as a cause. When the opinion was expressed that the disability was predominantly the result of the worry she had had about her husband, she accepted this opinion readily. Had the symptoms been hysterically related to the head injury she would have resisted the opinion proferred and sought the alternative.

We have seen that in hysteria the disability is suggested to the patient, or there is some relatively minor physical disability, the exaggeration of which is suggested to the patient. The connection between the desirability of the symptoms and their presence is repressed. This repression or inhibition is an essential part of the hysterical mechanism. The patient with hysterical blindness, for example, is repressing the normal visual impulses received from the eye—that is to say is inhibiting their appreciation at a normal level of consciousness.

This psychological repression was observed experimentally in animals by the great physiologist Pavlov who said, as a result of the study of conditioned reflexes in dogs, "Inhibition was evoked in the cerebral cortex by any sensory stimulus to which, from the point of view of the dog's general economy or well-being, it was better that the dog should not respond." The dog, for example, would not respond by salivation to stimulation which would normally evoke it, because it had been taught that it was undesirable to do so. This is a practical demonstration of an hysterical mechanism, and it is not surprising that Pavlov, who had such insight into it, should have become the father of Russian psychology with its special successes in brain-washing techniques.

Let me also offer a neurological example of psychological inhibition. Normally when a person has good vision in both eyes and one of the muscles which moves one eye becomes paralysed, he suffers double vision when he looks in the direction of movement of the paralysed muscle. A number of people suppress the double vision and will deny that it occurs, although when tested by covering first one eye and then the other it can be demonstrated that they are seeing the object in different positions with either eye. When both eyes are open they only *look* with one of them. It has been suggested that many of these patients are Melbourne supporters.

Hysteria is associated in many people's minds with the practice of religion and this aspect of hysteria must be considered if we are to attempt a proper understanding of it. A tendency to associate hysteria with religion may have arisen because for

some persons the practice of religion depends rather on an emotional than an intellectual allegiance. Or perhaps it is rather that so many of us assume that this is the case. Furthermore, it is assumed by a number of people that miracles are to be explained away, either as a natural phenomenon or as the relief of hysteria.

It may be, of course, that hysteria has been more readily recognized in a religious context just as, for example, the flaw in the false claim of a miracle may be more easily detected by a person who believes that miracles are possible rather than one who does not. Orthodox Christianity is the enemy of all deceit, whether subconscious or otherwise, just as it is the enemy of superstition. Hysteria flourishes where it is unsuspected and is unrecognized. This is the second important principle to understand, namely that it depends not only on the suggestibility of the patient but also upon credulity of those from whom an advantage is to be obtained.

The great Jesuit, Father Herbert Thurston, has written fascinating historical accounts of mystics who were saints and of hysterics and of impostors who developed a reputation for sanctity among at least some of their contemporaries. In his book *The Physical Phenomena of Mysticism* he examines the accounts of some of the stigmatics. Concerning a nun, Lukardis of Oberweimar, who was apparently born about 1276 and who died in 1309, it was written:

> "Also with regard to the hammering in of the nails of Christ's cross, as she carried the memory of it inwardly in her heart so she represented it outwardly in action. For again and again with her middle finger she would strike violently the place of the wounds in each palm; and then at once drawing back her hand a couple of feet *(ad distantium unius cubiti)* she delivered another fierce blow in the same spot, the tip of her finger seeming somehow to be pointed like a nail. Indeed, though it appeared a finger to sight and touch, neither flesh nor bone could be felt in it and those who had handled it declared that it had the hardness of a piece of metal. When she struck herself in that way there was a sound *(tinnebat)* like the ring of a hammer falling on the head of a nail or an anvil. On one occasion a person in authority, thinking this kind of blow was a sham or a mere trick, in order to find out the truth put his hand in

> the way. But when she had struck but once he hastily drew back his hand, declaring that if he had waited for a second blow he would have lost the use of it for ever. With the same finger, at the hour of sext and again at none, the Servant of God used to strike herself violently on the breasts where the wound came. The noise that she made was so great that it echoed through the whole of the Convent, and so exactly did she keep to the hour of sext and none in this practice that the nuns found the sound more trustworthy than the clock . . . Furthermore, it should be noted that the Servant of God, before the stigmata appeared, endeavoured, out of her great longing, to open the places of the wounds in her body by boring them, as it were, with her big toe *(sua majori pedica quasi fodiendo)*."

As Father Thurston points out, it would be rash to suppose that in all cases of stigmata the wound must be held to have been consciously or unconsciously self-inflicted. I suggest that it would be rash also to conclude that the nun Lukardis was not a woman of great virtue, although Father Thurston makes no comment on this point and Lukardis has never apparently been considered as a candidate for canonization, that is to say as a model of virtue.

In my opinion the diagnosis of hysteria does not involve any moral judgement whatsoever. In the first place the theologians tell us that in order to commit a moral fault the person concerned must have knowledge that what he is doing is wrong and he must perform the action with free assent of his will. Even in cases of malingering it may be rare for these conditions to be fulfilled, at any rate to the extent of a serious fault. So this involves another important consideration.

I have never been able to see the difference between the mistake of diagnosing a patient's symptoms as being, say, a carcinoma of the stomach when in fact they are hysterical, and the mistake of diagnosing symptoms as hysterical when they are due to carcinoma of the stomach. For some persons the diagnosis of hysteria is regarded as offensive and this is because for them it implies a moral judgement. This difficulty bedevils a number of doctors, so that they hesitate to persuade the patient firmly and optimistically that the disability is not as bad as has been feared and that he may perhaps make an early effort to return to work.

For those persons who find any sort of mistake in diagnosis by a doctor offensive, I should like to say that the only doctors who don't make mistakes in diagnosis don't make diagnoses. They are scientific Mugwumps who have yet to learn that "truth comes more easily from error than confusion".

To return to the nun Lukardis, what advantage did she gain from her disorder? Perhaps the reassurance that her devotion was as intense as she wished it to be. Perhaps there was a misguided zeal for the edification of the other members of her community. Perhaps it was her subconscious wish to draw attention to herself in order to impart some knowledge which had been concealed from the wise and prudent.

In his book *Medical Diseases of War,* Sir Arthur Hurst also discusses the more florid manifestations of hysteria, which were seen particularly during the First World War but which are no longer so common because they are readily diagnosed nowadays, that is to say the credulity of the observers has disappeared. These included paralyses, contractures, tremors, fits, deafness, blindness, loss of memory and mutism. Of these only episodes of loss of memory are now at all common. Loss of memory still occurs as an hysterical disorder because there is a reservoir of credulity amongst those persons who have not yet learned to distinguish it from unusual varieties of epilepsy.

During the First World War the hysterical disorders were often attributed to shell-shock, a mysterious effect of concussion of the brain and spinal cord from blast. Later on it was appreciated that identical symptoms occurred in persons who had never been on active service, so that the absurd position was arrived at that in order to have your symptoms attributed to shell-shock you had to be blown so many feet away from where you had been standing or buried for so many minutes.

The advantage of the disorder in these cases was obvious enough. It offered a means of escape from an intolerable situation, a means which allowed the person to escape the charge of cowardice and to maintain his own self-respect. This is not to say that the man was a coward; it is very nearly to say the opposite and, in any case, breakdown under the stress of battle may be the result of many factors including prolonged fatigue, malnutrition, poor unit morale and is more likely to occur in those who, though certainly not cowards, are men of peace rather than of war. There were a number of extraordinary examples in the last war of the same individual giving way to

fear at one time and yet at another behaving with the most extraordinary heroism.

On one occasion two soldiers were sheltering in a trench beneath a truck during an air raid. After a little time one of them announced his intention of looking outside to see how things were going. As he did not return, soon his comrade determined to follow him but was horrified to discover his headless body just beyond the truck. Instantly he became blind, as we can understand, but this blindness persisted and the reason for the persistence of the blindness was that it offered him the chance of being invalided home.

In compensation cases major hysteria occurs occasionally, but the majority of instances are not so gross and consist perhaps of an exaggeration of an organic disorder. To understand many of these conditions we have to understand that hysterical mechanisms are involved in the daily life of all of us. If we have a prejudice, for example, we close our eyes to the just claim of the person or the group against whom the prejudice is directed. Credulity is evident enough in the flourishing state of unorthodox medical practitioners, the belief of many persons in astrology and in crackpot religions and in the wholesale swilling of drugs that goes on throughout the population. Some persons believe that it is impossible to achieve great heights in athletic pursuits unless breakfast consists of walnuts and grass sprayed with disinfectant. Some persons even believe in water divining; some that trailing a chain from a car may prevent motion sickness.

The diagnosis of hysteria does not depend merely on the judgement of how much disability ought to arise from a particular organic disorder. There are many positive signs of hysteria and I now propose to discuss some of those which appear on neurological examination.

In compensation cases where the greater the disability the greater the compensation, various hysterical disabilities may coexist. In the recognition of hysteria we may say, in the first place, that as the disorder is the result of suggestion, the paralysis or other disability corresponds with the patient's concept of such disorder. When loss of smell is claimed examination may reveal that there is loss of understanding of the natural distinction between smell and taste, so that the patient complains of the loss of true taste. Unlike the sense of smell, taste is mediated by nerves which have other functions and there

will exist evidence of loss of these other functions if taste be really impaired. In fact it may be said taste is mediated by so many nerves that the complaint of loss of true taste is always hysterical.

In testing the vision, the visual fields may be abnormal in characteristic ways, such as having a spiral outline. There may be an obvious incongruity between the visual acuity, the size of the field and the patient's ability to get about on his own. Testing the visual fields with different sized objects may reveal an absence of the normal proportion.

In testing the eye movements there may be spasm of the muscles which causes the eye to turn inwards, so that the patient looks in a cross-eyed fashion. In other cases he may complain of closing up of the eye and drooping of the eyelid, whereas careful observation reveals that the condition is really a concentration of the muscle which closes the eye. An apparent facial paralysis affecting the corner of the mouth may be seen on inspection to be a sustained contraction of the muscle which purses the lips together on that side.

There are tests of hearing involving the use of a tuning fork and more technical tests which may portray the existence of a pattern of response quite unlike that found in organic disease.

When a patient with organic hemiplegia grips the observer's hand with his normal hand, an associated movement occurs in the paralyzed hand, sometimes even when no voluntary movement can be performed at all but no associated movement occurs in hysteria. Also in organic hemiplegia, if the supinated arm is completely relaxed and then cast, it falls in a position of pronation, but in hysteria it does not turn. When muscle power is being tested it can often be observed that the effort made by the patient increases considerably with persuasion. Sometimes the apparent paralysis of the limb can be observed to be an immobility imposed by strong contraction of all the muscles of the limb, so that it is held rigid.

When there is loss of sensation it may surround the point which has been injured or a land-mark in the body such as the nipple, or it covers what the patient would regard as a natural segment of a limb, for example affecting the whole of the hand to the wrist or perhaps the whole of the upper limb as far as the shoulder. The limit is often determined by some chance occurrence such as the level to which a limb has been uncovered.

Sensory loss of these patterns does not occur in organic diseases. Furthermore the borders of the anaesthesia are often remarkably sharp in hysteria, although careful observation will often demonstrate that they vary considerably from time to time. When a series of stimulae are required in succession from the normal to the anaesthetic area, it may be several inches lower than when the tests proceed in the opposite direction. In organic disorders there is usually an intermediate zone of reduced sensibility.

It is by no means uncommon for complete hemi-anaesthesia to occur in hysterical subjects. Such a finding is virtually pathognomonic of hysteria. It is one of the cardinal neurological signs of the disorder. In these cases, in my experience, it is a regular finding that the patient can be readily confused by testing with the legs crossed or the fingers inter-locked. The patient then fails to call a number of touches on the normal side and responds to a number on the anaesthetic side and becomes confused and embarrassed as he becomes aware of his mistake. It is observations like these which persuade me that some degree of insight is for practical purposes present in every case. On account of this I feel that treatment by way of explanation is fruitless, because it betrays to the patient a lack of insight on the part of the doctor, that is to say a lack of insight into the patient's insight.

It is often said that the diagnosis of hysteria requires past evidence of hysterical disorders. I most heartily disagree with this view. In the circumstances of a compensation claim the only method of securing an advantage may lie in an exaggeration of the disability. This may be the first time hysteria has suggested itself as a likely technique. It is often easy to see why the chance of a large cash settlement has come at a most propitious time. Hysteria, in my experience, is more common in motor accidents where the person involved is not preoccupied with questions of blame for the accident—that is to say where the patient was a passenger or the victim of a drunken driver. It is very unusual to encounter hysteria in sporting injuries, such as in injuries to League footballers where there is a strong incentive to recovery and there are few circumstances in which the completeness of the recovery is more rigorously put to the test.

The final dilemma to which I have reference is one of logic. It is the fallacy of the *post hoc ergo propter hoc* argument. It

finds expression in a favourite question asked of the doctor in Court—"Do you think Mr. So and So would have had these symptoms today if the accident had never happened?"—with the implication that an answer of "No" means that the symptoms must have been caused by the accident. This conclusion does not, of course, follow. We shall not properly understand hysteria until we understand there is no causal relationship between an injury and subsequent hysteria.

It is not unknown for a patient who, for example, has developed backache, gradually to have convinced himself that he sustained an injury to his back at work and ultimately to be able to describe it in great detail.

It would be very naive to imagine that the persistence of the disorder after successful settlement proves that the hope of the financial gain was not the main cause of his factor. There may be little concern that the credulity of the patient's doctors, lawyers, and the members of the compensation court might be rudely shattered, but the patient has to go on living with his relatives and friends. There is, in addition, his need to preserve his self respect.

Hysteria, therefore, is not so much a disability as a tactical method caused by the conscious or subconscious desire to secure advantage from a pregnant situation. It is unfortunate that legislation which was designed to improve the lot of injured workers should have so fostered its development.

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DR. WILLIAMS:

IN the first place I must confess to an almost complete lack of knowledge of the art of psychiatry and although this hiatus has been greatly filled in the last half hour, I cannot hope to approach the problem from this viewpoint. The only qualifications I have for addressing you on this subject are, firstly, the experience gained in dealing with quite a large number of these cases both in consultation and, regrettably, arising in my own

practice. Secondly the possession of, I trust, an average quota of commonsense and it is this sense particularly which I hope to apply to the analysis of this problem.

The varieties of presentation are manifold although the sequences in the history repeat themselves with depressing regularity. The type of case I see is somewhat different from those described by the previous speaker and a typical case might be constructed as an illustration.

The patient is almost always a male and of the labouring class, aged roughly from 30 to 45 years and commonly a New Australian. His command of English will be poor and the Italian figures prominently. While all sorts of injuries are seen, back strains reign supreme and produce by far the worst examples of the syndrome.

The curtain rises as the worker strains his back at work and having consulted his doctor is told he has a torn muscle and must rest up for a few days. There is no improvement and physiotherapy is prescribed. After a course of this treatment which may vary from seven days to seven months, he is referred to a consultant who either manipulates his back or puts him in a brace. With no improvement after further months, an operation may be performed but relief is still elusive.

Now the doctors' reports make mention of "functional overlay" and the patient becomes difficult to manage. The lawyer and the psychiatrist now both come on to the stage and there is much wrangling and writing and finally all are agreed that the only solution is to finalise the claim at whatever percentage disability the Board will allow.

The Court scene follows and the wretched patient gathers up his spoils and disappears.

This is how it all appears on the surface and the casual observer might even believe that it is all the fault of the worker himself. But if we look a little closer, the worker appears in a much better light and a multitude of aggravating factors appear.

I do not propose to discuss the treatment of the established condition of "compensation neurosis" because it has been my experience that there is *none* apart from a financial settlement. Instead, I believe it more profitable to analyse the causes and in so doing perhaps provide a remedy.

The Doctor

I have placed the doctor first for consideration because I believe that he must shoulder a large burden of the blame.

Many of the cases are undoubtedly medically induced. They are induced by inefficient or improper treatment or overtreatment, and of the three, overtreatment is probably the commonest evil. More specifically we can enumerate our failures as follows.

Failure to make a correct diagnosis at an early stage. This may be neither easy nor possible but the failure to do so means that the proper corrective measures are not begun early and instead the patient is subjected to a long and useless period of non-specific "treatment" losing hope and spirit all the time.

The physiotherapist must not escape detection here for he has a regrettable tendency to persist with his methods month after month when it should be obvious that he is not doing any good. One sometimes sees the absurd state of affairs when a patient is prescribed rest and physiotherapy—in itself a contradiction—goes to bed but gets up every day to travel by public transport to visit the therapist where he is given heat treatment! The heat treatment is delivered by a fancy machine, is commensurably expensive but in effect is in no way different from a domestic hot water bottle.

Failure to explain to the patient the nature of his injury and to maintain an optimistic air regarding his recovery both in time and quality. In the initial approach to the patient the doctor may overemphasize the seriousness of the position so that from the outset he begins to worry about his future earning capacity. Fear is added to his already crowded symptom complex.

In this regard it is interesting to recall a survey carried out by an industrial doctor at a large works in Birmingham several years ago. He found that, in a large group of employees presenting with painful backs, those who were told they had a slipped disc remained off work 50 per cent longer than those told they had pulled a muscle, regardless of the actual diagnosis.

Unwillingness to obtain consultant advice until the patient or the Insurance Company asks for it. This is not a common failing but when it occurs the task of the consultant is made much more difficult. The consultant himself may aggravate the patient's feelings of despair by criticising the previous management and suggesting that "if only such and such had been done he would now be back at work". Such statements are always in bad taste and nearly always untrue.

Failure to allow the patient to return to work when he feels he can. This is an extension of the doctor's pessimism and in this regard it is well to remember that the patient is nearly always right.

The Patient

The patient in turn is not without his faults and these contribute in fair measure to his own downfall. It is well known that the incidence of "compensation neurosis" falls heavily on New Australians but this is not due just to an accident of birth on their part. A poor command of the language is probably the most potent factor for they find themselves with no understanding of their condition nor can they understand the reasons for the measures carried out to help them, or appreciate why some of these may fail. They have a natural mistrust of the Australian doctor and often express the opinion that if only they could return to their own country, all would be well.

It is interesting to recall that in this regard, European specialists treat their patients in a most cavalier fashion by our standards and at least in the higher realms of surgery no discussion of any sort appears to take place. The surgeon is a dictator and the patient entrusts himself blindly to his care. I admit that it is difficult to reconcile this with the view that lack of understanding plays a part in the production of neurosis.

All these patients, New and Old Australians alike, commonly exhibit unstable personalities. Many are ill-educated and have never known leisure or acquired the facility to enjoy it. "I've worked hard all my life", they say, and "this doing nothing is driving me round the bend". Unaccustomed leisure soon runs to boredom and with loss of wages looms the threat of insecurity. Those who are sufficiently badly injured to merit continuous hospitalization in the orthopaedic ward of a public hospital, are often much better off for there they find companionship and occupational therapy to pass the hours and almoners to advise with their problems. They realize that their own problems are not unique and they see a continuous stream of patients recovering and returning to their environment.

Those treated under the system of private practice are often left largely to their own devices. Their time is filled doing the housework while the wife goes out to work and by increasing visits to the pub for companionship.

As time drags on, hope is progressively lost and now the possibility of reward emerges. It is now that malingering may be added to confuse the already complex medical picture but I believe that in most cases this has its basis in despair rather than in a conscious desire to malinger.

From a practical viewpoint when the goal of work is aban-

doned and reward substituted, further attempts at rehabilitation usually fail.

In summarising what has been said about the patient and his faults it must quickly be seen that many have an environmental rather than an intrinsic basis.

The Employer

If we accept the fact that many of these disasters could have been forestalled by having the patient usefully employed at a stage when he has incompletely recovered from his disability, then we must turn our attention to the employer to see why this has not been accomplished.

Every employer is primarily in business for the purpose of making a profit. There is nothing reprehensible about this, for survival and with it the workers' jobs are only possible when the employers' business is profitable. However, it does mean (and this applies particularly to the employer of small numbers) that the employer cannot afford to be philanthropic. He may also not unreasonably take the attitude that, having paid large premiums to an Insurance Company, he is no longer under any obligation to make further financial sacrifice to facilitate rehabilitation of the employee. While the employee is off work receiving compensation payments, he can engage a substitute without incurring any loss to himself but once the patient is returned to him he may have to face a number of problems. Thus, the substitute may have proved a better worker than the man he replaced, or if a substitute has been unobtainable it may have become apparent that this particular employee could well be done without.

Again, and this is the greatest difficulty, if the patient returns without being fully recovered and cannot do his normal job, the boss now has to support two men to do one job. Under these conditions the original employee is usually fired. Every worker knows these hard facts and is therefore unwilling to sign on again unless his recovery is complete.

Here lies the crux of the rehabilitation problem. I believe that this is the greatest single factor in prolonging the number of work days lost after industrial injury. Some of the very large firms have tackled the problem energetically by providing a half-way house for workers where their activities are graded according to their capabilities. This sort of useful and purposeful employment is the best form of rehabilitation and cannot be replaced by departments of physical medicine and the like. I

suppose this is largely due to an attitude of mind. In the workshop the patient improves his physical condition as a byproduct of the work which is claiming his attention. In the clinic, he is trying to improve but the work is a chore and the wages commensurately low.

If the insurer and the employer were to co-operate in this field, much would be gained.

The Insurer

In many cases my sympathy goes out to the insurer for certainly the interpretation of the Workers' Ccompensation Act is far more liberal than was ever intended. Its ramifications are now so extensive that it constitutes almost a complete social service. It is open to abuse and indeed is openly abused.

Numerous examples come to mind. Cartilage injuries of the knee are surprisingly common on the way to work on Monday morning when it is patently obvious that they occurred during the week-end's football. The worker injured in a fight at the pub on Friday night is considered compensable because it occurred in the course of his usual way home. Appendicitis is commonly accepted although what it has to do with work heaven only knows and I believe even pregnancy initiated at work has been held compensable.

In the face of all these extraordinary rulings of the Board most insurers nevertheless honour their obligations fully and efficiently. That a few do not is not surprising but as the overall effect of this is insignificant with one exception I do not propose to go in to this more fully.

Sometimes there is prolonged initial haggling over acceptance of the claim and payment of compensation. This has a most evil effect for it throws the worker into debt, antagonises him against the Company and sows the seeds of insecurity.

On the whole, however, the insurer plays little part in the production of neurosis. He usually plays the part of a spectator who has bought an expensive seat in the front row.

The Lawyer

In their approach to the problem the lawyer and the doctor enjoy view-points and aims which are entirely opposite.

Whereas the doctor is aiming to rehabilitate the patient as completely and quickly as possible, the lawyer is only interested in presenting his client's condition in the worst possible light with the sole object of gaining for him the highest settlement.

In the belief that he is furthering the patient's cause the lawyer may actually aggravate his condition by advising that he should not return to work until the settlement has been secured. The same evil effect is often produced by referring him to an endless succession of specialists until a suitably pessimistic report can be obtained.

At the Court hearing a medical witness possessing information essential to the truthful presentation of the claimant may not, and often cannot, be called and the authority who is called may give such a poor showing under cross-examination that his real beliefs bear little relationship to the opinions extracted from him. Except for those few accustomed to it, cross-examination can be a most trying experience, for especially in the sort of cases under discussion, the opinions given are based more upon art than science and cannot be proven.

One other aspect that deserves mention is the acute discomfort the doctor feels in describing the neurotic or malingering features of the patient when that worthy is sitting a few feet away. For some extraordinary reason assassination of members of the legal profession has never become a popular pastime of dissatisfied patients but I believe many orthopaedists are uncomfortably aware of the fate of several of their colleagues some years ago in Brisbane and tend to be more lenient in their opinion under these circumstances.

The nett result of all these things is that the doctor often leaves Court convinced that Justice as he sees it has not been done. A good deal could be done to overcome this if the Board were reconstituted to include a Medical Member, for this alone would prevent barristers and doctors alike from accepting as evidence opinions which at times are utter tripe.

In summing up, I do not propose to offer a blueprint for the future as, having analysed the causes, I believe that the cures are self-evident.

One important facet, however, requires further research. What is the fate of these people after the claim is settled? It is a singular fact that the majority are not seen again either by their own doctor or by others and the inference is that many of the so-called "permanent disabilities" recover at least to bread-winning level.