The Ellard Collection

Hysteria and malingering

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'Hysteria and malingering' is the third of the late Dr John Ellard's essays reproduced from the book *Some Rules for Killing People*.[1] Dr Ellard, revered former Editor of *Modern Medicine of Australia* and *Medicine Today* and a distinguished psychiatrist, wrote many essays in the 1970s and 1980s on society's most controversial and vexing issues. These were published in various journals including *Modern Medicine of Australia*, and a selection were chosen by Professor Gordon Parker, then Professor of Psychiatry at the University of New South Wales, for publication in 1989 as the book *Some Rules for Killing People*.* The essay 'Hysteria and malingering' originally appeared in a 1980 issue of *Modern Medicine of Australia*.

One of the central problems in psychiatry is to understand why people do what they do. A mystery is encountered when the motivation is obvious enough, but the person concerned cannot, or will not, acknowledge it. Any useful discussion of this problem will involve such questions as whether or not there is a mind; if so, what its parts and functions may be; is voluntarism a tenable hypothesis; and what is a proper analysis of lying. This article considers some of the notions advanced over the last few thousand years, how some of them have had quite terrible consequences, and what the author finds useful.

MedicineToday 2017; 18(3): 70-75

This essay will follow one of the great traditions in medicine. The literature in this area is not only ancient and extensive, but also distinguished by the fact that in some thousands of years not only has it advanced very little but also recently it has tended to go into a decline. I believe that I shall be within that tradition. Since I am a practical man, without much understanding of the abstract, you will forgive me if I put the issue before you into a concrete problem and at first deal with the particular rather than the general. Imagine, if you will, that a large group of us is attending a conference and we are suddenly surrounded by aliens from another planet. Their leader – there is always a leader in these stories – informs us that we have been captured so that they can eat us, and that they propose to do it now. But, their religious observances forbid them from eating anyone who has a limp, so all those who limp are free to go, while those who remain behind will be devoured. Now I will warrant that the conference hall would immediately resemble the Workers' Compensation Commission on a busy morning as we made our painful and hesitant ways out the door. And I would know, as I limped out, that each and every one of you was a malingerer, as indeed I would be myself. So far no problem, for we all know that normal men under appropriate circumstances will malinger, because it is the sensible thing to do.

Let us pass on to the difficult bit. The frustrated and hungry aliens blast off to some other more hopeful place and we are left untroubled. In the course of my ordinary affairs, I encounter some of you around the city during the succeeding weeks and I observe that you are still limping. I reassure you, pointing out that the aliens are well past Alpha Centauri and still going strong. You

* Ellard J. Some rules for killing people. Parker G (ed). Sydney: Angus and Robertson Publishers; 1989.

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thank me, looked relieved and limp away. Then I read in the newspaper that our compassionate leader has said that everyone who has suffered from the alien invasion will be compensated and that the going rate for limps is fifty thousand dollars. I discuss this with you; you look puzzled and say that the only desire you have is to be restored to health and that the money is of no interest to you. Indeed, your solicitor has sent you to many orthopaedic surgeons in the hope of achieving a cure, and you are currently having physiotherapy twice a day, seven days a week – to which you are taken in a taxi. And you limp away again, a little more noticeably. Here we have it. We have behaviour which is usually associated with physical disease, appearing in its absence; following an incident which should not have left one with an enduring disability. There is an obvious benefit attached to the persistence of the symptoms. I might ask myself if such a thing has happened before – does the literature contain accounts of men and women manifesting symptoms usually indicative of somatic pathology, but in its absence? If it does, what is the explanation?

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Our trail begins about four thousand years ago, in the fragments of the *Kahun Papyrus*. Here we encounter descriptions of physical symptoms attributed to migration of the uterus up into places where it should not be. Given this aetiology, the remedies were logical enough. One sat the patient – necessarily female – on a chamber pot filled with sweet-smelling infusions, so as to coax the migratory uterus back into its proper place, while at the same time one caused the patient to swallow foul tasting concoctions so as to drive the uterus down away from where it should not be. One of the herbs used for this purpose in those days was asafoetida; it may interest you to know that the pharmacopoeia of the Royal North Shore Hospital in use in the 1950s offered tincture of asafoetida as a remedy for hysteria. I warned you not to look for rapid progress. Similar descriptions and remedies are to be found on the *Ebers Papyrus* from the sixteenth century BC. But here an important and new therapeutic principle is encountered. Until now, therapy has been rational. If the malady is due to upward displacement of the uterus then it is sensible to use a carrot and a stick to urge it back to where it should be. However, listen to this ... 'To cause the womb to go back to its place: an ibis of wax is placed on charcoal and let the fumes thereof enter into her vulva.' Why an ibis? An ibis is the symbol of Thoth, one of the most powerful male deities of Egypt: amongst other things he was physician to the gods. Hysteria, doctors and the genitals – we shall meet that combination again.

"The thirty-fifth aphorism of Hippocrates gives us the term hysteric (from hystera, the uterus) ... "

We do not know how many millennia of observations and theorising preceded the Egyptian hypothesis, but we do know who came next – the Greeks. The thirty-fifth aphorism of Hippocrates gives us the term hysteric (from hystera, the uterus) and also another remedy: 'When a woman suffers from hysteria or difficult labour an attack of sneezing is beneficial.' Obviously enough, if you cannot coax the uterus down to where it should be you might be able to sneeze it down. The Greeks made the sexual aetiology of hysteria explicit. Deprivation of sexual relations causes the uterus to dehydrate: in its search for moisture it rises, thereby impeding the function of the other organs as it attaches itself to them. Thus the globus of globus hystericus is the womb itself, obstructing swallowing. Variants on the Egyptian remedies still abounded, but more importantly, marriage was recommended as the most effective cure. I grieve to say that there are still practitioners making the same recommendation on grounds no more substantial than those known to Hippocrates. The inscriptions from the Aesculapian temples provide us with many case histories which nowadays we would perhaps regard as consistent with hysteria. Paralysis, blindness and mutism were disorders commonly presented to the priests and commonly cured. One inscription from the temple of Aesculapius at Epidaurus may have particular relevance to our quest: 'Nikenor, a lame man. While he was sitting wide awake, a boy snatched his crutch from him and ran away. But Nikenor got up, pursued him, and so was cured.'

Now what was wrong with him?

The need for brevity prevents us from admiring the contributions of other great physicians – of Celsus, Arateus (who described manic-depressive psychosis) and Sorarius, but we must

pause for Galen. He recognised the absurdity of the notion that the uterus can move unfettered about the body, thereby anticipating the Royal North Shore Hospital by some twelve hundred years. He offered instead the opinion that sexual abstinence causes suppression of semen in both sexes – in terms of the physiology of the day. From that there followed a specific remedy; we read in *De locis affectis* the following case history:

Following the warmth of the remedies and arising from the touch of the genital organs required by the treatment there followed twitchings accompanied at the same time by pain and pleasure after which she emitted turbid and abundant sperm. From that time on she was freed of all the evil she felt.

Be it noted that Galen knew what to do, knew how to cure his patient but that he still clung to an incorrect anatomical and physiological explanation of what he saw.

Towards the end of the second century, then, things were reasonably clear. A mixed bag of physical disorders including blindness, mutism, paralysis, anaesthesia and disorders of consciousness were attributable to hysteria, itself due to sexual frustration. The Egyptians used a wax ibis, and Galen used his fingers – either way it was becoming clear that the remedy involved sexualisation of the relationship between the physician and the patient, symbolic or explicit. If we were to abandon our search at this point then we would be left in no doubt about our limping contemporaries. There is little resemblance between their symptoms and those of hysterics, and the cause is quite different. They do not have hysteria and our first suspicion – that they are malingering still, for we know that they malingered in the first place – is the most reasonable conclusion to draw.

However, I warned you when we began that the literature has shown an unfortunate tendency to deteriorate in recent years and we are now to see the beginning of that. You will recall that for many years there was a close and ambivalent relationship between doctors and priests – after all at one time they were the same person – but now, after Galen, the priests go on top. For Galen sexual abstinence was a pathological condition leading to hysteria. For St Augustine, three centuries later, the situation was reversed – abstinence was desirable and the carnal pleasures impure and reprehensible. The Western preoccupation with guilt was launched and accelerating. By the ninth century, at the time of Charlemagne, hysteria was a form of bewitchment. By the fifteenth century the *Malleus Malificarum* had been written, and the remedy for paralysis, anaesthesia, and disturbances of consciousness was no longer orgasm, but drowning, or burning at the stake. Things had come a long way since Galen. Instead of today's neurologist, looking for anaesthesia with his pin from his lapel, by the seventeenth century there were 'common prickers' – expert witnesses plying their trade up and down the countryside of England and Scotland. The anaesthesias they found brought torture and death to those who possessed them.

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The sexual basis of these aberrations was as explicit as ever, both in the persecuted and their persecutors. Witchcraft could only arise from magic, which in turn arose from the devil. And how did the devil communicate his power? – by assuming the corporeal form of incubi and succubi and indulging in every kind of carnal lust and all manner of filthy delights. Indeed, Kramer and Sprenger, the authors of the *Malleus Malificarum*, took the matter further and laid down that any sexual pleasure at any time under any circumstances was derived from the devil. Sadistic and perverted beliefs such as these multiplied apace, and this wretched period in human history could preoccupy us for more time than it is worth if we had the scope to permit it to do so. Let us instead attend to the Reverend Francis Hutchinson, Chaplain in Ordinary to His Majesty and minister of St James's Parish and Bury St Edmunds. In his *An Historical Essay Concerning Witchcraft* he wrote:

Courts of Justice may as well hang People, upon their Confessions, for the Murders they think they commit in their Dreams, as for what they fancy they do in these Trances. What if this Girl, in this Extacy of Mind, when she had not the Use of her Reason, had made a Compact, and thought she had set her Name to it, and joyned with other Witches in Murders, and confessed them? What wise Man would have turned such a Confession to her Hurt? Physick for Madness would be proper for such a one; but a Stake, or Gallows would be barbarous. It would be harder yet to hang other People for what these Brainsick Persons fancy they see them do.

The Reverend Francis Hutchinson took hysteria and psychosis away from the priests and gave them to the doctors. The last victim, a young nun, was burned alive in the marketplace at Wurzburg in 1749 after what was in retrospect an epidemic of hysteria in a convent.

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Before we see what a mess doctors made of the problem let us note two things which must find a place in our narrative. The first is that the word 'malingerer' turns up in 1785, in Grose's *Dictionary of the Vulgar Tongue*. It is a military term, for one who made pretence of sickness to evade his duties. What sort of sickness? What did the malingerer manifest? Paralyses, blindness, convulsions, mutism? Not at all – ulcers of the legs, artificially produced. It is difficult to think of two conditions less likely to be confused – hysteria and malingering. The second thing to be noted is that during all the years we have traversed another process has been in train. Western man has been slowly elaborating and clarifying the notion of an unconscious part of the mind. No doubt the other great civilisations were doing much the same – or better – but we must confine ourselves

within a familiar compass. In the eighteenth century not only was the notion of unconscious process well established, but it was beginning to be recognised that such processes might provide the mainspring of much behaviour. Jean Jacques Rousseau embarked upon a self-analysis which preceded that of Freud by more than a hundred years: 'the true and primary motives of the greater part of my actions are not as clear to me as I have for a long time imagined.' While the fact of unconscious motivation could not be denied, nevertheless we shall see that its recognition provided us with some insoluble riddles which have deflected most people's attention from more significant issues.

We have now assembled all our elements: hysteria, unconscious processes, the medical profession, and the presence of symptoms which confer advantage, or at least avoid disadvantage. From this heady mixture was generated such a fog of confusion that we still wander in it, bemused. We can see it coming by the time of the American Civil War. The physicians of that time – one hundred and twenty years ago – described a condition they called 'nostalgia', 'a mild type of insanity caused by disappointment and a continuous longing for home'. During the early part of the war, 5200 cases of nostalgia required hospitalisation, even though medical opinion held that it was a moral problem and not a medical one. Nevertheless, this view eventually prevailed and both the diagnosis and the condition were discouraged, with the result that it disappeared. Perhaps you can guess what happened: there was not an epidemic of limping, but in the next three or four years there were hospitalised 58,000 cases of neuralgia, 66,000 cases of headache, and 145,000 cases of constipation. One is reminded of the disordered action of the heart of World War I, and the innumerable obscure alimentary disorders of World War II; one is certainly not reminded of hysteria.

However, since both the hysterics and the soldiers who were avoiding duty had symptoms without somatic pathology, the temptation to bring them together was irresistible, and it was not resisted. The problem was that whereas there was some reason to believe that the classic hysteric was primarily unconsciously motivated, this was far from the case with the much larger group of those deriving obvious gain, for whom a better established term was available. We can see the confusion so engendered in the medical documents of the day. Let me quote, for example, from a clinical paper I have chosen from *The Lancet* of 19 June 1886 by Dr Willoughby F. Wade, senior physician to the General Hospital, Birmingham. He says, 'cases of hysteria may be usefully, if not scientifically, divided into three classes: first, the simple, genuine, or involuntary cases; second, those in which there is unconscious exaggeration; third, those in which there is conscious fraud or deception.' His treatment is essentially that of outwitting the patient: that is, although he recognises three kinds of hysteria, one of them fraudulent, nevertheless he treats all hysterics as if they were frauds. For example:

Thus I entirely checkmated a girl who pretended that her bowels had not been open for weeks. I told the mother the truth (which was that I knew it to be untrue), and got her to tell the patient that we did not think anything of it; that some people had evacuations and others had not; that there was no rule about such things. With this somewhat audacious statement – which she, of course knew to be untrue, but could not well repudiate without spoiling her case – the patient's renewed attempts to excite interest in her case were consistently met, and she was ultimately beaten out of the field.

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The exception to this form of treatment is to be seen only in cases of hysterical coma, which curiously, he treats with an enema of asafoetida, thereby confusing the Egyptians, the Greeks and the Royal North Shore Hospital.

Wade's classification is essentially that of Robert Carter, a wise English physician born in 1828 to die in 1918, whose long life therefore encompassed many of the problems we are brushing over so quickly. Carter is almost forgotten; instead we remember a powerful contemporary. For it was a critical time, and all that was needed was a charismatic man to scramble the concept of hysteria hopelessly and completely and then to carry the world with him in error. He arrived: his name was Charcot. An assessment of Charcot's significance involves us in difficulty and paradox. One may say, for example, that most of his writings on hysteria and hypnosis were quite wrong. Neurologically he proceeded by making his observations first and then, by intuition, reaching a generalisation which made everything clear. He was a master of classification and order; his hysterical patients, who had been neurotic far longer than he had been a neurologist, took good care to produce phenomena which were as organised, rehearsed and spectacular as his own lectures. Since his public descriptions of hysteria were on a neurological basis his hysterics faithfully presented him with symptoms and signs which could be interpreted as due to dysfunction of the central nervous system. And yet we have evidence to suggest that not only were they deceiving him, but that he was deceiving everyone else. Freud, in Paris, at one of Charcot's Tuesday night at-homes heard Charcot talking to Brouardel about a married couple who had arrived from the Far East, the woman a confirmed invalid, the man impotent. Charcot suggested that there might be some connection between the symptoms in the two people, and Brouardel hesitated. I quote Freud:

For Charcot suddenly broke in with great agitation, 'but in such cases it is always something genital, always … always ... always'; and he crossed his arms over his stomach, hugging himself and jumping up and down on his toes in his own characteristic lively way. I know that for one second I was almost paralysed with amazement and I said to myself, 'Well, but if he knows that, why does he never say so?'

That was in 1885. In 1893, a few days before his death, Charcot told Georges

Guinan that 'his [Charcot's] concept of hysteria had become decadent and his exposition of the pathology of the nervous system must be revised'. Perhaps he had come to terms with himself over knowing what he did not want to acknowledge; we shall never know. However, the damage was done. Charcot's failure to understand, or failure to be honest about hysteria had moved it firmly into the status of a disease, to be studied by neurologists. You will recall that at that stage of his career Freud was a neuroanatomist and a neurophysician. Hysteria had become respectable; worse was to follow, malingering was to join it.

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How can I say that Charcot made malingering respectable? Listen to Janet, another great French neurologist. There were two hysterical patients with concentric contraction of the fields of vision, which, if it were the case, meant that they walked about with only a small circle of central vision. Janet says:

I showed [Charcot] two of our young patients playing very cleverly at ball in the courtyard of La Salpetriere. Then, having brought them before him, I remarked to him that their visual field was reduced to a point and I asked him whether he would be capable of playing at ball, if he had before each eye a card merely pierced with a small hole.

Charcot hesitated but was not impressed. If that is not enough then let us consider the case of Blanche Wittman, whom Charcot used to present to eminent legal audiences to show how hysterics might commit terrible crimes in a state of somnambulism. She had given her demonstration, shooting, stabbing and poisoning her imagined victims most obediently. Charcot and the eminent audience withdrew, leaving Blanche in a state of somnambulism still, in a room littered with imaginary corpses. The medical students who remained behind told her that she was alone and that she should undress and take a bath. The lady who could murder without turning a hair had a tantrum and woke up. And finally Guillain, Charcot's own biographer:

In 1899, about six years after Charcot's death, I saw as a young intern at the Salpetriere the old patients of Charcot who were still hospitalized. Many of the women, who were excellent comedians, when they were offered a slight pecuniary remuneration imitated perfectly the major hysteric crises of former times.

The naiveties of those days extend down to the present. Open the standard psychiatric texts of today and you will read that a careful psychiatric interview will always make clear what is unconscious motivation and what is not. You will read too that psychiatrists rarely see malingerers, a statement easily made if one is incapable of recognising them. Some American psychoanalysts have returned to the nineteenth century position that malingerers are of necessity sick people to do such a thing. Since successful malingering may return as much as one hundred thousand dollars it is not difficult to see who is most out of touch with the world. Well then, if we have reached such a state of confusion how can we escape from it? Fortunately there is a clue. Things improved when the priests were chased out of the arena in the eighteenth century; let us ask ourselves what would happen if we were to chase the doctors out in the twentieth.

"Hysterical symptoms ... are a language, not an illness. The patient is portraying, without the use of words, the way in which he wishes to be considered sick."

Those whom we are discussing, all of them, are impersonating people with diseases. Whether or not they know that they are impersonating is difficult to discover in most cases and impossible in some. Whether or not this distinction matters depends on how one conceptualises the whole thing. For example, if we say that A is impersonating a man with disease X then there is no logical reason to regard A as diseased at all, but instead he is manifesting something else other than a disease. What is he manifesting? Generally I find myself out of sympathy with the writings of Thomas Szasz, but in this particular issue I must go along with him. Hysterical symptoms, to Szasz, are a language, not an illness. The patient is portraying, without the use of words, the way in which he wishes to be considered sick. The aim of the communication is to secure an advantage, which may be dependence, power or money. Such a language is adopted because within the Judao–Christian Western communities the rules of behaviour which exist favour helping the weak and helpless. Medicine is of necessity involved in assisting the weak and helpless, but it is not difficult to show that patients are sometimes treated as inadequate and incapable people when in fact they might take a much larger part in their own salvation. Under these circumstances we cannot be surprised if patients with particular needs play the rules of helplessness to the limit.

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There are, of course, many rules which humans need to have in order to cope with the ordinary burdens of living. By no means all of them are explicit, and one of the useful techniques developed in psychiatry in the past twenty years or so has been to describe many aspects of human behaviour in terms of rules, and the games which those rules constitute. The late Eric Berne's book *Games People Play* achieved very large sales because it had something useful to say which everyone could understand. No one would think for a moment that the games described in that book were diseases; they are simply the rules governing the transactions between the principal player and those in his environment. Might it not be useful to categorise hysteria as yet another game, for if we do that we rid it of the notion of disease just as surely as we rid it of the notion of demonic possession. We may find that one association has been quite as harmful as the other. How then can we best describe hysteria? Here I depend substantially on Szasz's analysis:

1. Hysteria is a form of nonverbal communication, making use of a special set of signs

2. It is a system of rule-following behaviour, making special use of the rules of helplessness, illness and coercion
3. The end goals of the game are domination and interpersonal control, often with some further end in view. The essential strategy is deceit.

The game exists because there is something which the principal actor wants which he or she cannot get because under the ordinary rules of society he is not entitled to it. Therefore, he uses the rules of hysteria or malingering because they are the usual rules which obtained in his family group, or because, due to some disorder of his psychological development, these are the rules with which he has been most comfortable and most successful during his life. If you will accept this description of hysteria then the hysteria/malingering difficulty disappears forthwith, for exactly the same description will apply to both. Further, one can use exactly the same techniques of management, with predictable results.

"... the understanding and management of hysteria have been confused by the importation of two irrelevant models – the first demonological, the second medical."

Let me give you two examples of management, both from military psychiatry, for here the problem can present acutely and the remedies can be assessed with some objectivity. During the North African campaign in 1943, the number of United States soldiers being repatriated to the United States for psychiatric discharge rose rapidly until it became clear that if the situation continued unchanged the United States army would be decimated. Inspection of those being returned led the War Department to signal the North African theatre to the effect that there was little difference to be made between those being returned and those being inducted. I hasten to add that the vast majority of psychiatric diagnoses and decisions at that time were not being made by psychiatrists. Now, learned committees might have spent hundreds of hours deliberating about the true nature of the symptoms causing the men to be repatriated for discharge. Were they hysterical or malingered? Was the motivation conscious or unconscious? Nothing could have been a greater waste of time, for such questions are usually unresolvable. Instead, the game was abolished. It was promulgated that no one could be repatriated and discharged for psychiatric reasons and for a considerable time no one was. When it became permissible again then the small number of irretrievable psychotics and so on was duly discharged, but there was no backlog at all of the other complainants and the crisis disappeared. There being no game, there were no players.

The second example I observed myself in Saigon in 1967. At that time there were some twenty thousand United States servicemen in that city, together with a large number of civilian advisers and other personnel more difficult to classify. It was a disagreeable and anxious situation and there were many pressures from back home to be quit of it all. I asked where were the overdoses, the florid hysterical symptoms and the self-inflicted wounds one might expect to see under these circumstances. Or, if not that, where were the men offering to do these things if they were not repatriated. I was told that no one had seen any for some time. Those indulging in behaviour of this kind were told that it was recognised as an immature way of demanding privileges to which they were not entitled and which they were not going to get. Persistence in demanding might lead to retention in Vietnam for a longer period than otherwise anticipated so that everything could be sorted out, so the complainant might as well get on with his normal duties if he wanted to get home as quickly as possible. There being no game, there were no players. You might suggest that the would-be players of that game simply had turned their attention in another direction, and won there. Some may have, but there was certainly no detectable large-scale move across to another area. For example, the number of those in military gaols declined significantly during the period under review. And we are not merely playing with words. The rate of psychiatric discharges from the United States forces declined by a factor of seventeen during the period 1941–1976. No doubt many influences contributed to that decline but there seems little doubt that the significant one was the application of the principles which I am advocating to military psychiatry. Let no one think that I would argue that similar considerations apply to other conditions such as depression; here one might expect an appropriate response to orthodox treatment.

"The answer ... is to look on both hysteria and malingering as a form of communication, or as games which have much in common."

Let us then summarise the propositions I am putting to you. I have argued that the understanding and management of hysteria have been confused by the importation of two irrelevant models – the first demonological, the second medical. The first led to the domination of hysterics by others, with dire results for the hysterics; the second has led to hysterical mechanisms controlling the environment at least in some contexts with results that we all know. The problem of malingering has become enmeshed with this problem, producing further confusion. The answer proposed is to look on both hysteria and malingering as a form of communication, or as games which have much in common. It is pointed out that where this principle has been used operationally confusion has abated and no one seems permanently disadvantaged. While some may fail to get what they want whenever they want it, in the longer term they may achieve the benefit of learning other more efficient and less convoluted means of communication. If we can rid ourselves of unnecessary hypotheses, woolly logic and the errors of history then we have a chance of dealing with these complex issues as directly as we would hope that our patients – and our families – would deal with us.

And what of those who are still limping? What are we to call them – malingerers or hysterics? While the last word has not been written yet, I would suspect that it doesn't matter much, provided that we all have our meanings clear. At the moment we have not. MT