonstrating the overdeterminism and hierarchical layering mentioned above, I should like to refer in the briefest fashion to the case of a young man with a history of almost lifelong asthma. A therapeutic experience with this patient lasting for many years gradually revealed the weblike network of interrelating etiologic streams expected and so usually found behind the presenting façade of the chronic and debilitating asthmatic symptom. Of the complex maze of underlying psychologic mechanisms which emerged, some played a role in bringing on the physical signs or symptoms, while others represented the psychic meaning to the patient of already present somatic manifestations. There was thus also a combination of both conversion factors in the sense in which we are using them and organo-neurotic symptoms (see below). The wheeze, for example, not only represented symbolically a desperate crying and passive longing for the mother, but was also an expression and equivalent of severe anxiety and at the same time was of itself, especially when severe, a cause of anxiety and even fear of death. Of most interest to us, however, at this point are the multi-layered symbolic conversion meanings of the surface symptomatology as they expressed a variety of underlying polymorphous-perverse motivational drives.

Thus, to mention but a few of these factors, the desperate sucking in of air meant at the deepest levels to suck in his mother's milk, while his barrel chest represented a container within which he retained milk and love and narcissistic supplies. The lack of a free and unhindered communication of maternal love and supplies, which received its most exquisite setback to this particular patient at the time when his two-year-younger brother was born, was transformed into and is now retained in his periodic difficulty in exchanging air between his "innards" and

the outside world. The frequent flow of mucus represented tears and the narrowed bronchial passages expressed and paralleled his totally inadequate general line of contact with objects and people.

From dreams and other material it also emerged, however, that fluid or mucus or any extruded liquid was also equated with blood, which expressed violent, murderous revengeful thoughts, on both an oral and anal-sadistic level, against those at whose hands he had felt rejected and forlorn. Simultaneously, from a higher phallic level, such ejections of fluid represented also seminal emissions, which in reality came out in an impotent and ineffectual way, diluted and encumbered with numerous conflict-laden pregenital wishes. His sick and tender chest cavity also represented an opening into which he would retreat when hurt and in which he periodically lived, when sick, for long periods of time. Many of the weird respiratory sounds which were periodically emitted were seen, from dreams and other associations, to be the equivalent of jeering anal wind which he was directing toward his persecutors and neglectors.

We see thus in this patient what, in his own words, he described as a "cauldron with a witch's brew," of every possible pregenital ingredient of polymorphous-perversion content, leading up to the final common pathway of the all-encompassing asthmatic state. Leaving out for the moment the organo-neurotic admixtures and determinants which played their prominent role as well, we see a multipiked conversion process spurred on by energy from multiple and diverse sources rather than concentrated from any one well spring of etiologic energy.

Incidentally, during the course of a prolonged psychoanalytic treatment there occurred a gradual reversal of direction of many of the above-mentioned phenomena. Paralleling a considerable improvement in his physical state, his tears, for example, came to flow more outwardly, from his eyes instead of into his chest, and accompanied by the appropriate affective and psychic inner experiences. Instead of internal somatic episodes, there were first externally directed behavioral attacks, and finally more realistic outside action, reflected in his general life situation, and in his relationships with his peers, his loved ones and in his work. The progression moved in general from internal (pathological) somatic
episodes, to more appropriate internal psychic and somatic experiences, to external action. Through and alongside this improved communication with the outside world was a wider and increased passageway for the intake and passage of air as well, with less of a need to use the latter periodically and symbolically to express otherwise insoluble psychic conflicts. This whole structure, however, with its almost lifelong pattern, is still a tender and delicate edifice, with periodic regressions to be expected and only the most cautious outlook justified.

The above experience relates to a symptom complex, asthma, in which a diverse progenitality is not unexpected. It is presented, however, as a particular construction which can serve to demonstrate, in an intense and perhaps exaggerated way, what obtains to a lesser degree in many if not most other less complex and less advanced syndromes. Thus, as a fitting contrast to the above, I can mention another involvement of the respiratory tree, a globus hystericus occurring in another patient. While the symptom in this patient produced, with certain similarities to and many differences from the asthmatic patient above, similar episodes of desperate gasping for air and fears of choking, the central psychopathology was of course considerably different. Basically phallic in its orientation, the underlying substrate of the pathology in this case concerned a series of cystoscopies to which the patient was frequently subjected, in an agonizingly traumatic way, between the ages of about six to seventeen for various diagnostic purposes. While the present symptom reflected mostly of course a severe hysterical process, based on unremitting castration anxiety, with a displacement upwards from the neck of the penis to the throat, this explanation proved to be deceptively incomplete and multiple interpretations along these lines were insufficient.

Thus this seemingly simple and classical syndrome required also a very protracted psychoanalytic experience, with the uncovering of a complicated etiologic network not dissimilar to the case described above. It will not, of course, surprise any clinician, at this stage of our knowledge, that the symptomatology in this case rested equally on a multiple pregential base. The periodic spasms of the neck muscles were derivatives not only of the threatened phallus trying to clasp and extrude the invading cystoscopic apparatus, but expressed as well many overwhelming oral and anal impulses and threats, with anxieties derived from these various levels. A series of focal illnesses and medical invasions had occurred from his first year on, beginning with diphtheria at eleven months, and extending into a long and impressive series of episodes and maneuvers, upon which we cannot elaborate at this point. Suffice it to say that the presenting globus symptom, classically a conversion, was not only a conversion hysteria, but was amply admixed with compulsive and even more regressive determinants.

**Limiting Borders**

This discourse has thus far been in the direction of widening the conventional concept of conversion, of extending its borders and freeing it from rather narrowly held limits which have here-tofore generally confined it within a specific psychopathological syndrome and significance. Let us turn now to examine the other end of the problem, to see how far indeed these borders are to extend, and where the limits should be drawn.

Methodologically, it is a common problem, when one explores theoretical areas in our science, to be confronted with the principle of a spectrum or a continuum and certain inherent problems which go along with this. We meet up with this principle rather frequently, such as, to mention but a few examples, in the question of "psychoanalysis and psychotherapy," or "pathological versus normal defenses," or "primary- and secondary-process thinking," etc. The theoretic problem is always, in these areas of continua, to describe and account for white, gray and black, to be aware of the intermediate zones and transitional phases without insisting on too sharp dividing lines, and yet at the same time to acknowledge and maintain differences, to prevent the whole from becoming a blur. One must avoid two equally erroneous directions, i.e., either the temptation to delimit too sharply and restrict the particular concept for the purpose of some kind of exclusive domain, or in contrast, the opposite failing of being so wide open and all-inclusive as to extend the continuum *ad infinitum* into all contiguous areas, until the original concept becomes quite diffuse and meaningless thereby.
In applying these two directions of limitation to the subject of our investigation, we will see that thus far we have devoted our attention to undoing what we consider to have been a too rigid restriction. With regard now, however, to the opposite end of the spectrum, it is equally important to establish certain definite reservations and to counteract an inclination of some to move too far in the opposite direction. Thus, it is necessary to define most clearly the limits separating the conversion process from its various contiguous phenomena.

In this connection, the first line of demarcation to be noted is that not every shift or movement from the psychic to the somatic, nor every use of the soma for psychic purposes, is to be considered to constitute a conversion. The latter should be limited to instances of an active deflecting process which, under the pressure of frustration engendered by conflict, necessitates such a diversion from course. It is not to include the normal band of discharge processes occurring in the accustomed channels of flow of psychic energy from one system to the other. There is a normal and automatic and continuous flow from soma to psyche to soma again (this will be elaborated in further detail below), which unites the whole into an indissoluble psychobiologic entity. Instincts are psychic derivatives which arise from somatic sources, and which discharge their tensions again into both psychic and somatic structures. The soma may serve as the object of an instinct, or as the executive apparatus of an ego function, as in sublimation, purposeful action or some forms of gesture. Conversion should not coincide with all psychophysiology, which would be the case if its applicability were broadened to include every change or switch, in the above continuum, from one system to the other, and in either direction.

Since to a greater or lesser degree any or all parts of the body are involved and stimulated to some extent in a complex final psychic expression, this would become so generalized a concept as to lose its meaning. Conversion, as we would restrict it, is a sequel to conflict, mild or severe. It is an active ego process, in the direction of symptom formation. Though the latter may vary considerably in the degree of ego alienity, from the most exquisitely ego-alien presenting pictures of the original conversion-

hysterical syndromes to various types of unconscious muscular tensions without conscious awareness, they are all of the nature of pathological defensive formations in the service of maintaining homeostasis. Conversion thus occurs with energy in conflict, unneutralized, and drive oriented. It is to be differentiated from the background type of psychic-to-somatic discharge which takes place automatically and continuously without instituting the process of conversion, and with the use of neutralized energy in predominantly a conflict-free sphere of the ego.

Another restriction and differentiation applies to the fact that conversion should not be considered to include somatic-to-psychic, which, to be holistic and complete, some might be tempted to encompass equally. Since, however, this direction of deflection is also, if one pauses to consider it, such a ubiquitous flow, the term would lose its meaning in any specific and localized way. That the biologic base is an ultimate source for psychic processes was a consistent view of Freud's, and, although neurophysiologists have by no means yet provided the finer answers as to its minute nature, many disciplines are at work toward this end. The flow of this energetic process from the soma to its psychic derivatives, were this too to be regarded as within the totality of the conversion process, would again militate against the latter retaining any specific or useful meaning. Conversion thus connotes a specific and only a special kind of switch of energy, a displacement, under the pressure of defenses, from psychic to somatic innervation and discharge.

There is finally a third division and plane of cleavage to be maintained and sharply defined, namely, that between the conversion process and the group commonly connoted as organ neurosis, a differentiation which is made by most previous authors on this subject and which there is no reason not to retain. (The term "organ neurosis," incidentally, leaves much to be desired, but this is not too relevant to our present focus of interest.) If conversion is to be limited, as is the case in our original definition, to those changes in physical function which express symbolically and in body language repressed instinctual impulses, this leaves outside its domain that large body of somatic clinical phenomena which are inevitable but nonspecific sequelae of
psychic tensions, undischarged affects, and the chronic dammed-up state. While this is without question the case, and while the latter group does indeed exist (Freud, 19; Fenichel, 11, p. 236) and does represent physical pathology without specific psychological meaning, there is a tremendous overlapping in which the true conversion process utilizes and takes over organ-neurotic conditions to fulfill its own requirements.

Indeed, while conversion hysteria in the old sense has become quite a clinical rarity, it is precisely its extension into these other areas, as well as into the more diffuse and more prevalent character neuroses of today's clinical variety, which gives the conversion process its continuing clinical ubiquity. Thus, for example, it is almost universal experience to be aware of the symbolic meaning engendered by the symptoms in a case of ulcerative colitis, or in the symptomatology of the average ulcer patient, or in the otherwise organ-neurotic cardiac neurosis. While the ultimate discreet physical lesion, in the form of the final ulcer, or the urticarial wheal, or the cardiac arrhythmia, may no longer in and of itself represent a distorted instinctual derivative, one cannot deal with the total symptomatology of any of the so-called true psychosomatic or organ-neurotic syndromes without finding the picture replete with symbolic conversion mechanisms. These occur when, either in the numerous intermediate steps preparatory to the final physical lesion, or in the use to which the latter is put after it occurs (somatic compliance), there is a transposition of either or both arms of the underlying psychic conflicts into the functional somatic sphere. Thus there is no extensive psychoanalytic clinical report of an ulcer patient without observations about the oral meaning of the gastric contractions or tensions, nor of a case of ulcerative colitis without an abundant reference to the incessant struggles around anality expressed in physical terms, nor of an asthmatic, or a neurodermatitis, without similar reconstructions of the symbolic distortions at various levels inherent in the multitude of physical and functional alterations. The asthmatic case cited above is a case in point. In most cases, therefore, the resultant psychosomatic syndromes would be a combination of the organ-neurotic and the conversion processes.

In fact, it is precisely the extension of the conversion process over the entirety of the pregenital zones, such as described in this communication, which gives it this wider applicability, and is consistent with its extension into the gamut of the organ neuroses as well as to the more diffuse character neuroses. Incidentally, these same considerations, describing the role of conversion in these multiple and diffuse syndromes, lead to a disagreement with the previously mentioned view proposed by Alexander (1), and favored also by Grinker and Robbins (29), of the division in which conversion is limited to diseases of the voluntary body systems, while organ neurosis is considered to subsume only the neurovegetative, endocrinologic, and autonomic functions. This division is seen not to hold up under empirical observation, for it is readily seen from such data as offered above, not only that symbolic expression can be forthcoming from any of the visceral organs and functions as well as from the voluntary and skeletal ones, but also that psychosomatic disease can afflict skeletal and voluntary structures as well. Indeed, to hold too sharply to such a demarcation is almost in the direction of maintaining that the one process, conversion, is more consciously (i.e., voluntarily) motivated, while the other is more unequivocally unconscious or involuntary, a division to which I doubt that anyone would adhere.

Margolin's "fantasy of function" in psychosomatic involvement (36) can be considered a link between these two processes. Our view is supported by Schur, who states "the demarcation between voluntary and autonomic innervation as criterion for the faculty of symbolic representation has been drawn too sharply" (44, p. 144). Fenichel feels similarly, pointing out that "both types of symptoms occur in both realms" (12, p. 308). Incidentally, the bridge linking the two sides of this disputed point may be precisely the point emphasized in this paper, i.e., the broader etiologic range of the conversion phenomenon. A limitation of conversion etiologically to the hysterical level would be more in keeping with the concept of the restriction of its executive apparatus to a voluntary or higher nervous system organization, while those who see it extending over the autonomic nervous system as well are thereby giving support, although many of them have not stated so, to the necessary accompanying view of a broader etiology.
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From the considerations given thus far, we see a spectrum in the range of possible concepts of our understanding of the conversion process. This range would be seen to extend from the one end, which represents the original severe restriction of conversion to the precisely hysterically oriented, to the opposite point of view in which conversion would be regarded as every and any flow of energy from one organization into the other, in either direction, from psyche to soma or the reverse, and from normal automatic conflict-free movements to the most pathologic ones. I believe, as stated above, that there are unnecessary confusions at either end, and would hold to the view that an adherence to either of the above extremes betokens a failure to connote in as useful and meaningful a way as possible the essence of the conversion process. While no doubt a continuum certainly does exist, as emphasized by Felix Deutsch (9), and as it does in all other psychic processes as well, it is submitted that it would be advantageous to describe a concrete beginning and end, as I have attempted and espoused above in this communication. The normal and original psychosomatic bond, which is indissoluble, is certainly the genetic base upon which the conversion phenomenon rests, but this does not make it the same thing.

This limitation of the conversion concept within the borders described is seen to diverge and to be at direct variance with the views being proposed by Deutsch and followed in the main by his various co-workers at this panel (14). Thus Deutsch’s (9) intriguing but complex theory of conversion as due to a sequential series consisting of projection, object loss, symbolization, and retrojection leads him to consider conversion as a continually active process embracing virtually all of psychophysiology and operative in both normal and neurotic processes. To this point of view we have taken exception and differed as noted. Other contributors from this group have extended conversion rather indiscriminately in the direction of the psychosomatic or organo-neurotic conditions without making a sufficiently sharp distinction between them. Such is the case, for example, with Ludwig’s description (34) of the patient who developed a carcinoma of the left vocal cord, where many complex factors other than conversion were no doubt at work, not the least among which were probably

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the stimuli registering unconsciously from the organically affected part. Similarly Silverman’s (47) patient who developed successively a polyp of the colon, uterine fibroids, a growth in the right breast, and a cyst in the abdomen, or the cases studied and described by Menzer-Benaron (38) of complex menstrual changes accompanied by multiple endocrinologic dysfunctions, cannot by any means be considered to represent only “various aspects of the conversion process” but rather merge into various other types of psychosomatic and organic states. Such a grouping together of diverse and complex phenomena is an oversimplification and fails to make proper and necessary distinctions and differentiations. In the discussion of these papers, Gifford (22), after registering some reservations, justifies such an all-inclusive broadening of the concept of conversion on the basis that no term exists which is comprehensive enough to include normal and other transient psychophysiological phenomena, severe psychosomatic disorders, and classical conversion hysterical symptoms. I would submit rather that this would give conversion a totally different connotation than it has had in its historical development, and would mitigate completely its present meaning. A more logical all-inclusive concept, it would appear to me, would be some such term as “somatization,” as used by Schur (44), with “conversion” limited to the specific segment as described, a formulation which would retain its essential meaning while sharpening its accuracy and its borders.

FURTHER THEORETICAL CONSIDERATIONS

To explore further now the theoretical basis of the process of conversion one must always consider the genetic development and the matter of precursors and anlage. Thus, genetically one notes that the to and fro movement between soma and psyche is operative from the very beginning of life and that, as Fenichel also states (11, p. 216), the expression of psychic states in terms of physical body function is in principle not at all surprising. Body and mind reactions interrelate from the beginning as an integrated psychobiological unity. Anxiety itself, as Freud (20), Schur (43, 44, 45), and many others point out, has its phylogenetic origin in a biological response. The original affects of pleasure and un-
pleasure are body oriented and stem from bodily processes and states. In the primary model of affect, as given by Rapaport (42), pleasure and unpleasure depend on the state of bodily satisfaction or the lack of it, as brought about by the giving or withholding breast object. Similarly, the primary models of action are based upon the various states of bodily need; and, finally, the model of thought is based upon a hallucination of the giving breast for the sake of bodily satiation.

Gradually, during the course of development the psyche is interposed between body and world in an ever-increasing complexity, causing the increasing hierarchy of delay, postponement, and displacement which gradually interposes the entire complex fabric of mental processes between bodily states and discharge processes. Although the areas of interaction between these bodily and mental processes become increasingly more subtle, obscure, and complex, the indissoluble bond, uniting them as from the very beginning, remains ever between them. Instincts are the psychic representatives of somatic sources. Processes of stimulation and discharge enjoy continued back and forth movement from one system through to the other. Affects are psychic discharges into the somatic interior, a circumstance which is a genetic precursor not only to conversion but to every instance of somatization. The ego is originally a body ego. Greenacre (25) has commented upon the earliest physical anlage of defenses, and it is of course well known how, for example, the psychic defense of introjection is based upon the physical activity of eating and incorporation, identification upon internal metabolism, denial upon vomiting or other forms of physical ejection, etc. Schur calls such early bodily actions “precursors of defense” (44, p. 143). Of the derivatives of instinct with which we deal, affects and action are seen to be still directly connected with bodily processes, while the more psychological instinctual derivative of thought is nevertheless also known to be an experimental bit of action, which is more indirectly, but just as definitely, ultimately thus connected with bodily processes.

While interrelating thus constantly between themselves, both body and mind stand as partners in relating the organism to the outside world. While originally the line of communication is most
directly from soma to an external source, as for example in the exchange from infant’s skin, face, body, mouth, voice, to mother, there is a gradual interposition of first a simple, then an increasingly complex psychic apparatus taking over this function of communication and object relations. Maturation and development go with an ever-increasing elaboration of these intermediate psychic modes of contact and discharge, with a subsequent minimizing of the more direct uses of the soma. The latter, however, are of course not abandoned but are permanently maintained, and operate in general in a more refined and attenuated form, very much as with the “taming of affects” (Fenichel, 10) in the course of maturation and development. Along these more differentiated channels of expression, somatic avenues are provided for the discharge of attenuated and neutralized energy, which both give expression to instinctual derivatives as well as provide for the possibilities of ego mastery, such as in sublimation and in purposeful action.

The process of conversion is then characterized by a regressive movement, backwards from the acquired psychic interposition to the more primitive, original and direct somatic discharge. Fixations facilitating such a development may have occurred at one or more nodal points of genetic development, such as in a heightened intensity of frustration and with it of somatic activity at the very earliest archaic preverbal period, or in excessive somatic erotization during the oedipal phase, or in a conflict-ridden use of the soma for purposes of aggressive discharge during anal development. Greenacre has described certain other specific types of pregenital patterning which facilitate such fixations (23). As in the psychosomatic process, such regression is comparable to the “physiologic regression” described by Michaels (39), and used also by Margolin (36) and by Grinker (27), and is related to the “physiologic infantilism” of Hendrick (30). The tools of maturation are rejected and caveman implem ents are again used instead.

This regression, which is incidentally in accord with Schur’s concept of resomatization with ego regression (44), is characterized by the abandonment of purposeful action in the service of the ego, the giving up of adaptive and reality-based mechanisms, and
the return to a drive-organized use of any or all parts of the somatic apparatus. The latter subserves primitive needs, reverts in general from secondary toward primary process, stands upon infantile mechanisms, utilizes nonneutralized energy, and, as all symptoms, is a compromise formation between instinct and defense. Incidentally, this movement from instinctual impulse to somatic innervation is not a direct one, but traverses an intermediate phase of fantasy, either conscious or unconscious, a point which has been amply noted by many in the past. Thus Freud early pointed out the role of these unconscious fantasies in the genesis of hysterical conversions (18), while Fenichel stresses the prerequisite of “introversion,” or the turning from reality to fantasy, as a precursor to conversions (11, pp. 216-217). More recently Arlow (2) has described the analogy between the conscious fantasies accompanying masturbation and the conscious or unconscious repressed fantasies preceding conversions as well as many other psychoneurotic symptom formations.

Interestingly, while one would think that the increased reversion to direct soma would be accompanied by an increased tendency to external action, such is not usually the case, for, just as in dreams or in the analytic situation, the “sluices to motility” are first closed before the soma is thus used. In fact, the ability and prerequisite first to block these avenues is probably a precondition for the development of at least many types of conversion. A conversion patient is rarely an actor-out. (On the other hand, this is only seen to be true in one sense, in conversion symptoms which are “bound.” One might also consider various of the impulse neuroses, for example, kleptomania, as unconscious symbolic bodily actions, and in this sense conversions. While at first one might be tempted to restrict conversion to bound energy, or to a more or less static process, if one stops to remember that a hysterical convulsion is a classic conversion symptom, then sporadic functional discharge processes, as long as somatic apparatus is used, are certainly also to be included, and might therefore include certain neurotic or impulsive outer actions. Freud also considered conversion hysteria to be “cathetic processes which are either permanently maintained or intermittent” [20, p. 58; italics mine].)
not occur until later as stated. Of course, the mechanism, once in existence, can then be utilized to bind or discharge impulses and content from any level or direction, which would have no bearing on its original genesis. In fact, it is no doubt the case that an appreciable spurt in the use of this mechanism does take place in the phallic phase, accompanying the generalized increase in erotization, and that this process led to the frequency with which conversion was heretofore equated with this phase. Actually, it is a process which, once established, runs up and down the scale, a formulation which is in keeping with the thesis as well as the clinical data presented throughout this publication.

The symptoms themselves may express either libidinal or aggressive impulses, in any combination, and each using either the voluntary or the visceral organ systems. Fenichel notes that any part of the body may be the locus of conversion since any part is subject to erotization (11, p. 216). The same holds true for the fact that specific loci or organs may serve as the executors of aggression, each perhaps in a different way and according both to the anatomy and the individual genetic history. Impulses and defenses are both given vent to in any amount, and in varying proportions, dependent on the particular presenting symptomatology. The individual syndrome is of course usually overdetermined, as in any psychiatric symptom. A tic, for example, can serve to discharge not only the obvious aggressive impulses, but can and does provide libidinal gratification as well. The syndrome of generalized maladie des tics, studied by Mahler and Rangell (35), showed especially well the kaleidoscopic nature of the underlying symbolic meanings behind the presenting surface symptom façade, impulses indicating points of fixation as well as regression at multiple pregenital as well as phallic levels, and a complex combination of defenses as well as instinctual derivatives. The tics are at one time a holding on and a going away, a discharge of a variety of impulses and of affects, and at the same time a diffuse defensive action against showing any of these. And in all respects they fulfill the requirements of being called conversion phenomena, though it would be doing them much injustice to call them conversion hysteria.

We come next to a most intriguing and remarkable problem which has been associated with this subject from the very beginning, that of “the mysterious leap” from the psychic to the physical. This phenomenon, within the process of conversion, which, with its dramatic flare, has long captured our imaginations, has gathered unto itself, I believe, the mystery and wonderment stemming from all psychic processes in general, having been the first to be studied and standing, as described above, as a model for all the others. For, without wishing to minimize the value of mystery or drama, I should like to venture the question of what is different about this particular leap from all other leaps in our science. Thus Alexander notes that this leap is no different from what takes place in any common motor innervation (1, pp. 40-41), and Fenichel remarks that this switch from one sphere to another is in principle nothing strange (11, p. 216). And we may add that indeed this is so. Of course, fortunately it does not detract from this mystery but rather adds a deserved note of mystery to all other comparable mental or, for that matter also physical processes, to observe that this leap, while mysterious, is no more mysterious than many another psychophysiological or somatopsychic or even intrapsychic event. Thus, for example, is this leap from the psychic to the physical in its essence any more of a challenge or a problem or a wonder than the corresponding reverse phenomenon from the physical to the psychic? Or is there anything clearer in the jump from physical stimulation to thought process or to affect sensation? Or does one know any more about the jump into the delusion or into a hallucination, which, though the traversing is here from one psychic element to another within the same general framework, is certainly no less remarkable or elusive a phenomenon. Or one might add the leap into a fantasy or a journey into a dream. Perhaps our leap has acquired to itself the wonder of all these.

While Ferenczi has offered the intriguing phrase of “hysterical materialization” (13) and Katan “hysterical isolation of the id” (31), the mystery is no closer to being solved. While our con-
tributions may relate to one side or the other of this enigmatic juncture, it is most difficult to say what actually takes place at the “synapse” itself. Of course the problem of conversion is not solely the problem of the leap, but extends over a wider arc, beginning with the first reverberations of the motivational drive, and including the secondary uses to which the symptom is put. While psychology adds to our knowledge of the afferent or efferent arm of this reflex pattern, the occurrences at the “synapse” remain still a great domain for both neurophysiologist and psychoanalyst to explore, and where perhaps they will yet meet. To this end minute clinical observations, such as many of those which were offered at this panel (14), will well serve. We need perhaps extensive observations in the field of micropsychophysiology to elaborate in any substantial way upon this obscure but fascinating phase of human conduct.

The observation of transitional states or of patients in flux or in *status nascendi* occasionally offers an opportunity for additional understanding of fluid clinical conditions. Such, for example, was a case I observed recently in which a long period of hyperacusis occurred in a patient en route to the development of a paranoid delusion, and which aided in observing directly the pathogenesis of the latter symptom. In many instances, the couch and the therapeutic situation offer such opportunities to observe transitory and shifting states and to study psychic and even physiologic events in *status nascendi*. Here and in this way the hope for a micropsychophysiology is occasionally fulfilled. When, under these conditions, the generally regressive movement proceeds toward undifferentiation and primitivization of responses, we have the chance again to observe both more primitive interactions between psyche and soma, and occasionally even more dominantly body types of reactions to external psychic stimulation.

Under these regressive and controlled conditions, our daily observations are replete with examples and demonstrations of symbolic body language, a mode of communication and of indirect expression of psychic products which is so common as to compete quite strongly with the more differentiated and expressive mode of verbal language. Thus we frequently see patients who are at the crossroads of body-mind expression, with an inability to choose automatically one medium or the other. Felix Deutsch has contributed much along these lines in his observations on analytic posturology (7). The silent patient, for example, may quite characteristically speak with his body, with the tonus of his musculature, with his general and specific posturology, with the state of his perceptual system, with facial expression, mimicry and visceral reactions. This is a large subject, about which, due to the pressures of time and space, we must restrict ourselves to only the following few meager clinical examples at the present time.

At a particular point in a patient’s analysis, the nature of his “free” associations had the following characteristics, that there were more or less long, tense, silent pauses which were then suddenly superseded by simultaneous bursts of voluminous discharge both into words and into rather chaotic postural and motor activity. While he uttered many garbled and confused verbal expressions, which characteristically failed to communicate very much, he at the same time indulged in orgies of varied and restless movements, being unaware of the latter until they were pointed out. While mumbling many combinations of both clear and unclear sentences, he would gesticulate wildly, move his head frantically from side to side, snort and snuffle, twist his body up and down and laterally, alternately bend and extend his legs at the knees, turn his head toward and away from the examiner, rub his hands, crack his knuckles, etc. (his friends called him “kinetic”!). Such random discharge activity was a form of body language and expressed meanings unknown consciously to the patient. His productions represented in fact the differentiation between his previous communicability to both mother and father. He could “talk” only to mother, whereas to father he never communicated anything in words, but certainly did in actions, which for the most part were defiant, rebellious, and contrary ones. Thus, this simultaneous discharge via both psychic and somatic organ innervations represented bisexual and biparental transference reactions. It could be frequently seen how this patient struggled between the alternatives of psychic (verbal) versus somatic expression. This is perhaps seen universally, although to a much lesser degree, in the internal struggles which take place in the supine patient on the analytic couch. Regression outside of the
service of the ego favors and facilitates such body language, whereas the sturdy ego with an efficient observing function would tend to restrict body language in favor of the more insight-producing mental apparatus taking over. Incidentally, it was of special interest to learn that this patient's only sibling, a younger brother, was a stammerer. The patient's verbal and motor expressions had even before then struck me as stages in the development of tics and stuttering, forerunners or aborted equivalents of these latter pregenital conversions.

In another patient in a similar therapeutic situation, the transition to conversion symptom could be seen in a more advanced stage when in response to an otherwise insoluble psychic situation she developed the habit of "her hands falling asleep" during the therapeutic sessions. This was a conversion phenomenon which occurred quite readily and which at different times was seen to have different meanings, at different levels of functioning and development. Thus, in many typical situations the hand going to sleep had libidinal implications in which she herself was going to sleep, i.e., with the analyst. At another level it expressed, from earlier phases of development, the most condescending disdain for the analyst who "put her to sleep with his boring and ineffectual remarks." The symptom represented aggressive drives as well as libidinal ones, and defenses as well as impulses. In one sense, she was withdrawing, i.e., going away in a defensive flight, while at the same time she was inviting the analyst to go with her, both of which of course had specific reverberations into her past. The sleeping hand also represented her total body and self-concept, picturing herself visually and symbolically as an empty, dull, boring, soporific character. The symptom, a conversion phenomenon in its very nature, was, as all psychic events, characteristically overdetermined, meaning at one and the same time that she was helpless and inadequate, hostile and withdrawing, seductive and rebellious, stemming from a broad spectrum of regressive points. It would have been an inaccurate narrowing of its varied meanings to have limited the understanding of this symptom to a phallic or hysterical significance, and to have overlooked the manifold shadings of mean-

ings from multiple aspects of the genetic past which this relatively simple symptom was able to furnish.

SUMMARY

In summary, we see how we have extended the meaning and significance of the conversion process to cover a more varied galaxy of psychic events. The historic conceptual linkage between conversion and hysteria has been loosened, and it is suggested that conversion can occur along the entire gamut of psychopathology, at any stage of libidinal or ego development. Though covering a wider range of phenomena than hitherto generally employed, the focus is still on the distorted use of physical or somatic innervation for the symbolic expression of the derivatives of repressed psychic products. It is submitted that the criteria presented fit better the observed data as well as make for a more consistent theoretical construct. We have, moreover, carefully described the restricting outer limits of this phenomenon so that it is clear that conversion is not to be equated with all of psychophysiology.

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