MEDICINA NEI SECOLI
Journal of History of Medicine and Medical Humanities
37/1 (2025) 33-46

Revised: 20.11.2024
Accepted: 20.01.2025
DOI: 10.13133/2531-7288/3093

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Galen on faking pain*

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ABSTRACT

Faking pain and other symptoms is an emerging and controversial topic in medical literature. It was already addressed by Galen in the short writing *Quomodo morbum simulantes sint deprehendendi*, the major excerpt of the *Commentary on Hippocrates' Epidemics book II*, lost in the original Greek but surviving in Arabic translation. Using case histories, Galen analyzes malingering and illness deception building a theory which is still worthy of attention. This paper aims at reconsidering Galen's text, highlighting its most important and significant features, in order to better understand the ancient view on simulation and put it into a medico-historical context.

Key words: Galen - Quomodo morbum simulantes sint deprehendendi - Commentary on Hippocrates' Epidemics book II - Faking pain - Malingering - Illness deception

*I would like to thank those who have read, commented on, and discussed this article with me. In particular, I wish to thank Stefania Fortuna. I owe the referees valuable suggestions and insights to be developed in future investigations. The idea of an article on Galen's view on simulation and the modern psychoanalytic theory came to me while reading a copy of Freud's Studies in hysteria which was offered to me by Lea having belonged to her late father Dino – psychologist, master and friend: to write was to continue our lively conversation.

1. Faking pain and other symptoms in medical literature: an overview

Faking pain and other symptoms represents a currently relevant and controversial topic in medical literature, a major feature of modern medicine according to a benchmark study[1]. In order to introduce it, a recent handbook gives an example[2]: a primary care physician examines a patient complaining of a stomach pain, sharp, on the left side, during all day and worsening after a meal; it started three weeks ago after a family quarrel and is unexplained; the physician asks a few questions to figure out the cause, but nothing really helps: some causes, such as exercise, indigestion and ulcer, can be ruled out, but the performed tests are all inconclusive. What could be the diagnosis? Is the patient trying to get attention, or faking pain in order to obtain prescription drugs? How to ascertain if the patient is simulating and prove suspicions? This case is just fictional, but neither implausible nor rare, and it has been reported that up to a third of patients have symptoms without explanation[3].

Illness related deception matters, in addition to primary care physicians, to psychopathologists and psychologists. Recent studies consider a set of simulations. The simplest type is represented by fiction: deliberate falsification, exaggeration and production of symptoms for external benefits – such as obtaining financial compensation or medication, avoidance of criminal proceedings or work obligations – are currently classified as malingering. Malingerers may decide to put fiction into action, f.i. by adding chemicals to a urine sample or self-harming in order to produce physical evidences. Since such cases can be detrimental to healthcare, even if they do not represent real illnesses, malingering may require clinical attention according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)[4].

A falsification that is not motivated by external benefits implies a disorder within the *spectrum* of the somatic symptom and related disorders[5]. If the subject fakes, exaggerates, or produces symptoms intentionally with no other aim than to assume the sick role, the physician should hypothesise a factitious disorder – earlier, and in very dramatic cases, called Munchhausen syndrome[6]. To get the attention and emotional support generally granted to the sick, the subject may engage in a wide range of clinical varieties, usually familiar to him, replicating mental illnesses and psychiatric symptoms or taking unnecessary drugs and medications. Some subjects undergo treatments, but if questioned or challenged, deny or change caregivers. Also, a shift from the conscious to the unconscious is not uncommon. In case of suspicion, psychiatric counselling will be helpful in framing the subject's personality; contact with family and friends may also be useful, although these subjects often live isolated or seek help far from home.

Aside from factitious disorder, a somatic symptom disorder in general concerns individuals who experience pain and other symptoms with significant distress, in the absence of a diagnosable problem: these subjects do not fake it to get attention as in

fictitious disorder, nor do they produce symptoms for external purposes as in malingering, but they are really ill[7]. Hence, they look for relief and solution to their problems, feeling depressed and anxious about their health. They may seek out many caregivers and even invasive treatments, and this may go on for years. For this disorder to be diagnosed, the symptoms must be observed over a timespan of at least six months, with any other diagnosis already excluded.

More serious and rare is the functional neurological symptom disorder – formerly known as conversion disorder and earlier as hysteria[8]. In this case the subject's psychological state materialises into physical symptoms. The symptoms – stupor, paralysis, muscular atony, tremor, speech difficulties, loss of sensitivity, deafness and blindness without an organic cause – would suggest a neurological disease, which must be excluded by means of neurophysiological investigations however. The distinction is hard, and it may benefit from certain clues, especially the type of pain reported (f.i., a real neurological impairment would cause numbness along the whole arm, while in the functional neurological symptom disorder numbness will be confined to the hand) and external elements (f.i. the patients' attitude, which in the functional neurological symptom disorder is typically carefree: a kind of apathy, also known as *la belle indifference*, which is possibly due to hyperactivation of the frontal lobes). The subjects are usually young women – no coincidence that the ancient name hysteria, from the Greek ὑστέρα (uterus), rested on the biological view that women would be weak and prone by nature to unexpected and uncontrolled emotional outbursts[9].

A different condition makes subjects believe that they are ill. Generally speaking, this would be called hypochondria, but it can degenerate into illness anxiety disorder[10]. In this case, subjects are overly concerned about having an illness and feel anxious about their health, demanding investigations or avoiding them. They may detect symptoms in their body and interpret everything as a negative sign, and conversely seek reassurance on the Internet, from friends and relatives, and again from doctors, but nothing persuades them for good.

Bearing this range of possibilities in mind, we shall better understand the challenge that the case exemplified in the first paragraph could represent for a physician. Certainly, practitioners have the ability to discern between real and fake by considering suspicious facts and behaviours and mistrusting the most imitated symptoms, such as delusions, mutism, depression and confusion, but reality and faking can amalgamate and become indistinct to the point that even a differential diagnosis between a psychiatric pathology and a feigned illness can be hard[11]. As Carl Gustav Jung (1875-1961) wrote in an expert report that will be presented later, the distinction is so hard because malingerers no longer even know they are faking, as they are lying to themselves[12].

Looking at the subject from a historical perspective, it would seem that simulation was not seen as a disorder long before Jung, who was in turn influenced by Sigmund Freud (1856-1939). Hence, it can be worth considering the ancient theory of simula-

tion as attested by Galen of Pergamon (129-216 AD), author of the writing *Quomodo morbum simulantes sint deprehendendi* (Πῶς χρὴ ἐξελέγχειν τοὺς προσποιουμένους νοσεῖν)[13]. This will lead to a better understanding of the Galenic view and hopefully to an outline history of the concept of simulation.

2. Texts and contexts

This paragraph provides a brief presentation of the texts that will be discussed in the following. The short writing *Quomodo morbum simulantes sint deprehendendi* (*Sim*.) actually represents the major excerpt of the *Commentary on Hippocrates' Epidemics book II* (*CEp.II*)[14]. The latter was composed by Galen at the beginning of his second sojourn in Rome (169/177-180) and was subsequently lost[15]. It is well known that the text printed in the Kühn's edition is a Renaissance forgery[16]. The real text, however, survives in the Arabic translation done by Ḥunain ibn Isḥāq (9th c.; *CEp.IIAr*)[17]. The studies on the Arabic translation allowed to identify *Sim.* as an excerpt of *CEp.II*, showing that it is actually an abridged version of an originally broader commentary on *Ep.II* 2.10[18]. The identification caused much surprise to the editors of the excerpt, Karl Deichgräber and Fridolf Kudlien, who renamed it *Simulantenschrift*[19]. Their reaction is fully understandable if we consider and correlate the Hippocratic and the Galenic texts.

The text of *Ep.II* switch between the reporting of individual cases and general nosological descriptions[20]. This can be observed in section 2, which opens with nine aphorisms dedicated to patients, such as Serapis, Moschus and Aristaeus' brother-in-law, until aphorism 10, which stands out for its general character. Here is the Greek text according to Smith[21]:

> Ὀδύνας τὰς ἰσχυροτάτας, ὅτῳ τρόπῳ γνοίη ἄν τις· ἴδιος φόβος, αἱ εὐπορίαι, αἱ ἐμπειρίαι, κ αὶ αἱ δειλίαι.
> (*How can one recognize very serious pains? Peculiar fear, simple treatments, experiences, cowardice*).

In this text Smith distinguished two parts (Ὀδύνας – τις / ἴδιος - δειλίαι), that may not be related[22]. Nonetheless, he interpreted the text as a whole, more precisely as a discourse consisting of question and answer about the diagnosis of very severe pain. In my view, the unity is plausible as satisfying the sense of the Hippocratic triangle[23], with the first part concerning the disease (Ὀδύνας – τις), and the second part concerning partly the physician (αἱ εὐπορίαι, αἱ ἐμπειρίαι), partly the patient (ἴδιος φόβος… καὶ αἱ δειλίαι).

In the second part two major variants are offered by the Galenic tradition. First, the adjective ἴδιος, that is "peculiar", comes from Galen's interpretation, as the Hippocratic manuscripts present the participle ἰδών to be referred to γνοίη ἄν τις, as printed by Littré (*de quelle façon apprécier*)[24]. Second, a variant of εὐπορίαι, namely εὐφορίαι,

was read by Galen in the edition by Dioscorides and Artemidorus Capito, also printed by Littré (*tolérance*)[25].

As for the Galenic commentary, we would expect a discourse about pain and pain diagnosis – a topic that is extensively explored in Galen's *oeuvre*[26] – such as that of the made up commentary[27]. Yet the real commentary develops a completely different topic, namely faking pain.

According to Galen, individuals fake to make others believe that they are ill for many reasons; laymen expect physicians to discern it, as only physicians can distinguish pathological realities and feigned, reproduced or drug-induced symptoms. Some individuals fake physical symptoms such as injuries, others fake psychic symptoms such as delusions and abnormal behaviours. All such cases require clinical assessment, as the case of very severe pain, mentioned in the Hippocratic lemma. The Galenic procedure is illustrated on the basis of two case histories[28] – other three are just evoked within an *excursus*[29]. The cases are examined by means of medical experience and resourcefulness (ἐμπειρία μετὰ τῆς εὐπορίας) – two of the four elements mentioned by Hippocrates. Medical experience teaches the physician which signs come along with pain, such as agitation and trembling, cold extremities, pallor, cold sweats and irregular pulse; as for the pulse, in subjects with severe pain the number of small beats is greater than that of large beats, and the number of weak beats is greater than that of strong beats; furthermore, the symptoms or type of pain reported by the patient must correspond to the affected parts. Also, medical experience allows to assess the pain experienced by the patient in relation to the regimen he is on; patients' compliance with the therapy; and his opinion about the prescribed treatments. Notions from experience are effective if combined with resourcefulness, from which intuitions based on reasoning, i.e. suspicions (τοῖς εὐπορουμένοις λογικῶς - ὅπερ ταὐτόν ἐστι τῷ τοῖς ὑπονοουμένοις), spring. Thus, the physician must be able to consider clues outside medicine, both in the circumstances and in the patient – to whom the other two elements mentioned by Hippocrates refer (ἴδιος φόβος and δειλίαι). The fear shown by the patient shall suggest that his pain is severe and also real. The cowardice towards invasive and painful treatments should cause suspicion, because a sick person is expected to face any therapy. With regard to the patient, also the quietness (εὐφορία) could be seen as a clue, because those who are really experiencing pain should look agitated and restless. The physician must also consider to what extent the patient is well informed about illnesses and therapies; keen to lying; and subject to an authority that may force him to act against his will.

In summary, Galen interpreted the Hippocratic text of *Ep.II* 2.10 by introducing into the discourse on pain diagnosis the event of faking pain, which must be anyway ascertained by the physician and rejected as false. The choice of the topic may be unexpected, as already said, but it can be understood in light of at least two elements in the text. First, in a passage surviving only in the Arabic, Galen referred to the types of pain and their connection to the affected bodily parts recalling his own treatise *De*

locis affectis[30]. This treatise imparts, together with *De usu partium*, the Galenic doctrine of pain. So far, *De locis affectis* has been dated after 193[31], but *CEp.IIAr* seems to contradict this hypothesis and suggest backdating the pathological treatise to the first half of the 80s of the 2nd century[32]. In this scenario, having the composition of *De locis affectis* behind him, Galen probably found it unnecessary to discuss pain and pain's role in clinical practice further, and so chose a new topic for *CEp.II*.

Secondly, the topic of simulation was worth investigating, as highlighted at the very beginning of the text. In the first lines, indeed, Galen claimed that illness deception was a common problem taking a toll particularly on laymen (οἱ ἰδιῶται). This seems plausible if we consider how many episodes of simulation occur in the Greek literature. I will recall just a few of them: according to an ancient tradition attested by the *Cypria* (7th/6th c. BC) Odysseus pretended to be insane in order to avoid joining the Trojan war and was caught by Palamedes, who kidnapped the young Telemachus to test Odysseus' mind. Aristophanes (446-386 BC) filled his playwrights with characters faking pain and illness: f.i. in the *Frogs* Santia claims not to have fought at Arginuse because of an eye pain (vv. 190-91); in the *Women at the Thesmoforia* Mnesilochus, disguised as a woman, claims to have feigned a colic and an urgent evacuation to leave home at night and meet a lover (vv. 483 ff.); in the *Lysistrata* a woman pretends to be in labour, even though she was not even pregnant the day before (v. 744 ff.). Later on, Alexis of Thuri (fl. 350s-288 BC), author of the lost playwright *The man afflicted with glaucoma*, possibly represented the protagonist faking blindness. Also, Menander (c. 342-291 BC) made simulation the pivot of the *Shield*, where Chairestratus, a man who is frail and melancholic by nature, feigns to suffer from a fatal illness, which is then diagnosed by a (false) doctor (vv. 339-43). A lesser-known episode can be found in Xenophon's novel (1st-2nd c. A.D.), where the heroine Anthia, who has been sold to a pimp, escapes prostitution by imitating an epileptic fit and inventing a history about the origin of the disease following a curse; the pimp is frightened and let the girl go[33]. Through this quick review we approached the time of Galen, who possessed a vast clinical experience, but also a solid memory of Greek literary tradition, as pointed out in recent studies stimulated by the rediscovery of *De indolentia*[34]. If simulation was so frequent and habitual in the Greek world as literature makes us believe, it is fully understandable that Galen decided to address this topic providing physicians with a guide to diagnosis which could also relieve laymen's concerns.

3. Case histories (I and II). Method.

Having introduced the matter, Galen moves on reporting two case histories[35]. While focusing on the subjects of the cases, Galen outlines a general method, in dialogue with the Hippocratic lemma, but also with his own doctrine, as already noted.

The first case concerns a man summoned to the town assembly, who complains of colic. Suspicions of simulation soon arise from external elements: the patient is renowned to Galen from previous occasions, when he used to enquire about the medical treatment; he used to be apprehensive and frightened by the smallest thing, but at this time he only asks to apply compresses without demanding the treatment to be continued; he does not ask for a medication, the so-called *Philonian*, although he knew that this had been beneficial against colic to another man; he does worry definitely little, until the colic suddenly ceases along with the assembly. The clinical assessment confirms the suspicions, as all typical causes of colic can be ruled out in his case. At this point, Galen talks to the patient showing himself aware of the simulation and praising him for his ruse, and finally obtains a confession.

Generalising the case, Galen reconnects with Hippocrates, mentioning three of the four key-terms of the lemma. To assess the reported case Galen made use of both medical experience, to exclude a causal relationship with the previous regimen, and common sense, to decide what discourse and behaviour to adopt, identifying with the Hippocratic ἐμπειρία and εὐπορία – with the latter understood by Galen as the capacity to pick up clues beyond medical competence: in this case, the subject stopping complaining exactly when his civic obligation stops. Clinical assessment should take into account also the φόβος, i.e. the fear that accompanies very severe pain in a subject – in this case, absent, although the patient was fearful by nature.

The second case is more complex. It concerns a slave boy, a running escort for his master, complaining of intense pain in his knee, thus unable to work. Also in this case, Galen suspects that the pain is a ruse on the basis of external elements: the patient was expected to travel that very day; also, he was capable of lying. Seeking confirmation to his suspicions, Galen talks to another slave boy, not too fond of the patient, finding out that the he was having a love affair with a woman. With regard to the knee, it does show a large swelling, but this was clearly produced by a plant with revulsive properties, that is the *thapsia Garganica*; on the other hand, a traumatic origin can be ruled out, since the slave had not run excessively or jumped and had not been beaten previously; even the regimen is was on could not have produced an excess of blood (*plethora*).

Also in this case, Galen decides to talk to the patient, yet aiming at empirical verification. Indeed, he asks the slave boy about the type of pain he is experiencing and notes that he hesitates and contradicts himself – he speaks of tension in the joint; of the knee throbbing; pierced by an arrow; pricked by needles; burdened as if by a boulder; of pain extended to the whole leg; then of the bone giving way. Thus, Galen performs a test: he applies on the patient's knee a drug, announcing that it will stop the pain – actually it is a coolant that will only alleviate the heat generated by the *thapsia*. Shortly after, however, the slave states that the pain has gone; of course, if the pain had been caused by an internal inflammation, the coolant would have not soothed it but instead intensified it.

Generalising the case, Galen reaffirms his method: the medical experience made it possible to assess the clinical facts – in this case, the swelling in the knee, the correspondence of the qualitative description of the pain to the cause and the affected part, and the subject's response to the therapy; the resourcefulness helped the physician to understand the patient and identify the external benefit for the simulation – in this case, enjoying the company of a lover, for which the patient injured himself. Such a behaviour explains itself with the natural disposition and the social status of the subject: he is a liar and also, as a slave, he is subordinated to his master, just like the above citizen was subordinated to the State, and in general, being forced to act against one's will must be seen as a reason for feigning. To assess a case, the physician must also consider the patient's δειλίαι, that is the cowardice, or fearfulness, he shows in front of invasive, painful and costly treatments, such as amputations, cauterizations, and administration of hellebore, or sacrifices of beloved things, such as drinking wine, food, baths and sex, which he knows to be unnecessary. Therefore, physicians should submit to patients the most drastic remedies.

4. The other three cases (excursus). Concept

The above method has an emphasis on adaptability: in the discussion of Case I Galen makes clear that common sense is required to identify the appropriate approach to the patient in each situation (ἐφ' ἑκάστῳ πράγματι). This claim makes even more sense if we think back to all types of simulation classified by the current medical studies. But how did Galen understand simulation? Or at least which concept of simulation can be inferred from his text?

Had Galen presented only the first two cases, both concerning simulations intentionally enacted by the subjects in order to escape obligations, could we have retrospectively identified his understanding with malingering. This is the most recognisable type of simulation for a clinician, who is pretty soon projected in its confutation, as confirmed by the title of Galen's excerpt, Πῶς χρὴ ἐξελέγχειν τοὺς προσποιουμένους νοσεῖν[36], actually translated *How to detect malingerers*.

In this regard, it must be said that the idea that pain without clinical explanation should be considered simulated, and therefore contradicted by the physician enjoyed a very long life across centuries and cultures. Suffice it to recall the reception of Galen's excerpt in the 16th century, as it inspired the work of some of the founding fathers of forensic medicine, such as Battista Codronchi (1547-1628), Fortunato Fedele (1550-1630) and Paolo Zacchia (1584-1659)[37]. Furthermore, looking at the history of the medical theory of simulation, in the 19th century as organicism was pervading the scientific culture, the sick person was entitled with protective measures, such as exemption from work, rest and treatment, while reprobation and punishment were inflicted to the person who, in the absence of brain lesions, was deemed a liar – and this was the fate of hysterical patients for a very long time[38]. Yet at the beginning of 20th century, sir John Collie, most likely

the best-known medical examiner of cases of suspected fraud and desertion, produced his *Malingering and feigned sickness*; in the preface the author presents his work with a tough moral judgement: "This work deals with a very dark side of human nature, and does not admit of the display of that sympathy which I trust all genuine cases receive"[39]. Yet Galen's stance towards simulants was much less harsh tough. This emerges from his approach to the subject of Case I, which is reported at full length in *CEp.IIAr*, as follows: "I became convinced that he was not telling the truth about the colic he complained of and that I had been wronged even though he was a friend. When he wanted to take to bed, I said to him: 'How skillfully and well you have deceived me by claiming to be in pain to avoid being forced by the assembly of the people of the city (to do) something you do not like, and you could not escape it unless you had used this ruse for yourself!'. By expressing approval for his ruse and praising him for it, I encouraged him to admit it"[40]. It is clear that Galen does not deny this malingerer psychological tact and understanding. Rather, his approach is similar to that adopted to address patients with soul's affections. I would just recall the case of a man reported in *The affections and errors of the soul*: a Cretan friend of Galen, a good person, yet prone to anger, who often used his hands, and even legs or objects that came to hand, on his servants[41]. While travelling from Gortyn to Pergamon, Galen happened to see this man overwhelmed by rage, seizing a great knife and injuring two servants in the head. Later on, seized with remorse, the man offered Galen a strap to beat him for what he had done. Galen responded with laughter, but then – he wrote: "I promised to give him the blows, if only he would in turn grant me one very small favour […] I commanded him to submit his ears to an argument that I would expound: this would be his punishment […] I discoursed at some length, explaining what sort of schooling is appropriate for the spirit of rage in us – that of the word, of course […] this person […] improved greatly in the space of a year"[42]. This practice, a talk therapy and psychotherapy *ante litteram*, is not far from the approach adopted in Case I, so much so that one wonders whether Galen may not have seen simulation as related to soul's affections[43].

When dealing with this question, the other three cases reported in the *excursus* surviving only in *CEp.IIAr* must be considered[44]. This *excursus* may seem peculiar in the context, yet must have been consistent in Galen's view. It evokes three cases occurred to Chrysippus, his pupil Erasistratus, and Galen himself. More precisely, a woman who believed she had swallowed a snake was cured by Chrysippus, who gave her an emetic drug and made her find a dead snake into the basin where she had vomited; a man who imagined, with significant distress, that he had been called by his name by a dead person was treated by Erasistratus, who made him believe that he already knew him and that he was the person who had called him; a woman pining away as if she were suffering from melancholia or an unspecified grief was assessed by Galen, who found out that her condition was caused by a secret attraction for a servant, as reported at full length in *De praecognitione*[45].

These three cases are not homogeneous – the third concerns a somatic manifestation of passion, while the first two concern psychic phenomena, i.e. delusions – but all pertain to subjects who do not simulate symptoms intentionally or consciously, but really experience symptoms because of a physical projection and perception in reality of thoughts and feelings. All three doctors, after clinical assessment, chose the most appropriate approach to the subjects considering symptoms and circumstances from a psychological point of view. It has been noted that the whole *excursus* has been neglected by the compiler of the Greek excerpt as inconsistent with the subject matter of the writing[46], but it would appear consistent if we admitted that Galen did also conceive involuntary and unconscious simulation, as for somatic symptom disorders. If this interpretation were correct, and the idea of a relationship between simulation and somatization was already present to Galen, we would come across a very modern insight of the ancient view, for this idea was theorised only by the late 19th century, more precisely within the reassessment of the clinical picture of hysteria. This was supported in general by psychogenesis – an orientation opposite to organicism and somatogenesis – and particularly by the studies of Freud and Josef Breuer (1842-1925). Freud and Breuer, a physiopathologist who dedicated himself to psychiatry, met in Vienna, at the Institute of Physiology directed by Ernst Wilhelm Brücke (1819-1892), and together undertook research on the etiology of hysteria. Of particular importance was the case of Anna O. – one of the most famous of all case histories – immortalised as Case I in the fascinating *Studien über hysterie* (1895)[47]. The treatment used to address her condition – the talk therapy that she herself dubbed *talking cure* – made it possible to find out that talking about body pains and symptoms brings relief to the subject: this lies at the origin of psychoanalytic theory and practice.

Freud and Breuer's studies belong here because of the theoretical commitment to a psychological understanding of simulation. As for Anna O., it is reported that the patient felt herself split in two, with a bad-self influencing her mental states; the therapy, making her relive the most terrifying unconscious emotions which had produced nightmares and delusions, brought relief, but afterwards she reproached herself with the recurrent idea that she had never been ill and that the whole crisis had been simulated by her[48]. This idea is explained later on, in a theoretical chapter: in some forms of hysteria, the subject's psychic activity undergoes a split; during the seizure the conscious thought extinguishes, but afterwards it reawakens, and then intelligent patients admit that their conscious self was lucid during the onset and observed all the oddities they did or said: on this perception is based the self-reproach of simulation[49]. In addition, in the case of Elisabeth von R. (Case V), a young woman who complained of severe pains and fatigue in walking as well as in standing, in the absence of typical signs of hysteria, Freud hypothesised a simulation of physical symptoms effected by the body, recalling the well-known tendency of muscular rheumatism to simulate nervous affections[50].

Freud's early studies on hysteria had a great impact on Jung and influenced his aforementioned work on simulation[51]. This already emerges from Jung's *Zur Psychologie und Pathologie sogenannter occulter Phänomene* (1902), where simulation was traced back to the dissociability, namely the existence of multiple personalities with which the hysterical subject would identify. Later on, in the essay *Über Simulation von Geistesstörung* (1903) – in which simulation turns out as the focus of a psychiatric debate – the unconscious origin of simulation and its connection to hysteria were reaffirmed by assessing the case of a woman accused of theft and affected from hysterical stupor. In general, the subject would be carried away by the subjective degree of suggestibility and, being unable to maintain a firm conscious structure, would end up superimposing a second personality on his own, falling into a particular consciousness state, known as twilight state. Many prisoners and convicts observed by Jung convinced him of the negative influence on weak psychic conditions of both the environment and the affective dimension, which would exert a pressure on the subjects and generate confusion, too often attributed to simulation by the laymen, i.e. judicial organs.

Jung's viewpoint evolved and radicalised with regard to the physician's duty in his *Ärtzliches Gutachten über einen Fall von simulierter geisterer Störung* (1904), an expert report about the case of a spinner accused of theft, who looked disturbed when he was arrested. Jung maintained that it was a case of simulation of mental illness, yet, since the energy and attention tests performed on the subject showed that a lowering of the consciousness level came along with simulation, he preferred to speak of *semi-simulation*: a pathological behaviour, triggered in the subject by a strong affective complex towards his mother. At the end of his report Jung reaffirmed the great difficulty of assessing real and fake illness and proposed a rethinking of simulation, which would always represent a pathological state of psychiatric competence. In this regard he wrote: "a hysterical pulmonary haemorrhage is simulated, feigned, but this does not make the patient a malingerer; he is really ill, only not lung-ill. If the doctor calls the patient malingerer, it is clear that he has actually interpreted the symptom incorrectly, i.e. has not recognised it as a hysterical symptom"[52]. To the institutions and society of his time, Jung showed malingerers as humble and weak individuals, caught in an extremely difficult situation, albeit one overshadowed by deception.

5. Conclusions

Simulation of pain and other symptoms, both physical and psychic, is a relevant medical topic, which was perceived in different ways depending on historical and cultural factors. It was already addressed in the ancient Greek world, as attested by Galen's short writing *Sim*., an excerpt of the *CEp.II*, lost in the original Greek but surviving in the Arabic translation *CEp.IIAr*. A reconsideration of both the Greek excerpt and the

Arabic translation helped us to gain a better understanding of the Galenic thought on simulation and to put it into a medico-historical context. As for the diagnosis, Galen outlined a method that is hitherto valid: this relies on medical experience – encompassing notions about pain, its types and signs, and its relationship to regimen – and resourcefulness, particularly the common sense, essential for interpreting clues outside medicine, such as possible benefits deriving from the simulation, socio-economic situation of the patients, and attitude of the subject, who may betray himself if questioned, tested, or presented with painful treatments or deprivation of beloved things. On the contrary, the medical concept underwent considerable evolution through the ages. At first sight, the ancient view seems to be mainly concerned with deliberate simulations made up to escape works and obligations, corresponding to today's malingering, while modern studies consider several types of simulation due to new ideas and perspectives promoted by psychology and psychopathology. Nevertheless, the Galenic text as witnessed at fully length by the *CEp,IIAr* suggests that Galen already used a psychological approach to malingering and possibly assumed a relationship between illness related deceptive behaviours and psychic health. This idea would have been theorised only in the late 19th and early 20th century in the framework of psychoanalytic theories.

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