

## **DIFFERENCES IN THE LEVELS OF ANXIETY AND PERSONALITY VARIABLES BETWEEN CONVERSION REACTION PATIENTS AND OTHER NEUROTICS**

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*Thirty female patients, fifteen with conversion reaction and fifteen with other neuroses, were selected on the basis of unanimous diagnosis by three psychiatrists. DSM III criteria were employed in selecting conversion reaction patients. The two groups were compared on Urdu version of Taylor's Manifest Anxiety Scale and Socialization, Self Control, Responsibility and Sociability Scales of California Personality Inventory. No difference was found between the two groups on the Taylor's Manifest Anxiety Scale. On the CPI, while there were no differences on Socialization and Self Control between the two groups, the neurotic group scored significantly higher on Responsibility and the conversion reaction group on Sociability. The implications of these findings for therapy in Pakistan have been discussed.*

Conversion reaction, popularly known as hysteria, is a commonly observed disorder in Pakistan. As compared to West, this disorder can still be observed in its classic form in Pakistan and other developing countries. People display bizarre conversion symptoms which seem to be based mostly on somewhat primitive and misconceived religious precepts that are generally accepted by others without much critical thinking, which may be due to the lower level of education prevailing in the society. However, in the developed countries, conversion reaction is no longer a common neurotic disorder and is very rarely encountered in its classic form. People usually report vague psychogenic pains which remain untraceable. These differences may be due to high literacy rate, sophisticated systems of communication and higher levels of psychological awareness, all combining to make the mechanism of conversion less accessible to unconscious control (Bibb & Guze, 1972; Folks, Ford & Reagon, 1984).

Different explanations regarding the etiology of conversion reaction have been presented from time to time

(Jones, 1980). The most widely accepted explanation of conversion reaction, however, views it purely as psychogenic disorder (Breuer & Freud, 1955). It has been argued that unacceptable wishes and intrapsychic conflicts create anxiety and, hence, are repressed. Psychic energy blocked by repressed and unfulfilled desires gains expression in various physical channels resulting in conversion symptoms. With the appearance of physical symptoms, the anxiety produced by unconscious and unacceptable wishes is expressed symbolically and is, therefore, reduced. This dissipation of anxiety reinforces the future occurrence of conversion symptom. In addition to the reduction of anxiety, individuals get extra attention and sympathy, which become the secondary gains. As the patient not only feels relieved from the anxiety but also benefits from some secondary gains, she develops an attitude of nonchalance to her symptoms and treatment known as "Belle Indifference". Breuer and Freud (1955) viewed it as a cardinal feature of conversion reaction. Contradictory evidence to Breuer and Freud is available which indicates conversion as a defense against anxiety is not so complete that it could result in "Belle Indifference" (see, for example, Bibb & Guze, 1972; Chodoff & Lyons, 1958 ).

Conversion reaction as a neurotic disorder has some peculiar features which distinguish it from other neurotic disorders. Firstly, conversion reaction is not simply a disorder in itself, rather it is frequently a manifestation of other disorders. Secondly, it seems to borrow symptoms from all sorts of physical and mental disorders as it has no symptomatology of its own. Thirdly, secondary gains which are obtained by the patient in the form of attention and avoidance of Responsibility are a prominent feature of this disorder. Lastly, perhaps in no other neurotic disorder placebo serves the treatment purpose so completely, as it does in conversion reaction. In spite of this, however, there is still a tendency to diagnose conversion reaction in individuals who also exhibit some features of hysterical personality. Hence it was felt that enquiry into the personality characteristics may yield some discriminating features which could answer the question: if conversion reaction is a disorder of choice then what sorts of people are more prone to adopt it?

The importance of a specific personality type which more readily develops conversion reaction has been increasingly

stressed by personologists in the 20th century. Broadly speaking, there are two positions regarding conversion reaction and hysterical personality. One group believes that as conversion reaction and hysterical personality overlap these are to be treated identically (Marmor, 1953). Engell (1970) goes so far as to claim that hysterical personality is often a means for diagnosing conversion reaction. The other group believes that conversion reaction and hysterical personalities occur entirely as independent entities and that conversion reaction must be seen as separate from hysteria although conversion reaction and hysterical personality can co-exist and appear simultaneously (Bowlby, 1940; Chodoff & Lyons, 1958).

As more and more conversion reaction patients were observed and dealt with, a clearer picture of hysterical personality emerged (Bleuler, 1924). It was largely based on feminine qualities and ways in which a woman behaved in a male oriented society. Although any consensus is difficult to be found regarding the specific personality characteristics of conversion reaction patients, the importance of personality predisposition cannot be disregarded in assessing the proneness of an individual towards an illness. Therefore, it was felt that comparison of conversion reaction personality characteristics with other neurotics may discriminate some personality characteristics specific to conversion reaction disorder.

To achieve these objectives a list of most frequently reported personality characteristics among patients of conversion reaction was prepared with the help of lists given in various studies (Chodoff & Lyons, 1958; Jones, 1980; Lewis & Berman, 1965). Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (American Psychiatric Association [APA], 1980) was also consulted while preparing the above list. The broad dimensions of excitability, emotional instability, over reactivity, dramatization, attention seeking and unusual dependence were noted. As these characteristics pertain more closely to normal population, those personality inventories were scanned which were developed for normal population. As a result, four scales of California Personality Inventory (cited in Megargee, 1977) namely Sociability, Responsibility, Self Control and Socialization were picked which seemed to be corresponding to the frequently reported characteristics of conversion reaction patients.

The purpose of this study was thus to explore specific personality characteristics of conversion reaction patients which could distinguish them from other neurotic patients. "Belle Indifference" syndrome was also tested so that the role of anxiety could be better understood in conversion reaction disorder and subsequently a better therapeutic programme could be formulated. The following five hypotheses were formed.

- 1) Conversion reaction patients will score significantly lower on Manifest Anxiety scale as compared to other neurotics.
- 2) Conversion reaction patients will score significantly lower on Responsibility scale as compared to other neurotics.
- 3) Conversion reaction patients will score significantly lower on Socialization scale as compared to other neurotics.
- 4) Conversion reaction patients will score significantly lower on Self Control scale as compared to other neurotics.
- 5) Conversion reaction patients will score significantly higher on Sociability scale as compared to other neurotics.

## METHOD

### Sample

The sample consisted of thirty female patients selected from the outpatient department of the Mayo hospital, Lahore. One group consisted of fifteen conversion reaction patients and the second group had fifteen neurotic patients which included anxiety neurotics, reactive depressives, and obsessive compulsives. The diagnosis of neurotic group essentially emphasized the absence of physical and mental handicap, lesion or organic disorder and absence of a psychotic episode.

The diagnosis of conversion reaction patients closely followed DSM III criteria. It was based on the presence of obvious primary and secondary gains, minimum of one physical symptom which could be accounted as purely psychogenic, acute onset, elimination of epileptic fit and disappearance or subsidation of the symptoms with a placebo drug.

The two groups were matched in terms of age, education and parents' income/economic status (table 1).

Table 1

*Age, Education and Income of Conversion Reaction and Neurotic Patients*

Averages	Conversion Reaction Group N=15	Neurotic Group N=15	t	p
Age	19.74	21.00	.081	n.s.
Education	9.50	10.73	.048	n.s.
Monthly Income	2,366	2,400	.230	n.s.

**Instruments**

The data were collected with the help of translated Urdu versions of Taylor's Manifest Anxiety Scale (MAS) (Shujahat, 1980) and California Psychological Inventory (CPI) (Iftikhar, 1986).

Urdu version of MAS has been adapted from the original Minnesota Multiphasic Personality Inventory (MMPI), (Hathaway & McKingley, 1943). It consists of fifty items with response alternatives. California Psychological Inventory gives an overall picture of personality across eighteen dimensions (Megargee, 1977). Although best results regarding a personality profile are only possible if all scales are administered, yet there is ample evidence that any scale can be administered independently according to the required information. The four scales used in this study were Socialization, Sociability, Self Control, and Responsibility.

## Procedure

The female patients selected for this study were first administered Manifest Anxiety Scale (MAS) and then four scales of California Psychological Inventory (CPI). All the psychological tests were administered in Urdu and orally to eliminate any error which could occur by misunderstanding, non-comprehension or omission of the items. Due to the length of CPI the entire data were collected in two sessions. Each session consisted of about 60 to 90 minutes. Subjects were assured of complete privacy, and confidentiality was observed during the entire procedure.

## RESULTS

The hypotheses regarding levels of Anxiety between the conversion reaction patients and other neurotics did not yield any significant differences. Similarly, no significant differences were found on Socialization and Self Control (table 2). However, on the levels of Anxiety and Socialization scales there was a trend among the means of the two groups in the indicated direction. Hypotheses regarding Responsibility and Sociability traits were supported as conversion reaction patients scored significantly higher on these scales as compared to the other neurotics.

Table 2

*Means of Conversion Reaction and Neurotic Patients on Anxiety, Socialization, Self Control, Responsibility and Sociability Scales of CPI*

Scales	Conversion Reaction Group N=15	Neurotic Group N=15	t	p
Anxiety	28.33	29.06	0.26	n.s.
Socialization	28.33	32.73	1.19	n.s.
Self Control	41.53	37.06	1.38	n.s.
Responsibility	24.13	34.46	2.98	$p < .01$
Sociability	34.46	24.13	2.04	$p < .05$

## DISCUSSION

The hypothesis related to levels of anxiety based on the "Belle Indifferences" attitudes of the conversion reaction patients was rejected in the study. Although both the groups exceeded the normal threshold of experiencing anxiety as they scored higher than the reported normal range (Shujahat, 1980) of MAS, no significant differences were found between the two groups. In fact, it was observed that conversion reaction patients tended to report their symptoms in an exaggerated manner. The attitude of "indifference" was not directed towards the symptoms but rather towards the treatment and prevention of symptoms in future. Chodoff(1974) supports these findings that conversion reaction patients are fully aware of the secondary gains of their illness and exploit it for their benefits. These patients take deep interest and delight in describing about their illness. They also usually try to coerce the therapist into thinking that their symptoms are severely disabling and, therefore, they should be hospitalized. Bibb and Guze (1972) also reported accompanying feelings of depression and anxiety which confirms the dubious position of "Belle Indifference" in these patients.

The hypothesis regarding Sociability is supported. This indicates that conversion reaction patients are more sociable and outgoing and they generally exhibit extravert personality characteristics as compared to the other neurotic patients. It may be assumed that this personality characteristic is present as a trait and can be observed in their daily life. The hypothesis regarding Responsibility is supported whereas those related to Self Control and Socialization are not supported by the findings. In fact, Responsibility, Self Control and Socialization measure interpersonal adequacy with special emphasis on social values and norms. All these three scales are interdependent and belong to the class II of CPI scales. Grouped with Tolerance, Good Impression and Communality, "they assess some aspects of socialization, maturity, responsibility and interpersonal structuring of values" (Megargee, 1977, p. 56). The subjects of this study, namely, the neurotic patients and the conversion reaction patients do not differ in the extent to which they have internalized the values as measured by Socialization scale nor in the degree of Self Control. They, however, differ in the degree to which they have conceptualized and understood the values

as measured by Responsibility scale. Logically, if there is no difference between the two groups on Socialization and Self Control then there should be no difference on Responsibility scale as well. However, as the results contradict this it may be inferred that conversion reaction patients are not primarily irresponsible, rather they may be seeking escape from conflict situations by assuming this stance. Gough (1987) has described the scale of Responsibility also in terms of low scores and high scores. Lower scores indicate "not overly concerned about duties and obligations and may be careless and lazy". If this is viewed in relation to other aspects of conversion reaction patients and the defense mechanism of repression and denial, it can perhaps be assumed that they unconsciously adopt irrational ways like incompetent handling of day to day affairs, requiring continuous guidance and supervision for simple household activities and being generally dependent so that they are not left alone under any circumstances. This successfully serves their purpose of (a) relief from anxiety, and (b) gaining attention and sympathy of significant others.

A number of factors may be contributing in the rejection of hypotheses related to Socialization and Self Control such as personality differences, effect of identification or modelling and associated psychopathology. Bowlby (1940), Chodoff and Lyons (1958) and Lewis and Berman (1965) support that conversion reaction is not limited to hysterical personality. In fact, it is a defense available to all sorts of people suffering from different psychopathologies. Further more, conversion reaction may occur merely as a result of modelling (Roy, 1979) as it is also found to be present among other members of the family. However, keeping in mind that the two groups were matched on demographic variables, further investigation in the personality patterns of conversion reaction with specific reference to the Responsibility and Sociability traits is required. On the basis of this study, a different therapeutic plan can perhaps be proposed. In the prevalent mode of treatment, which centres around the removal of symptoms, the relief is quick but temporary. The patient usually returns with symptom substitute. As this study suggests that responsibility and sociability are important personality dimensions of these patients, a long-term treatment may be formulated which aims at improving these dimensions of their personalities. Therapeutic programmes involving other family members can be designed in such a manner that these patients are placed in



easy social situations in which they have to assume a responsible position. Totally non-threatening situations can be later changed to more responsible actions involving greater social approval and recognition. Furthermore, as the secondary gains are also important, not only as an essential feature of this disorder but also as the reinforcing agents of maintaining it, the parents should be counselled to reinforce these patients on adapting socially approved behaviour. More research, however, is required for understanding of family dynamics to make better therapeutic programmes.

### CONCLUSION

This study gives insight into the course of conversion disorder and associated features as found in Pakistani society. Supporting the findings of other studies, it demonstrates that conversion reaction is a defence available to all sorts of people. Conversion symptoms do not merely function as a way of relieving anxiety, rather, as an escape from the social consequences of being in a conflicting situation. Further, indepth investigation is required regarding the Responsibility trait as it holds a contradictory position. Irresponsibility, in combination with impulsivity, has been a constantly reported feature and if it can be shown that this trait is merely a manifestation of many frustrations and having no constructive way for the sublimation of energy in the lives of such patients, the therapeutic programme can be changed from medication to psychotherapy. As in most cases, family seems to be the primary reinforcing agent, a deeper analysis of family patterns, behaviour model and traditional role approval would also be extremely helpful in uncovering factors contributing to this illness and thus helping in formulating a treatment plan.

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