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Hysterical Conversion
I: A History

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'Hysterical conversion' dates from a century before Freud, from an important attempt to rationalise the nosological status of hysteria. Freud's own concept of 'conversion' followed as a quite independent synthesis of 19th-century medical thinking on the subject. Subsequent analytical usage of 'conversion' which has influenced the description of hysterical syndromes within mainstream psychiatry, has not been consistent with Freud's own.

Conversion's three phases

The concept of hysterical conversion is widely assumed to have been a Freudian invention. This paper shows the history of hysterical conversion to have been longer. Through a series of three versions, the concept has met varying needs through three different crises in clinical history. In each instance, conversion offered a concept capable of linking cases with disparate physical features, so that they became assimilated within a way of thinking that found them difficult to accommodate otherwise. In an 18th-century attempt to reconcile anomalous cases to an excessively rational diagnostic system, hysterical conversion distinguished hysteria from other disorders on the basis of its formal properties within that system. In the 19th century, its reappearance marked an attempt to accommodate cases that could not be formulated in terms of descriptive pathology by recourse to aetiology as an independent source of organising concepts. In 20th-century psychoanalytic writing, where aetiological formulae were to prove less and less specific for any given type of case, conversion was detached from the concept of hysteria and reserved for clinical material set apart by its semiotic properties.

In all three instances, the nature of the difficulty, and of the solution offered by the versions of conversion, locate important weaknesses within the operation of each clinical paradigm. These supply the context against which each version of conversion is presented here, with an emphasis upon factors internal to the discipline concerned. The recent adoption of hysterical conversion within medicine and psychiatry, and some implications that carries for the state of their fabric, provide the subject of Paper II (this issue, pp. 378–389).

The conversion of disease: hysteria in the age of Ferriar

It was Hunter & Macalpine (1963) who drew attention to the use made by the English physician John Ferriar of the term 'hysterical conversion'. Even before this, the term 'conversio' was employed in the Middle Ages to refer to a propensity shown by what was then termed 'suffocation of the womb' to develop into other diseases following a 'crisis' (Jacquart & Thomasset, 1988, p. 175). This use of 'conversio', to be found among 15th-century commentators on Avicenna such as Jacques Despar, anticipated the meaning bestowed upon 'hysterical conversion' by Ferriar once 'hysteria' had become a substantive disease; it has been neglected in the two comprehensive histories of hysteria (Veith, 1965; Trillat, 1986).

Ferriar's description of hysterical conversion

In the second volume of *Medical Histories and Reflections*, Ferriar (1795) discussed a general concept of the 'conversion of diseases' by which

> "new symptoms arise . . . which require a different designation, and which either put a period to the original disorder, or combining with it, alter the physician's views regarding the prognostics, or the method of cure." (p. 1)

Conversions could arise in many contexts: when one recognised disease develops into another; when it predisposes to the subsequent development of another; or through the ill-advised therapeutic suppression of a disease. (On the last, Ferriar deplores for instance how hysteria and hypochondriasis would convert, perhaps fatally, into scirrus of liver, dropsy, apoplexy, or palsy through medicinal use of "spirituous liquors" (p. 56).)

The disease of hysteria, however, enjoyed an anomalous position alongside other diseases. It had its own characteristic symptoms, and like others could itself arise through conversion from other diseases, for example:

> "Fevers often terminate into hysterical disorders, especially in women; men too, are sometimes hysterically inclined, upon recovering from typhus, for they experience a capricious disposition to laugh or cry, and a degree of the globus hystericus." (p. 37)

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It was in the very nature of hysteria that, once established, conversion could supervene while hysteria was still undeniably present:

> "the histories of unusual chronic diseases, are absolutely cases of conversion: to be convinced of this we need only refer to SYDENHAM's description of hysteria and gout." (p. 69)

This characteristic propensity to repeated conversion was different in these two cases:

> "There is a strong resemblance between hysteria and gout, in the power of counterfeiting different diseases, but with this material distinction, that the hysterical representations are commonly void of danger, while those produced by gout are often more dangerous, than the simple disorders they imitate." (p. 23)

Thus, in contrast to other instances of the conversion of diseases, in

> "hysterical conversion . . . the body possesses a power of representing the most hazardous disorders, without incurring danger; of counterfeiting the greatest derangement in the circulating system, without materially altering its movements; of producing madness, conscious of its extravagancies, and of increasing the acuteness of sensation, by oppressing the common sensorium." (p. 12)

Ferriar reflects:

> "Nature, as if in ridicule of the attempts to unmask her, has in this class of diseases, reconciled contradictions, and realised improbabilities, with a mysterious versatility which inspires the true philosopher with diffidence, and reduces the systematist to despair." (p. 12)

Ferriar and the limitations of classical taxonomy

In these remarks, Ferriar appears to be in dialogue with several protagonists. One of these is Sydenham, with whom Ferriar had a special sympathy having devoted his own MD to Sydenham's greatest single contribution to medicine, the description of the natural history of 'variola' (smallpox). Sydenham's interest in clear description and precise classification is echoed in Ferriar, as is his interest in the peculiarly taxing nature of what Sydenham still called the 'hysteric affection'. Sydenham's own descriptions of hysteria had been at odds with Ferriar's in several significant respects, however. The clinical description of the 'hysteric affection' offered by Sydenham (1848, p. 85 *et seq*) had had three major components: a set of characteristic signs and symptoms (which included the voiding of large quantities of limpid urine, shifting sensations of cold, and odorous eructations); a chameleon-like capacity to imitate other conditions; and a tendency to be associated with disturbances of the 'passions' (this last being subject to much misinterpretation by later historians).

Although Ferriar was not primarily concerned with the clinical description of hysteria, the passages already quoted from his treatise imply he was in agreement concerning its visible signs, while differing somewhat from Sydenham with regard to its consequences for the sufferer. Ferriar's allusion to the lack of 'material' alteration during hysterical imitation contrasts with Sydenham's belief that considerable post-mortem collections of fluid were compatible with the diagnosis. And while Ferriar points to the dangerlessness of hysteria, Sydenham warns of the grave dangers of failing to diagnose it (Sydenham, 1848, p. 111). The clue linking such differences is, of course, Sydenham's views on the pathogenesis of hysteria, which he put down to "faulty disposition of the animal spirits" (p. 91). The ability of the animal spirits to selectively inhabit regions of the body accounted for the polymorphous nature of hysteric affection's symptoms and course: their quasi-humoral status made it fitting that during their derangement "the mind sickens more than the body" (p. 88). Ferriar offers no opinion on animal spirits, or indeed on the pathology of hysteria at all.

Other figures loom between Sydenham and Ferriar, notably William Cullen, Professor of Physick at Edinburgh while Ferriar was a student there in the 1770s. Cullen is renowned for his contributions to nosology and for his introduction of the concept of the neuroses as a broad class of conditions, among which he was to place hysteria. As a nosologist, Cullen had been impressed by the intricate taxonomies of such continental contemporaries as Linnaeus and Sauvages, becoming more ambitious for the formal completeness of his diagnostic schema than any of his predecessors at home. Cullen was also highly critical of any attempt to explain illness in terms of invisible animal spirits, and sought to explain apparently sympathetic action between remote parts as the result of nervous action. In this, Cullen was anticipated by Whytt (French, 1969, ch. 4), but whereas Whytt was willing to attribute the greater part of 'nervous disorder' to hysteria (together with hypochondriasis), Cullen was anxious to restrict the scope of hysteria as far as possible, complaining (with respect to hysteria and hypochondriasis) of the

> "great impropriety that almost every degree of the irregular motions of the nervous system has been referred to one or other of these two diseases." (Cullen, 1791, p. 103)

Cullen made no positive contribution concerning the pathology of hysteria. He referred to its abdominal origins in the 1860s in a manner reminiscent of Sydenham (Cullen, 1797). In his 'nosology' he

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followed Sagar and Sauvages in placing hysteria within the order of 'spasmi', where (along with epilepsy, chorea, asthma, tetanus, dyspnoea, pertussis, colic, cholera, diarrhoea, and diabetes) it is attributed to "irregular motions of the muscles or muscular fibres" (Cullen, 1827, p. 74), while in his "first lines on the practice of physick" the "proximate cause" of hysteria became "a turgescence of blood in the uterus, or in other parts of the genital system" (Cullen, 1791, p. 106).

However, as Foucault (1973) has pointed out, in Cullen's era anatomical considerations were of secondary importance in the identification of a given disease:

> "what communicates the essential 'body' of the disease to the real body of the patient are not, therefore, the points of localization, nor the effects of duration, but, rather, the quality." (p. 12)

According to Cullen, the essential quality of hysteria was one of 'mobility'. It was mobility that permitted one symptom to be rapidly substituted by another in the course of the disease, and the greater mobility of hysteria that distinguished it from hypochondriasis. This degree of mobility was itself a reflection of the particular 'sanguine' constitution that Cullen believed predisposed patients to hysterical illness (Cullen, 1797, p. 59). Although Cullen, scrupulously insisting on the separateness of hysteria from other conditions and the folly of overdiagnosis, had been reluctant to confer upon it powers of imitation, contemporaries such as Gregory did not hesitate to stress an imitative quality common to the cases of hysteria seen at the Edinburgh infirmary (Risse, 1988).

Ferriar's purposes become somewhat clearer when placed in this context. He acknowledged that his interest in the way diseases may substitute one for another had not been new – his use of 'conversion' here corresponding to classical concepts of 'epigenesis' or 'metastasis'. Making such transformations inherent to the character of hysteria, however, certainly was novel. Yet the development was a natural one once the pursuit of nosology had emphasised the separability of morbid entities rather than continuities, and had done so on the basis of newly conceived rational relationships rather than original nosographic discoveries (cf. Faber, 1923).

In Ferriar's writing, therefore, one finds little interest in the pathogenesis of hysteria, and hestitation as to how far any individual symptom might be characteristic of it. Instead, the qualities formerly subsumed under the notion of 'mobility' are used to describe a unique property of the formal relationship enjoyed by hysteria with respect to other diseases, and this is identified with 'hysterical conversion'. The propensity for 'imitation' that Sydenham had recognised, but Cullen had evaded, became the essential quality of hysteria within a medical discourse that valued taxonomic adequacy before other considerations.

While it dealt neatly with a challenging anomaly, Ferriar's concept of hysterical conversion appears not to have been adopted by others. Contemporaries such as Pinel, who cites Ferriar's volume in introducing his *Treatise on Insanity* (Pinel, 1806, p. 1), were nonetheless aware of it. Its rapid obsolescence is likely to be attributable not only to Ferriar having shared preoccupations peculiar to the Edinburgh school, but to a concurrent shift in interest away from the ordering of disease on the basis of formal resemblance, towards a nosographic renaissance founded more securely on pathological understanding. In most areas of medicine, this trend was to see the gradual replacement of the idiosyncratic labels of 18th-century nosologists with categories that could enjoy a wider consensus. However, the topic of hysteria would remain the object of contradictory and highly personal formulations throughout the following century.

The conversion of affect: hysteria at the time of Freud

Freud's re-adoption of 'hysterical conversion' in the 1890s followed nearly a century of disuse, and it was taken for a complete innovation. Indeed, the phrase now stood for a concept quite distinct in its referents, its character, and in its legacy.

Freud's usage of hysterical conversion

Freud adopted the term hysterical 'conversion' (*Konversion* in German) at the beginning of his career as a psychopathologist. In formulating the psychodynamics of hysteria, he reserved 'conversion' for a form of 'defence' that was (almost) exclusive to hysterical patients, and which accounted for the pathogenesis of what were in effect the least stereotyped of their physical symptoms. He introduced it:

> "In hysteria, the incompatible idea is rendered innocuous by its sum of excitation being transformed into something somatic. For this I would like to propose the name of conversion." (Freud, 1894, p. 49)

The process of conversion involved a separation of affect associated with the 'incompatible' idea, but not necessarily a disappearance from consciousness of the idea itself. Freud quickly came to equate an 'incompatible' idea with a traumatic one having an

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exclusively sexual content. Contrary to views then prevailing on predisposition to hysteria, he was not willing to preclude anybody from exhibiting hysterical symptoms so long as the content of this idea was sufficiently traumatic. Freud stressed that the symptoms that resulted were primarily fixations of physical patterns relating directly to events at the time of the patient's trauma. It was uncommon, therefore, for the relationship between the determining cause and the hysterical symptom to be a merely symbolic one, an outcome Freud claimed would be far harder for the psyche to achieve. In fact he explicitly distinguished between symbolisation and conversion as psychological mechanisms:

> "the mechanism of symbolization, which has its place, in some sense, midway between autosuggestion and conversion." (Breuer & Freud, 1895, p. 180)

According to Freud & Breuer, a wide range of symptoms were attributable to conversion: various pains and neuralgias, anaesthesias, contractures, paralyses, vocal and motor tics, paraphasia, haemorrhage, chronic vomiting and anorexia, deafness, visual and olfactory hallucinations are all cited in the preliminary discussion, or are to be found among the case histories in the *Studies on Hysteria* (Breuer & Freud, 1893, 1895). There are interesting discriminations between symptoms according to the mechanism of production: vomiting, paresis, selective aphasia and a tic are quoted as instances of the immediate effect of trauma (p. 4), while pain appears to reveal a more symbolic link to its origin with some frequency (p. 178 ff.). Moreover, classic hysterical symptoms of hemi-anaesthesia, contraction of the field of vision and epileptiform convulsions were thought impermeable to analysis in terms of past experience (Breuer & Freud, 1893, p. 5) and were not attributed to conversion at all.

Freud continued to refine his views on the pathogenesis of hysteria during the 1890s, and to refer to a mediating process of 'conversion' that involved somatic displacement of traumatic affect. Although he did not explicitly redefine it, the nature of the provoking 'incompatible' idea changed, while 'conversion' itself played a progressively less exclusive role in Freud's accounts of the pathogenesis of hysteria after 1900. Indeed, as Freud continued to describe and review the underlying mechanisms of normal as well as pathological psychic life, 'conversion', like patients having hysteria, received less and less of his attention.

In 1909, Freud introduced a new use for 'conversion', one that has been particularly influential (see paper II). He used the term 'conversion hysteria' to designate a particular hysterical syndrome, in contradistinction to the 'anxiety hysteria' he diagnosed in his patient Little Hans:

> "There exist cases of pure conversion-hysteria, without any trace of anxiety, just as there are cases of simple anxiety-hysteria, which exhibit feelings of anxiety and phobias, but have no admixture of conversions." (Freud, 1909*b*, p. 116)

From then on, references in Freud's writing to 'conversion hysteria' greatly exceed any to conversion as a mechanism.

Freud and the scope of the anatomico-clinical paradigm

The breadth of Freud's personal culture ensures that his thinking on many topics does not lack antecedents. As in Ferriar's case, his formulation of hysterical conversion resolved tensions peculiar to the medical thinking of the period, achieved by a synthesis of much of his immediate predecessors' work on hysteria. By the 1890s, a great deal had been done to further the programme of linking clinical syndromes to underlying tissue changes – the so-called anatomico-clinical method (Lain-Entralgo, 1961). Nosology adjusted accordingly as superficial descriptions were abandoned, new syndromes delineated, and the inevitability of evolution within diagnosis was more readily recognised. However, many disparate clinical phenomena were still subsumed under the rubric of hysteria, and the anatomico-clinical method spurred several potentially incompatible lines of thought. Essentially, hysteria had been cast as a frankly gynaecological disorder, as a neurological disease, and also as a condition that was peculiarly resistant to anatomico-clinical explanation. The first two cast shadows across Freud's conception; the third constituted its essence.

Until very late in the 19th century, a large body of medical opinion held that where hysteria was diagnosed, disease of the female reproductive organs would be found (cf. Hollender, 1972). Such attributions took various forms, the uterus, ovaries and accessory organs all being variously implicated, but were founded upon an apparent wealth of evidence, for example:

> "respecting the origin of hysteria, I have been led to believe, from the symptoms observed in these two hundred cases . . . that hysteria originates in the ovaria." (Lee, 1871, p. 23)

These beliefs were by no means exclusive to gynaecological specialists, as Griesinger's (1867) strictures to psychiatrists about the importance of genital lesions in the onset of hysteria confirm. Similar ideas of the reflex effects of genital changes figure in Benedikt's (1868) description of 'libido', the

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precursor for Freud's concepts of erotogenesis and his own libido theory.

While gynaecological accounts pursued an old line of association (Merskey & Potter, 1989), concurrent attempts to link hysteria to physical changes in the nervous system also had a significant pre-history (Merskey, 1983). In the 19th century, a crucial advocate of hysteria as a neurological disease was Paul Briquet, whose treatise on hysteria (Briquet, 1859) has been strangely neglected by modern historians (Mai & Merskey, 1980). Presenting hysteria as a "neurosis of the brain", Briquet defined it in terms of a set of neurological symptoms that should yield to pathological investigation like those of any other disease. Subsequently, Charcot, like leading neurologists elsewhere, accepted hysteria as a neurological syndrome, while discriminating between 'major' and 'minor' varieties that resembled epilepsy and chronic paralyses respectively (Charcot & Marie, 1892). He had to concede defeat in the search for structural pathology, attributing hysteria instead to a 'functional' lesion whose site was nevertheless expected to be anatomically specific according to its effects (Charcot, 1889, lecture XXI). The notion was a forerunner of Freud's own model of psychic physiology (Freud, 1895*b*), which was the framework that gave his mechanistic theory of hysterical conversion its shape (Knight, 1984).

The third line of study that the anatomico-clinical method prompted was the most decisive. It led to an explicit association not only with the absence of structural pathology, but with symptoms quite inconsistent with the effects of any other known pathology. Thus, in order to explain pain that was not commensurate with the recognised effects of local joint disease, Brodie (1837) had introduced the concept of 'local hysteria'. Within his neurological model, Charcot had recognised a necessary contrast between the pattern of symptoms such as seizures, paralysis, anaesthesia or visual failure that arose in hysteria and the pattern characteristic of other conditions. It was in elaborating these insights that Freud began his own study of hysteria. As he extended the teaching of the Salpêtrière in "Some points for a comparative study of organic and hysterical paralyses" (Freud, 1893), he noted

> "since there can only be a single cerebral anatomy that is true, and since it finds expression in the clinical characteristics of the cerebral paralyses, it is clearly impossible for that anatomy to be the explanation of the distinctive features of hysterical paralyses,"

hence his famous comment that "hysteria behaves as though anatomy did not exist" (Freud, 1893, p. 168, also, 1888, p. 49).

After observing the singular challenge hysteria posed to pathological explanation, Freud proceeded firstly to formulate hysteria in terms of its aetiology rather than reliable clinical findings, and then implicitly to redefine it to ensure that one aetiology would be common to all cases. This remarkable move set him apart from nearly all his predecessors, yet its significance has scarcely been acknowledged. One notable exception has been Carter (1980), who felt that these ambitions were prompted by the recent successes of 'germ theory' within German medicine. However, there is no documentary evidence of a direct influence here, while Freud's personal attempts to define syndromes within neurology do record how his preoccupation with aetiology arose. (In fact Freud's substantial neurological writings (Miller & Katz, 1989) have remained an area of extraordinary neglect, even on the part of writers who have argued for a 'biological' reinterpretation of his thinking (e.g. Sulloway, 1979).) At the same time as Freud was compiling his *Studies in Hysteria*, he was busy with his equally substantial work, *Infantile Cerebral Paralysis* (Freud, 1897). He took a critical approach to that diagnosis:

> ". . . it is neither equated to a pathologico-anatomical nor to an etiological entity. It is therefore probable that even clinically the term can only claim the value of a temporary entity that may soon be abandoned in favor of certain more coherent and possibly etiologically well-determined disease pictures." (Freud, 1897, p. 21)

Despite making descriptive innovations, Freud admitted himself unable to re-organise infantile paralyses on the basis of aetiology alone.

From his earliest writings on psychopathology, however, it is apparent that he came to the neuroses with the intention of linking each of the 'actual' or 'psychoneuroses' that he defined to a specific aetiology. As a psychopathologist he could enjoy an extraordinary freedom to realign descriptive boundaries according to unique causes, asserting his faith in 1895 that "when a mixed neurosis is present, it will be possible to discover an intermixture of several specific aetiologies" (Freud, 1895*a*, p. 113).

In the particular case of hysteria, a 'psychoneurosis', Freud was aware that his clinical predecessors, including Charcot, had attributed it to multiple causes, constitutional and environmental, physical and psychological. An important exception was Moebius (1894), who wished to define all hysterical symptoms as psychologically induced, either by emotion or by idea, and from whose ideas Freud was naturally keen to distinguish his own. He did so through a revision of a form of hysteria Charcot had already set apart on account of its

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characteristic aetiology. In Charcot's concept of 'hystero-traumatism', the particular pattern of physical symptoms that the (usually male) patient sustained following an accident were out of all proportion to injuries actually received, but could be understood in terms of the patient's own expectations of mutilation (Charcot, 1889, Appendix I). Freud & Breuer's guiding idea was that the clinical findings in most cases of hysteria, lacking a clear history of physical trauma, could be attributed to a past insult that was emotional in nature, and had subsequently been forgotten. Their *Studies on Hysteria* therefore addressed itself from the outset not to the task of defining hysterical illnesses, but to "discovering their precipitating cause" (Breuer & Freud, 1893, p. 1).

Freud's opinions underwent a series of refinements, in which he strove to keep an aetiology that might be common to all cases. The specific mechanism of 'conversion' had to be postulated by him when the variety of traumatic experiences that might precipitate hysterical symptoms still appeared to be relatively wide, and to be potential precipitants of other neuroses also. It allowed cases of hysterical neurosis to share a common predisposing cause in the form of a somatic weakness that favoured conversion (Freud, 1894). Subsequently, as Freud held all neuroses to be sexual in origin, yet distinct according to contrasts in sexual pathology, hysteria became identified with one specific form of traumatic precipitant, that is, passive sexual experience before puberty (Freud, 1896). This idea remained consistent with his original description of 'conversion' as a process, an 'incompatible' precipitating idea effectively becoming one associated with an earlier experience of this type (Freud, 1896).

Around 1897 two interrelated changes rendered the concept of hysterical conversion virtually redundant. One was Freud's well known renunciation of the seduction theory in favour of an emphasis on the ubiquity of infantile sexual experience and the role of fantasy (cf. Freud, 1907). The other was a gradual retreat from attempts to link types of neurosis to exclusive aetiologies, towards a willingness to discuss the aetiology of neurosis in general, and the concession that any given case was likely to be multiply determined (Freud, 1906). Hence, in Freud's later discussions of hysteria (Freud, 1908, 1909*a*) several alternative aetiologies are recognised. At first, the mechanism of 'conversion' was adapted to include the response to 'incompatible' ideas taking the form of unconscious fantasy (Freud, 1908), while it lost its exclusivity in the pathogenesis of hysteria. It became quite superfluous to Freud's (1909*a*, p. 231) account of the provocation of hysterical attacks, when a new understanding of libidinal economics entailed that attacks could be brought about 'organically' entirely by "internal somatic reasons". The concept of conversion became dispensable once there no longer needed to be an 'incompatible idea' to be defined against.

Freud therefore came to favour the usage referring to the syndrome of conversion hysteria once he had far less use for conversion as a mechanism. The term's implication of a consistent aetiology or process was already inconsistent with Freud's own thinking on hysterical symptoms. This contradiction was to be felt sharply during the present century.

Divorcing conversion from hysteria: the post-Freudian aftermath

'Conversion' was soon to regain a place in the vocabulary of many psychoanalysts, particularly among those sustaining a rather literal and institutionalised adherence to Freudian procedure within the US. However, despite appearances, none of Freud's heirs have used the term in a way comparable to his own.

The use of conversion by post-Freudian psychoanalysts

In subsequent analytic history, no single figure managed to appropriate 'conversion' for themselves, and a number of apparently divergent uses arose. It was to be ignored by Anna Freud in her catalogue of defence mechanisms (Freud, 1936), but discussed by Ferenczi. Ferenczi readopted the term to distinguish one subset of physical symptoms from those he attributed to a mental origin as a result of 'materialisation'. The products of conversion were distinct from other materialisations because they were displacements of a genital impulse only, and were couched in "a peculiar symbolic language" that he termed the 'hysterical idiom' (Ferenczi, 1919, p. 100).

A more radical reworking of the concept was offered by Fairbairn (1954), who explicitly reformulated the concept of conversion in order to make divergences clear between the 'object relations' approach to psychopathology that he prompted and the drive-led approach identified with Freud. Accordingly, Fairbairn (1954, p. 117) defined hysterical conversion as "the substitution of a bodily state for a personal problem". Rather than accept that symptom formation should be explained in terms of fixed patterns of libidinal development, as Freud's theory of sexuality had proposed, he suggested that

> "the data upon which the theory of erotogenic zones is based themselves represent something in the nature of conversion phenomena." (p. 121)

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These authors' acknowledgement of the association of conversion with hysteria notwithstanding, the most enduring revisions of 'conversion' have occurred within the American psychoanalytic movement, and have affirmed its estrangement from 'hysteria'. Already in 1922, Felix Deutsch, an analyst concerned with the treatment of patients with physical symptoms, suggested that "it must be assumed that a continuous conversion process . . . takes place in every normal individual" (1959*a*, p. 65) and that "it is during [all] periods of sickness that the conversion process finds an inconspicuous outlet, which is barred at other times" (p. 66). In fact, the broadening of the concept to include 'reactive patterns' such as blushing or perspiration had largely mirrored the clinical scope of Ferenczi's 'materialisation' (cf. Ferenczi, 1919, p. 96). The hysteric's conversion then

> "differs in so far as its development is based on a constitutional or predispositional inability to ward off emotional tensions . . . which . . . led to an inevitable transformation of great amounts of libido into organic manifestations." (p. 66)

Deutsch was to continue to try to formulate how a process of 'conversion' could be recognised even in somatisations that were not wholly psychogenic in origin. He was to achieve a mature, if idiosyncratic, position in which 'conversion' was typified as a compound process during which

> "the symbolisation of external objects leads to a retrojection of these lost objects via sensory pathways onto and into the body where they remain immanent and dormant." (Deutsch, 1959*b*, p. 95)

The divorce of conversion from hysteria, already apparent in this broadened conception, was absolute in a famous review by Rangell (1959). According to Rangell, conversion should apply to all somatisations that

> "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."

He states his conclusion that, owing to the range of phenomena it encompassed, "the process of conversion must perforce be divorced from the concept of hysteria" (Rangell, 1959, p. 636). It was a verdict which others such as Sperling (1973) were to uphold within the mainstream of American psychoanalytic thought.

De-hystericised conversion and developments of the analytic model

When Rangell asserted that his own formulation of conversion "retains in its essence the central meaning of the term as originally intended by Freud" (1959, p. 636), he was simply mistaken. Like those of other writers cited above, Rangell's observations reveal that 'conversion' had not only become associated with different complaints, but was a very different type of concept to that described by Freud. This discontinuity is rooted in the increasing autonomy of the discourse of psychoanalysis from its medical parent. An expansion of psychoanalytic theory, encompassing normal psychology and culture, in addition to a large slice of psychopathology, preceded a return of interest to the psychogenic physical symptom. Conversion hysteria became a focus at which the maturing new discourse would restake its perimeter, and readjust its relationship to medicine. Here, as in general, its ability to develop ordering concepts of its own would be critical if it was to steer away from the tramlines of diagnosis and pathology on which medicine was continuing to run.

Freud, in his pioneering contributions to dynamic psychopathology, had continued to emphasise continuities with medical thinking. He remained mindful of the relationship his own work bore to the descriptive psychopathology that, after Kraepelin's example, was dominating the practice of psychiatry. Indeed, Freud continued to make explicit his recognition that theoretical refinements should reinforce rather than defy nosographic distinctions. This is particularly clear for instance when he indicates the implications of his 'structural' model of id, ego and super-ego (Freud, 1923) for the whole field of psychopathology.

> "Transference neuroses [i.e. hysteria and obsessional neurosis] correspond to a conflict between the ego and the id; narcissistic neuroses [e.g. melancholia] to a conflict between the ego and the super-ego; and psychoses, to one between the ego and the external world." (Freud, 1924, p. 152)

While Freud's models of psychodynamic operations were in continual evolution, he outlined his view on their relationship to psychiatric description:

> "What is opposed to psycho-analysis is not psychiatry but psychiatrists. Psychoanalysis is related to psychiatry approximately as histology is to anatomy: the one studies the external forms of the organs, the other studies their construction out of tissues and cells . . . one is a continuation of the other." (Freud, 1917*a*, p. 255)

It is a telling statement, much of the further development of psychoanalysis demonstrating that the analogy was not to be sustained. In its terms, once the task of psychoanalytic research devolved to an extending network of clinicians, competing strains of 'histology' arose that often lacked a clear basis for comparison. In general, these also

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became increasingly estranged from the divisions of 'anatomy'.

Within the orthodox psychoanalytic succession (whose most prolific early representatives were Jones, Abraham and Ferenczi) one finds much initial effort dedicated to matching syndromes to aetiological factors, according to stages of libidinal fixation. The template of oral, anal, and genital pathologies was sketched by Freud (1907), highlighted by Abraham (1926), and engraved in the textbook of Fenichel (1945). However, it came under constant pressure for revision in the face of local theoretical innovations (such as recognition of the contribution of different ego states in symptom formation) as well as external concern that such an emphasis on the determining role of early experience was too exclusive.

The aetiological ideas attaching to 'conversion' were progressively modified in this light. In the terms of libidinal pathology, it was associated with conflicts that were increasingly, and finally exclusively, 'pre-genital'. Abraham (1921*a*), for instance, opined that a tic could be "a conversion symptom at the anal–sadistic stage"; Fenichel's textbook (1945, p. 232) vacillates around "the pregenital expression of predominantly genital wishes"; after further elaboration, Sperling firmly declares that "all conversion is pre-genital by nature" (Sperling, 1973, p. 569). The importance accorded to such instinctual fixations was challenged by the influence of environment, not least the widespread occurrence of hysteria in times of war (Abraham, 1921*b*). Freud's own remarks on "secondary purposes" had recognised the contribution of current influences (Freud, 1909*a*), although he had always insisted upon the secondary importance of immediate gains relative to primary unconscious conflict. The introduction of the notion of 'dependency needs' to account for the pathogenesis of conversion symptoms (Nemiah, 1967) proved a felicitous innovation here. Being instinctually driven (as a consequence of 'oral' fixation), but socially satisfied, the concept of 'dependency needs' allowed the evident use made of others by hysterical patients to continue to be referred back to primarily unconscious motives arising out of adverse infantile experience.

Nevertheless, 'conversion' emerges here as a grouping that could not be typified in terms of an exclusive pathogenesis, rather as Freud had had to admit defeat in trying to link 'hysteria' to acts of 'conversion' alone. It is a striking instance of the difficulties inherent in any attempt to apply psychodynamic insights to provide a broad rationale for classes of symptom formation. Freud himself had not been insensitive to the problem. His inferences about the 'proximate' causes of symptoms had been founded upon the analytic uncovering of meaningful links, by a method similar to that used to trace parapraxes or dreams to their sources. However, it was the most individual symptoms that opened themselves to interpretation in this way. These form the evidence for subsequent generalisations about pathogenesis, while it was the most frequent (and uninterpretable) symptoms that lent a grouping its stable identity (cf. Freud, 1917*b*). This had been the reason why, at a descriptive level, Freud's first idiosyncratic cases of 'hysteria' had already been unrepresentative of the 'hysteria' of Charcot. Its lasting consequence for psychoanalytic explanation was that any correspondence between dynamic psychopathology and a class of symptoms was not only necessarily indirect, but such generalisations themselves were open to reinterpretation. This was the substance of the critique of Fairbairn (1954), quoted previously, in which hysterical conversion was selected to demonstrate how even the apparently stable theory of erogenous zones was founded on a questionable transposition of the typical and the particular.

It is not surprising, therefore, to find less and less emphasis placed upon universal aetiological concepts in analytic attempts to characterise 'conversion'. Instead, morphological properties of its symptoms received increasing attention. The symptoms of 'conversion' were seen to be not merely meaningful, but to bear their meaning in a characteristic way. Ferenczi's early reference to their "peculiar symbolic language" has been quoted, and is elaborated in the definitions of Fenichel's textbook of conversions as "very specific representations of thoughts which can be retranslated from their 'somatic language' into the original word language" (Fenichel, 1945, p. 216). This emphasis upon conversion as manifesting peculiar qualities of idiom and grammar prompted qualifications of its clinical scope. Fenichel (1945, p. 236) suggested that:

> "not all somatic changes of a psychogenic nature should be called conversions because not all are translations of specific fantasies into a 'body language',"

and introduced the category of 'organ neurosis' to take care of cases that, while psychologically induced, were thought impermeable to translation.

It was in their role as elements in a unique language that conversion symptoms became essentially symbolic. This was a seemingly anodyne extension of Freud's position on conversion symptoms – he had maintained that any symbolic content arose secondarily (David-Menard, 1989) – but is quite antithetical to his complex views on symbolism. Certainly, the common inference that familiarity with general rules of symbol formation and shared meanings allow a symptom's meaning to be presumed

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is opposed to Freud's insistence on the primacy of (usually indirect) personal associations revealing a symbol's content (Forrester, 1980).

Furthermore, the linguistic analogy presented a paradox. It seemed to consolidate the identity of conversion by presenting it as a natural symptom set, yet it acted to undermine conversion's standing as a grouping in the traditional diagnostic sense. With a redefinition here of the analyst's task as one of translation rather than dissection, the identification of conversion, and determination of its scope, had (as Sperling (1973, p. 769), confesses) to depend upon the analyst's interpretative capacity, rather than the objective presence or absence of 'pathology'.

In this way, psychoanalysis progressed from seeing the conversion symptom still as a 'sign' of a circumscribed pathology, as the example of medicine would dictate, towards interpreting it wholly as an intentional 'sign', after the model of semiology. This detachment from the essential formulae of medicine resonated with wider trends in psychoanalysis, as a tension surfaced that is apparently inherent between the unfettered pursuit of meaning and attempts to establish categorical and genetic understanding. Rycroft (1966) has argued that psychoanalysis has itself been misunderstood, being a 'semantic' discipline that, since inception, has been an exploration into meaning rather than causation: Lacan (1966) has remodelled its theoretical framework to make a 'symbolic order' its explicit content, by which signification comes before all aspects of subjectivity. The separation of phenomenal and intentional 'conversions' from substantive 'hysteria' has epitomised this movement.

These developments are too recent for their implications to be clear. They do, however, find a remarkable confluence in the work of one particular analytic writer, Thomas S. Szasz, who was himself sure what they portend. Many readers are surprised to find that his chief polemic, *The Myth of Mental Illness* (Szasz, 1972), is devoted exclusively to conversion hysteria. Yet, given his wish to counter the pathologised thinking he found common to medicine, psychiatry and psychoanalysis, it is fitting he chose this arena, uniquely important to all three.

Szasz's radical scruples forbade him to refer to conversion by name, "the psychoanalytic theory of hysteria (especially the idea of conversion)" having remained "symbols of psychoanalysis as a medical technique and guild". Nevertheless, the alternative he offered was a "semiotical rather than a psychiatric or psychoanalytic analysis of hysteria" (p. 29). Echoing other writers that "hysterical conversion is best regarded as a process of translation" (p. 102), he elaborated an original theory of the kind of language in which hysterical symptoms were coined. This was a primitive, 'iconic' language whose essential feature was that it had a greater power than words to provoke action from others. This language comes into use only if more direct forms of communication are prevented, making the appearance of conversion hysteria as much the responsibility of those around the patient as of the patient themselves. A game results between several players "characterised by the goal of domination and interpersonal control" (Szasz, 1972, p. 255).

Szasz has provided firm flesh for the semiotic interpretation of conversion, while urging its dissolution as an entity as well as abolition of the term. As he believed any bodily symptom to be potentially an iconic communication, distinctions erected by other analysts between 'conversion' symptoms and those that were 'psychosomatic' or 'organ-neurotic' became quite superfluous. His analysis does much to encourage a broader shift of focus in psychodynamic thinking, away from historical connections in favour of horizontal ones. However, his faith that his analysis of hysterical conversion could be extended to the entire field of psychiatric 'symptoms' represents a curious denial of conversion's unique situation and history.

Coda: the products of conversion

Ferriar's ingenious formulation was destined to remain a footnote once independent developments ensured that nosology quickly moved on from preoccupation with the formal properties of disease. Freud effectively dispensed with the concept of hysterical conversion in his psychodynamic explanations once these transcended the theoretical model in which it had arisen, but it had been instrumental in promoting an aetiological paradigm that would initially dominate psychoanalytic theory.

The rehabilitation of conversion within psychoanalysis, increasingly independent of hysteria, has had two important effects. One has been to provide a vehicle that highlighted contradictions within its superstructure, as surely as conversion hysteria has done within medicine. The second has been its influence in shaping a concept of conversion hysteria that joined the diagnostic repertoire of psychiatry. This is the subject of Paper II.

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