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History of the Human Sciences 2010 23: 68
DOI: 10.1177/0952695109357128

HISTORY OF THE HUMAN SCIENCES Vol. 23 No. 2
pp. 68–85

[23:2; 68–85; DOI: 10.1177/0952695109357128]
http://hhs.sagepub.com

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ABSTRACT

Factitious disorder is the deliberate simulation of illness for the purpose of seeking the sick role. It is a 20th-century diagnosis, though the grounds for its introduction are uncertain. While previous authors have considered the social changes contributing to growth in the disorder, this article looks at some of the pressures on doctors that may have created the diagnostic need for a disorder between hysteria and malingering. The recent history of those disorders suggests that malingering would no longer be acceptable when applied to the potentially larger numbers involved in workers' compensation or in mass conscription. Equally, the absolution given to hysteria on the basis of the Freudian subconscious would survive only as long as that model retained credibility. Growing egalitarianism and changing doctor–patient relationships in the 20th century would no longer tolerate a sharp division between culpable malingering and exculpated hysteria, which may previously have been made on grounds of class or gender. They would contribute to the need for a mediating diagnosis, such as factitious disorder.

Key words conversion disorder, factitious disorder, hysteria, illness deception, malingering, Munchhausen's Syndrome

INTRODUCTION

Factitious disorder is the intentional production or feigning of 'physical or psychological symptoms . . . in order to assume the sick role' (APA, 1994: 471). Though it has only recently been recognized, it is now steadily reported by every medical specialty, with one estimate putting the rates of factitious disorders as high as 5 per cent of all physician encounters (Wallach, 1994). But is this apparent epidemic a new disease entity, or simply the recategorizing of patients who would previously have been diagnosed with something else? Is factitious disorder a new product of our particular time – of enhanced patient power and loosened family ties, of social welfare and state healthcare systems? Or is it a long-standing problem, previously hidden within labels such as malingering or hysteria, but now separated out on grounds that have since become important? Factitious disorder is usually described as lying midway on some kind of spectrum between malingering and hysteria (Jonas and Pope, 1985; Taylor and Hyler, 1993; Bass, 2001), both of which have been documented for millennia. By charting their recent courses and the tensions within them, we may shed some light on the uncertain ontogeny of factitious disorder, and the forces that contributed to its birth.

THE BIRTH OF FACTITIOUS DISORDER?

The first usage of the *term* 'factitious disorder' is usually attributed to Hector Gavin (1838), although he in turn cites the *Cyclopædia of Practical Medicine* (Forbes and Tweedie, 1833) as his source. Gavin included the term in his book on military malingering, to delineate a particular malingering subtype where the clinical evidence is tampered with or faked. The term was used sporadically over the next 100 years (for example, Fagge, 1886 and Kline, Spitler *et al*., 1949), but it was not until Richard Asher's seminal paper of 1951 that factitious disorder was described in its modern formulation – 5 cases of what he called 'Munchhausen's Syndrome', patients who travelled from hospital to hospital with simulated yet credible illness accounts, seeking medical attention (Asher, 1951). There then followed an extraordinary growth in reporting of factitious disorder (and Munchhausen's Syndrome) – from those first cases in 1951, to 2 reports in 1961, 4 in 1971, 15 in 1981 and 131 in 2001 (Kanaan and Wessely, 2010). It first entered the diagnostic canon in the *Diagnostic and Statistical Manual of Mental Disorders*, vol. III (hereafter DSM-III; APA, 1980), where it was distinguished from malingering on the one hand, and hysteria on the other. Robert Spitzer and Steven Hyler, two of the architects of DSM-III, wrote of the proposed definition:

> An entirely new diagnostic category in DSM-III is factitious disorder, which was included to fill the large middle ground between the hysterical disorders and malingering. 'Factitious' means not real, genuine, or

> natural and describes that which is produced by art or design. Factitious disorders are therefore characterized by physical or psychological symptoms that are voluntarily initiated by the patient. This differentiates the factitious from the somatoform disorders. The factitious disorders are also differentiated from malingering. In cases of malingering the patient also produces symptoms voluntarily but they are for a goal that is obviously recognizable with a knowledge of the environmental circumstances. In factitious disorders there is often no apparent goal other than to assume the role of a patient . . . (Hyler and Spitzer, 1978: 1502)

Factitious disorder differs from hysteria in that its symptoms are produced consciously rather than subconsciously (Hyler and Spitzer, 1978); it differs from malingering in that its motives are 'internal' rather than 'external' (WHO, 1992) – for psychological needs rather than, for example, to get money or to avoid punishment. What unites all three is the sense that there is something else going on – that they are not faithful presentations of illness. In the case of malingering, this is straightforward – the malingerer is pretending to be ill. In the case of hysteria, by contrast, the patient genuinely believes he or she has the problems presented with, and the 'deception' is as much self-deception as it is deception of the doctor (Bass, 2001). The patient with hysteria has a *bona fide* illness, needs medical treatment, deserves sympathy and support – is entitled, in short, to the full range of benefits and obligations of what Talcott Parsons called the 'sick role' (T. Parsons, 1951). The malingerer, by contrast, is viewed as a criminal.

If the differential consequences of diagnosis are clear, the diagnostic distinction itself is anything but. Hysteria and malingering may present identically to the doctor, in which case the distinction will depend entirely on the doctor's assessment of the motivations and self-awareness of the person before her or him (Spence, 2001). And if they lie on a continuum, then judging the dividing point on that continuum, with little evidence but enormous consequence, would seem to present a serious diagnostic difficulty. To which difficulty a mediating diagnosis to 'fill the large middle ground' between malingering and hysteria offers a partial solution (Halligan, Bass *et al*., 2003).

But why now? The obvious answer to this is that the problem was growing. However, a 'growing problem' can mean one of two things: either the population is changing, or we are changing our criteria for being 'a problem'. By analogy, an increasingly obese society will occur either if the population puts on weight, or if the weight threshold for 'obesity' is reduced. A 'growing problem' of factitious disorder could therefore represent an increase in certain kinds of patient presentations, or it could represent a change as to which cases are considered factitious 'problems' (or it could represent both).

Previous writers have tended to focus on the former – the patients, and the psychological, social and economic pressures that lead to their presentation. Changes in family structure and healthcare provision have been argued to create psychological dependence on the attention and support of medical staff in vulnerable individuals (Carney, 1980; Shorter, 1992). Socialized medicine and cultural acceptance of subjective disorders would provide the necessary grounds (Robinson, 2003). Disability benefits have been seen as inducements (Parsons, 1980). Going further, the medicalization of life (Furedi, 2005) and the culture of the victim (Dineen, 1996) might make illness something to be sought, even flaunted – as seen in the very public contrition of fraudulent Vietnam veterans (Burkett and Whitley, 1998). An increase in factitious presentations has prima facie credibility, therefore, in which case the introduction of the diagnostic term would simply reflect the need to identify a group previously so rare as not to warrant their own category.

But the other side of this 'growing problem' lies with doctors – with those diagnosing the problem. Doctors may have needed 'a mediating diagnosis' because those available to them were increasingly unacceptable – increasingly problematic. DSM-III certainly did not describe factitious disorder as being an entirely new phenomenon: 'In the past, some of the disorders classified here would have been subsumed within the category of Hysteria' (APA, 1980: 286). Quite why the authors thought a new category was needed is unknown. Spitzer wrote the definition of factitious disorder on the spot, after hearing a case-report and having a 40-minute conversation with two psychiatric colleagues (Spiegel, 2005). But he was not working in a vacuum, and his improvisation clearly met a diagnostic need: 'factitious disorder' has flourished, in a way that the other diagnosis created after that conversation – 'brief reactive psychosis' – has not. In what follows, we will explore some of the diagnostic need for factitious disorder in its origins within hysteria and malingering.

ORIGINS IN HYSTERIA

Hysteria is one of our most ancient illnesses. It was arguably described in pharaonic Egypt, and was a regular feature of Hellenic, Roman and medieval medicine (Veith, 1993). But, quite what it is, or was, is unclear. Clinical histories present a progressive march from models of hysteria as movements of the womb, to spiritual possession (Veith, 1993), to nervous irritability and gynaecological reflex (Shorter, 1992), before Freud seals its status as a psychiatric disorder (Breuer and Freud, 1895). But there are several ways in which considering this the same disorder are problematic. First, hysteria is, today, a syndrome rather than a disorder – it is a cluster of symptoms and behavioural traits – and this syndrome has not been constant over the centuries

(Shorter, 1992), whether by diagnostic decree (DSM-II narrowed the symptoms of hysteria to the neurological, DSM-III reverted to the previously broad range of symptoms, and then DSM-IV narrowed them again; Widiger, 1996) or as it mimics the medical conceptions of its time (Merskey, 2001). Furthermore, its diagnosis today requires the exclusion of a 'medical' explanation, something which doctors in the past will have had a more limited capacity to do, and which we cannot normally do retrospectively. Though ancient texts may describe 'classic' hysterical symptoms as *Globus*, aphonia, or fits, neurological explanations for these remain possible. Even those ancient references are in doubt, as competing historiographies discredited interpretations, arguing, for example, that the apparent pharaonic and Hippocratic renderings of hysteria are merely modern misreadings driven by scholarship already immersed in Freudian concepts (Micale, 1995). But, above all, 'hysteria' has had a political dimension. Diagnosing hysteria has been argued from a variety of perspectives to be an expression of power and dislike – and perhaps nothing more than that (Micale, 1995).

Drawing these together into a single history, therefore, confronts the reader with what can seem like a history of stigma, or at least of misogyny, from the medieval ducking-stool (Veith, 1993) to the clitoridectomies of the 19th century (Shorter, 1992). And from the Enlightenment we can trace yet another pejorative thread, the assimilation of hysteria with malingering. First, with the growing understanding of anatomy and physiology it became clear that hysteria did not fit into the existing biomedical model – it '*behaves as though anatomy did not exist*', as Sigmund Freud later put it (Freud, 1953a). Seventeenth-century neurologists such as Thomas Sydenham and Giorgio Baglivi were struck that hysteria seemed to be provoked by emotional factors (Veith, 1993). And by the 19th century it was increasingly accepted that both the initiation and the termination of the illness were psychosocial, as reported, for example, in the works of Robert Carter (Carter, 1853), Silas Weir Mitchell (Mitchell, 1885), and Jean-Martin Charcot: 'We now know without a doubt that . . . a paralysis can be produced by an idea, and also that an idea can cause it to disappear. But what happens in between is still a mystery' (Charcot, quoted in Shorter, 1992). This left an explanatory gap, which persists to this day. Deliberate simulation would fill the gap nicely, and a deep vein of such suspicion runs through 19th-century neurology. Dennis de Berdt Hovell built his career on defending hysterical women from the doctor's 'unjust imputation of fancy and wilfulness' (Shorter, 1992), and reassuring them that he believed their symptoms were real. Weir Mitchell wrote much of the difficulty in distinguishing hysteria from conscious simulation, and even how they might be found in the same person: '. . . the curious progress from simulation, not consciously imitative, to conscious unresisted simulation, and at last dissimulation . . . of mimicry passing into well-sustained fraud' (Mitchell, 1885: 81). And the many recorded cases of the kind of

outright 'hospital shopping', 'surgical addiction', or other flagrant deception in Victorian ladies were all diagnosed as hysterical, but treated with the same semi-secret derision then as now (Shorter, 1992).

It was Charcot himself, perhaps the greatest neurologist of all, who confirmed that the kind of neuropathological explanation he had discovered for motor neurone disease or multiple sclerosis would not be found for hysteria, as his clinical-anatomic method failed to find explanatory lesions on the post-mortem examination of brains from hysterical patients. But he did not yield to the scepticism of those who explained it as malingering. He remained confident that a 'functional' lesion would be found one day, when microscopes were powerful enough to detect it (Charcot, 1889), and until then offered a psychological model for the explanatory gap, in the form of hypnosis. Freud wrote of his efforts:

> The first thing that Charcot's work did was to restore its dignity to the topic. Little by little, people gave up the scornful smile with which the patient could at that time feel certain of being met. She was no longer necessarily a malingerer, for Charcot had thrown the whole weight of his authority on the side of the genuineness and objectivity of hysterical phenomena. (Freud, 1953b: 19)

Unfortunately, many of Charcot's cases of hysteria were notoriously staged by the patients to accord with his diagnostic formulation, and therefore remain in the Salpetrière (Szasz, 1961). When this was revealed after Charcot retired it seriously discredited hysteria (Shorter, 1992); however, the works of two of his students – Pierre Janet and, more spectacularly, Freud – provided some respite from neurological suspicion, in the form of further psychopathological models (Nadelson, 1996).

The Freudian model absolved hysterical patients from malingering, but closely identified them, nonetheless, through the notion of secondary gain – the motives a patient could have, quite consciously, for remaining ill – which he thought prominent 'in all fully developed cases of hysteria' (Freud, 1953d: 46). Later writers in the analytic tradition, such as Karl Menninger, retained this blurring of boundaries: 'Every neurotic patient makes some use of their secondary gain from illness . . . and to this extent every neurotic person is a malingerer' (Menninger, 1935: 508, n.). By acknowledging the secondary gain, but prioritizing the unconscious drives, it challenged 'the widespread fallacy of assuming that conscious motives can be regarded as explanatory of human behaviour' (ibid.: 509). Someone who might otherwise look like a malingerer could be considered hysterical nonetheless.

This absolution of hysteria relied on the success of the Freudian model of the subconscious – a model which suffered a slow death in the 20th century. The DSM psychiatric classification system steadily removed Freudian aetiology with each iteration (Martin, 1992). The decisive edition was DSM-III,

with its goal of aetiological neutrality. Strikingly, it observed that hysteria, now renamed conversion disorder, 'common several decades ago . . . is now rarely encountered': striking, because as DSM-III sounded the death knell of conversion, with the same stroke it observed the growing problem of factitious disorder.

The idea that hysteria was dying out in western societies was common at the time, and widely reported (Walshe, 1965; Veith, 1993), but this still requires cautious interpretation. For, just as with factitious disorder, a declining problem can have two explanations – falling numbers, or a change in diagnostic practice. In the case of conversion disorder, making the diagnosis required doctors to infer that a patient's behaviour was under subconscious control: if the doctor lost 'faith' in that inference, the obvious alternative would be conscious control – factitious disorder or malingering. In other words, as doctors stopped believing in the Freudian model they would see less hysteria and more factitious disorder (though they might still diagnose hysteria for other reasons; Kanaan, Armstrong and Wessely, 2009; Kanaan and Wessely, 2010). When surveys of unexplained neurological disorders today are conducted without consideration for whether the symptoms are felt to be conscious, subconscious, or the result of an undiscovered neuropathology, the rates remain stubbornly high – around 30 per cent of all neurology referrals (Carson, Ringbauer *et al*., 2000; Snijders, de Leeuw *et al*., 2004). It would seem that the problem of unexplained neurology has not vanished from the West; we are just less clear what to call it. Once again, doctors murmur that the distinction between hysteria and conscious deception is no longer a useful one (Maurice-Williams and Marsh, 1985; Hopkins and Clarke, 1987).

In summary, the history of hysteria can be argued to show not a steady decline into stigmatized malingering, but a base of suspicion and disregard from which it was briefly raised by the support of Charcot and of Freud; a period of respectability, even of popularity (Micale, 1995), that has fallen away as their authority crumbled.

ORIGINS IN MALINGERING

Malingering is the deliberate production or exaggeration of illness with the motive of obtaining some external reward or for the evasion of some onerous burden, such as military or penal servitude. Its story is no less ancient than hysteria's – as ancient as our oral and written records from history (Solon of Athens), literature (Odysseus) and scripture (King David). It may even antedate humans entirely, if zoologists are correct in attributing certain behaviours in primates to malingering (Byrne and Stokes, 2003). As a method of evading military service, it runs right through military history, to the present day (Palmer, 2003), though its scope was vastly increased by the

large-scale conscription of the American Civil War and the two world wars. As a means of obtaining financial reward, it required a system for compensation of sickness, which largely meant begging until the introduction of workers' compensation in the late 19th century (Wessely, 2003). As Sir John Collie put it in his 1917 book on malingering:

> Not many years ago it was practically only in naval and military arenas that one heard the term used . . . the workhouses and prisons probably provided other examples. The many provisions made by the legislature in recent years for securing benefits to injured workpeople have . . . presented material inducements to a much larger class, and they have not been slow to take advantage of them. (Collie, 1917: 1)

More recently, litigation has offered the prospect of ever larger payouts – and estimates of the proportion of feigned mild head injury in the USA, for example, now range as high as 40 per cent (Larrabee, 2003). With this kind of potential expansion, it would seem inevitable that malingering would move from the criminal or military fringes, a little closer to mainstream society. As the means to malinger spread from criminals and enlisted soldiers in the early 19th century to virtually the entire population today, doctors might reasonably extend their suspicions to cover vastly more of their patients.

How would doctors respond to this? A relationship of mistrust is antithetical to the Hippocratic paragon and, in more modern terms, to good therapeutic relationships. While reactions from doctors will have varied considerably, one might expect there to have been significant resistance. We shall outline three positions that can be seen, wittingly or not, as resisting the role of doctor as legal investigator: first, avoidance or even collusion with the patient; second, the medicalization of malingering; third, the creation of mediating diagnoses.

Doctors working for prisons, insurance companies, or the army may have been comfortable with a role as detective, but for most doctors in the 19th century this was new. Most medicine was private, with a doctor–patient relationship correspondingly defined (Szasz, 1961). As Cooter has described (Cooter, 1998), the requirement of 'civilian' doctors to assess malingering at the turn of the 20th century was met with deep distaste, and consequently with avoidance of the whole question of deception by many. Doctors obliged to rule on their patient's illness for the government would leave the decision to some more specifically designated investigator where possible, so retaining their relationship with the patient. This inevitably meant a 'laxness' in screening sickness forms (Cooter, 1998) that continues to this day (Hussey, Hoddinott *et al*., 2004), with laxness extending to active collusion in some cases (Halligan, Bass *et al*., 2003). Doctors could argue that from a purely medical point of view the consciousness or unconsciousness of a pretence was irrelevant (Rabkin, 1964).

This difficult situation could be avoided entirely by our second response: making malingering a medical diagnosis. This could be accomplished through the derogation of responsibility for the disorder to heredity, or by extending psychological models to encompass malingering. Both of these were considered from the 19th century onwards, but the latter is of particular interest for our purposes, as the boundary from hysteria was thereby blurred.

Descriptions of malingering from the 19th and early 20th centuries were often of functional disorders that were taken uncritically to be malingering given their military context (Anderson and Anderson, 1984). Yet, the ingredients for hysterical diagnoses were observed in these patients. Gavin in 1838, for example, reported that 'soldiers are often actuated by the same wayward fancies, so perplexing to the physician, which influence hypochondriacal or hysterical patients in the middling or upper ranks of life' (Gavin, 1838: 4). And as Freud broadened the reach of his model from hysteria to 'The Psychopathology of Everyday Life' (Freud, 1953c) he extended a psychological determinism, and an operative subconscious to all. So by 1917, even Collie, the nemesis of the malingerer, used the terms 'subconscious' and 'unconscious' freely in speaking of the manifold motivations of his patients – without, of course, raising the question as to whether this might make them hysterical (Collie, 1917).

The incorporation of unconscious motivation was one plank of pathologization, but the motives themselves were also widened to include those of hysteria. Gavin, again, in his list of malingering motives includes 'to obtain the ease and comfort of an hospital', and 'to excite compassion' in addition to the predictable 'avoidance of duties' (Gavin, 1838: 3). Roberts Bartholow, in his 1863 treatise on American Civil War malingering (Bartholow, 1863), offers a list of motives very similar to Gavin's, including choosing a 'career diversion' as patient rather than soldier. Byrom Bramwell, writing of malingering in civilian life in 1896, includes deceptions motivated by the desire to 'excite sympathy' (Bramwell, 1896), as well as the more familiar financial motivations. By the 1930s the incorporation of malingering as neurosis seemed complete (Cooter, 1998), but by the time of DSM-III such motivations as above would garner a factitious diagnosis, and malingering was not included as a psychiatric disorder (APA, 1980): a mediating diagnosis had relieved the pressure.

The formation of such mediating diagnoses represents the third response. Factitious disorder was not the first such diagnosis, but the latest in a tradition extending, again, to the 19th century. Railway spine, shell-shock, compensation neurosis, accident neurosis – all at one time occupied positions between hysteria and malingering (Shorter, 1992; Halligan, Bass *et al.*, 2003). Similarly to the medicalization of malingering, a mediating diagnosis would allow the doctor to acknowledge the deception while pathologizing it. The doctor could make a medical, not legal, 'diagnosis', keeping their medical hat on, and allowing the doctor–patient relationship to remain a therapeutic one.

Defining the differences between the diagnoses so as to permit this is not at all straightforward, however. The term 'mediating diagnoses' suggests some sense in which these disorders can have stood 'between' hysteria and malingering – but what sense could that be? What kind of a spectrum do they lie on? The usual response to this has been that they lie on a spectrum of motivation or of consciousness (Taylor and Hyler, 1993). There are difficulties with such a view, as we shall explore in the next section, but we here point out one important spectrum on which our disorders clearly *can* be separated. All of the mediating diagnoses have been understood as responses to social problems, to floodgates of human weakness opening (Wessely, 2003) – the availability of compensation, the possibility of medical retirement, the availability of free healthcare. In this way they retained a pejorative flavour – the patient was seeking compensation, avoiding combat, or misusing medical resources – while retaining them under the medical purview. And on this pejorative scale, on a spectrum of condemnation (Szasz, 1956), factitious disorder did occupy a medial position between hysteria (a problem deserving of sympathy) and malingering (a crime deserving of prison).

A SPECTRUM OF MOTIVATION?

We have considered how the decline of the Freudian model may have exposed hysterical patients to the distrust and dislike from which they had been briefly rescued. We also considered how the great expansion of the potential to malinger led to various strategies to preserve the doctor–patient relationship, and lessen the sting of diagnosing malingering. These would both have tended to push for the expansion of the 'middle ground' on the spectrum of condemnation. But such a narrative would not have been palatable to doctors, who do not like to think of themselves as making diagnoses on the basis of dislike to their patients. A 'mediating diagnosis' would have to be distinguishable on clinical grounds.

However, when we examine the definition of factitious disorder a little more closely it seems strange that it was ever considered to 'occupy the large middle ground between the hysterical disorders and malingering' (Hyler and Spitzer, 1978: 1502), for it does not appear to lie in the middle at all. It shares the deliberate deception of malingering, and it shares the internal motives of hysteria. It is not 'semi-deliberate' or 'semi-motivated', rather it occupies the ends of both spectra. The problem for doctors would remain how to understand deliberate deception, for whatever motive, as pathological.

The basic approach adopted was to argue that the pathology lay in the motive. Early papers wrote of 'addiction' to hospitals or to surgery (Barker, 1962), but by DSM-III the explanation was in terms of motivations that were themselves unconscious and pathological – a second-level pathology. For

example, Stuart Eisendrath, one of the most prolific commentators in the area, called it 'conscious illness-affirming behaviour deriving from unconscious motivations' (Eisendrath, 1984: 111). He thereby differentiated factitious disorder from the addictions, and aligned it with phobia instead, where patients 'know that they avoid the feared object, but do not usually have a conscious awareness of why they do so'. Taylor and Hyler argued that factitious motives were unconscious in that they resembled compulsions (Taylor and Hyler, 1993), the line taken by DSM-III (APA, 1980).

It is not clear where this confidence came from. Those working in the psychodynamic tradition, such as Carney and Brown (Carney and Brown, 1983), felt able to make confident statements about the hidden motivations of their patients. But, as Eisendrath acknowledged, 'only psychological inference may give a clue as to what these motivations are' (Eisendrath, 1984). The classification system ICD-10 was suitably circumspect: 'The motivation for this behaviour is almost always obscure' (WHO, 1992). What is clear is that factitious patients had been reported only in small numbers, and they had not generally been cooperative with doctors' explorations (Krahn and Li, 2003). But some of those who did cooperate described quite conscious motivations (Pallis and Bamji, 1979) that seemed to meet a clear need (Feldman, 2004). This would seem to be a serious challenge to doctors' requirement that the motive be pathological. That was how DSM-III most clearly differentiated factitious disorder from malingering: 'Whereas an act of malingering may . . . be considered adaptive, by definition a diagnosis of a Factitious Disorder always implies psychopathology . . .' (APA, 1980: 285). Without this requirement, the clinical distinction from malingering would be difficult to sustain (Turner, 2006).

JUSTICE AND THE SPECTRUM OF CONDEMNATION

The struggle to differentiate the disorders clinically might not matter so much if the spectrum of condemnation were not so easy to discern. Without a clinical distinction, doctors would have to diagnose the disorders – with such divergent consequences – on non-clinical grounds. And there are suggestions as to what these grounds may have been, as condemnation was not evenly spread in society. Bartholow, for example, found malingering to be an affliction of the working class, and in particular of German-Americans (Bartholow, 1863). Gavin saw it as a problem mainly afflicting the Irish (Gavin, 1838). Others thought it largely a problem with Poles or with Jews, or, clearest of all, a problem affecting foreigners (Dembe, 1998). Malingering was understood, until the 20th century, to be simulated illness among soldiers or prisoners – lower-class males. Whereas hysteria was understood to be

gynaecological well into the 19th century, and a particular problem for the upper classes, with many doctors noting that only their gentlefolk suffered hysteria, and that becoming poor could be curative (Shorter, 1992). Any examination of the history of hysteria or malingering thus reveals a striking dichotomy: while distinguishing the conditions by clinical or psychological means can be very difficult, distinguishing the conditions by gender or class can be very easy. All our Victorian soldiers were found to be malingering, irrespective of their psychology; all our Victorian ladies were found to be hysterical, irrespective of their deception. Without a clinical basis, such differential condemnation would today seem manifestly unjust.

Of course in the 19th century there was little thought that illness might be socially constructed. The differential application of hysteria and malingering would have found ample support in essentialist theories of hereditary degeneracy and feminine weakness. But the 20th century was a very different time, and in this final section we briefly consider one force that would have made this diagnostic division increasingly problematic: egalitarianism.

We have already discussed the widened scope of malingering, with the advent of workers' compensation and mass conscription. The initial suspicion for some was that this increase was due to malingering – for example, as the German medical profession reacted to Bismarckian social welfare legislation during the Kaiser Reich (Eghigian, 2000). But such a response risked indiscriminately criminalizing vast numbers of people. A further challenge came from the First World War, as the military and medical authorities were confronted by ever-increasing numbers of soldiers with functional illness – invariably males, often officers, and sometimes decorated heroes (Bourke, 1996). Though there had been many who had questioned the gender or class predilections of hysteria before (Micale, 1995), the contest over the status of shell-shock presented an unavoidable challenge to the distinction between malingering and hysteria: the upper classes were capable of malingering, or men were capable of hysteria. Those who argued that shell-shock was hysterical prevailed (Jones and Fear, 2007) – a dramatic shift from the time of Gavin less than 100 years earlier, when all such syndromes were considered malingering by default. And these shifts have been sustained. Men now constitute around one third of conversion disorder (Akagi and House, 2001), and patients represent all classes of society – if anything, conversion disorder is more common in lower socio-economic groups (Stefansson and Messina, 1976). Both shell-shock and workers' compensation were contentious issues, which could not be ignored by the medical establishment. Inevitably, the harmonization of the treatment of men and women, rich and poor, was explicit in the thinking of some doctors – and in the thinking of politicians (Cooter, 1998). It was part of the founding creed of socialized medical services, such as Britain's NHS. And with that change of service came a substantial shift in the doctor–patient relationship.

The difference in the relationship between a 19th-century doctor and his wealthy clients, and a 19th-century doctor and a prisoner could not have been clearer. The wealthy clients were his livelihood, and he must please them; with the prisoner, the doctor would be employed by the court, not the patient, and a discovery of 'malingering' would typically be welcomed. That relationship changed with socialized medicine (and to a lesser extent with insurance-based services), such that the physician now worked for the patient and secondarily for the state, in most situations (Szasz, 1961). It is easy to imagine how diagnostic practices will have changed in step: doctors will have been reluctant to ascribe malingering to their 'clients', but instead to find their illness 'medically unexplained'. This, we suggest, would exert an 'upward' pressure on the cases at the malingering end of the malingering–hysteria spectrum.

At the top end of the spectrum, doctors would be typically less beholden to their individual patients for patronage, and perhaps *more* empowered to say what they thought. Doctors had felt that hysterical patients manipulated their carers to get what they wanted long before Freud. The Freudian model absolved patients for responsibility for this, even where there was clear secondary gain. But with the Freudian model in retreat, conversion disorder was more or less where it had been 100 years ago: waiting for a model. Doctors remained suspicious that their conversion patients were feigning (Pridmore and Skerritt, 2004), and this suspicion was now codified: the diagnostic manuals required that a diagnosis of conversion disorder, uniquely among mental disorders, could only be made once feigning had been excluded (WHO, 1992; APA, 1994). Doctors were left, then, with a set of illness behaviour that gave every impression of being willed, with apparent secondary gain, among a group that was no longer paying directly for their opinion. This, we suggest, can be seen as exerting a 'downward' pressure on the cases at the top of the malingering–hysteria spectrum.

CONCLUSION

Previous taxonomies may have been adequate to the task of Victorian medicine, but there was a 'growing need' for something in between malingering and hysteria. We have argued that some of that need may have come from doctors, adapting to the changes in their relationships with their patients: for a diagnosis without the condemnation of malingering, and without the sanction of hysteria, as diagnostic distinctions made on the basis of motive, or gender, or class, were no longer acceptable. To that end, those who advocated a single diagnostic entity, of dissimulating disorders (Jonas and Pope, 1985), may have reflected something closer to what doctors felt: that the range of motives may be important legally, morally and psychodynamically, but the important thing to the doctor was the simulation.

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