

More on the Myth?

Eileen Marshall Margaret Williams 21st March 2006

Myths in modern medicine? Impossible: in our enlightened times, do not outstanding advances in the science – if not in the art -- of medicine preclude any such possibility? The evidence suggests otherwise.

It was in 1996 – a long decade ago-- that attention was drawn to case reports which indicated that a whole professional community may be unable to observe a problem, thus tending to delete or abolish the problem, even though existing professional knowledge indicated that a different professional approach was available (ref: The Professional Historical Error. A Levy. Arch Gen Psychiat 1993;50:319-320).

Questions were asked if this had happened in ME, and if so, was psychiatrist Simon Wessely (of The Institute of Psychiatry and Guys, Kings and St Thomas' School of Medicine, London) in any way to blame? (ref: Denigration by Design? A Review, with References, of the Role of Dr Simon Wessely in the Perception of Myalgic Encephalomyelitis: Volume I [1987 – 1996]; pp 217; available at cost price from Professor Malcolm Hooper, Department of Life Sciences, University of Sunderland, SR2 7EE, UK).

Since then, other voices have drawn attention to the matter of an entire professional community being unable to observe a problem, noting the evidence of a disturbing element of pathological denial that seems to amount to an aversion to engage with reality that continues to be exhibited by certain UK psychiatrists, most particularly those who claim world-class expertise in the field of ME/CFS.

Following the response to “The Model of the Myth” (see Co-Cure NOT, MED, ACT, 17th March 2006), attention is here drawn (i) to a further item by Dr Niall McLaren -- himself a psychiatrist – who continues to expose the myth of the biopsychosocial model of illness with which Wessely School psychiatrists are so enamoured and (ii) to the intransigent refusal by Wessely et al to heed the advances of modern medicine to the extent that they appear to remain tethered by an obsession to equate ME/CFS with neurasthenia – which they claim is a biopsychosocial disorder -- no matter what the volume and credibility of contrary evidence.

It was noted that in its advertisement for the PACE Trial Manager (salary c. £34,000 pa), the Centre for Psychiatry at the Institute of Community Health Sciences (Barts and the London Trust) said: “Medically unexplained conditions are the commonest diagnoses in 40 per cent of primary care attenders and half of all new medical outpatients, with (an) enormous economic burden to the UK. The centre has a longstanding research interest in chronic fatigue syndrome (CFS) and chronic pain disorders. Epidemiological, psychophysiological and clinical trial methods have given a better understanding of the biopsychosocial basis for these disorders”. The advertisement may have been promulgating misinformation, because the evidence is that there is no such entity as the “biopsychosocial” model except in the minds of those who believe in it.

As McLaren points out: “preconception, bias and prejudice may determine what we see. In turn, what we see often serves to inform what we believe. By this means, science can slip into self-justification” and McLaren observes how an individual’s need to believe something determines what he sees.

In 1998 McLaren showed that the biopsychosocial model was a mirage (ref: A critical review of the biopsychosocial model. Australian and New Zealand Journal of Psychiatry 1998;32:8692) and in his 2002 paper he showed how reliance upon such a non-existent model is nothing but illusion (ref: The myth of the biopsychosocial model. Australian and New Zealand Journal of Psychiatry 2002;36:5:701).

McLaren notes that some psychiatrists repeatedly invoke Engel's biopsychosocial "model" and that they accept without demur (or references) that it is a reality, when nothing could be further from the truth.

He asks: "Why do these intelligent people (ie. psychiatrists), their reviewers, their editors and, above all, their readers, continue to pay homage to something that does not exist? How, for example, can Harari (an Australian psychiatrist) say that this sort of self-deception 'greatly enhances psychiatry'? Simply because he needs to believe it. Clearly aware that biological psychiatry doesn't provide such a model, that psychodynamic models are prescientific, that behaviourism failed its overblown promise and that sociology isn't even a starter, he embraced the putative biopsychosocial model without bothering to check the details. Had he done so, he would have found that it doesn't actually have any details. It consists of just three words: 'The Biopsychosocial Model', and nothing more".

Wessely School psychiatrists, however, are certain that their own beliefs and their reliance upon the biopsychosocial model are right. They have built their careers upon it, so they must be right.

A paper by Professor David Pilgrim (ref: <http://www.critpsynet.freeuk.com/Pilgrim.htm> THE BIOPSYCHOSOCIAL MODEL -- HAS IT RESCUED PSYCHIATRY?) confirms: "at the Institute of Psychiatry in London, by the 1970s the biopsychosocial model was established as a form of psychiatric orthodoxy. Prior to 1980, a biopsychosocial approach was being reinforced by a number of Institute staff, including Clare. As a further indication of the biopsychosocial model reaching the status of a temporary orthodoxy, at least in London, it came to gain the support of collaborating psychiatric social workers".

It will be recalled that it was the same Professor Anthony Clare who chaired the meeting at which the Oxford criteria for CFS were formulated and that Clare became notorious for informing those present – with some exasperation – that there was only one reason for calling the meeting and that was "a group of patients with a cluster of symptoms who get a lot of publicity" (ref: Consensus on research into fatigue syndrome. Jane Dawson. BMJ 1990;300:382).

The paper by Pilgrim seems to go some way to explaining the undue reliance upon the non-existent biopsychosocial model: "If a biopsychosocial model was applied thoroughly in all cases, then psychiatry might enjoy a boost in its acceptability to its recipients". Is this a good enough reason to deny and defy the ever-mounting evidence of complex biomedical abnormalities in ME/CFS?

As noted in "Denigration by Design?", the acclaimed psychologist Dr Dorothy Rowe is on record on 14th November 1993 in The Observer as stating "People who know absolutely that they are right are very dangerous"; more recently, in 2004 the former BBC anchorman Cormac Rigby wrote: "The greatest enemies of truth are those who think they have a

monopoly of truth” (see [“Wessely’s Wisdom? Some more open questions for Professor Wessely”](#): Co-Cure ACT: 18th January 2005).

What can explain the delusion that prevents certain psychiatrists from engaging with reality? Despite the significant evidence that destroys their misconceptions and shows their beliefs about ME/CFS to be wrong, Wessely School psychiatrists persist in their belief that it is a behavioural disorder that they believe is synonymous with “neurasthenia” and they continue tenaciously in their efforts to get ME/CFS re-classified as a mental disorder. Evidence-based reality seems entirely lost on this group of psychiatrists.

Wessely has been ploughing the narrow furrow of equating ME/CFS with neurasthenia since at least 1990 (ref: Old wine in new bottles: neurasthenia and ‘ME’. *Psychol Med* 1990;20:35-53); some 16 years later he is still entrenched in the same furrow and has seemingly failed to look beyond its confines.

It was in 1993 that Anthony David and Simon Wessely wrote in *The Lancet*: “Neurasthenia would readily suffice for ME” (ref: Chronic fatigue, ME, and ICD-10. Anthony David, Simon Wessely. *Lancet* 1993;342:1247-1248).

Ignoring the evidence of significant multi-system organic dysfunction in ME/CFS that has emerged since 1990, Wessely was a participant at the 2nd Consensus Conference in February 2000 in Kuala Lumpur that resulted in a World Psychiatric Association (WPA) Group of Experts’ production of a document called “Neurasthenia – A Technical Report” in June 2002. The word “Technical” does not sit easily in the domain of psychiatry, because according to the *Unwin Hyman Medical Dictionary* (9th reprint), psychiatry is defined as “The branch of medicine concerned with the management of mental illness and emotional and behavioural disorders”.

A Past President of the World Psychiatric Association in Geneva is Professor Norman Sartorius and it was Sartorius who during his term of office was the chief motivator for the project. It was the same Sartorius who edited “Psychological Disorders in General Medical Settings” (published by Hogrefe & Huber, 1990) that contained a chapter by Wessely (“Chronic fatigue and myalgia syndromes”) in which some of Wessely’s most quoted and damaging statements about ME/CFS appeared, for example: “Most CFS patients fulfil diagnostic criteria for psychiatric disorder”; “The description given by a leading gastroenterologist at the Mayo clinic remains accurate: ‘the average doctor will see they are neurotic and he will often be disgusted with them’ ”; “It is of interest that the ‘germ theory’ is gaining popularity at the expense of a decline in the acceptance of personal responsibility for illness. Such attribution conveys certain benefits; in other words, there is avoidance of guilt and blame”; “It is this author’s belief that the interaction of the attributional, behavioural and affective factors is responsible for both the initial presentation to a physician and for the poor prognosis”.

To announce the WPA “Technical Report” on neurasthenia, in May 2002 a “Consensus Statement on the Syndrome of Neurasthenia” was released by the Chairman of the WPA Group of Experts in Neurasthenia, Professor Edmond Chiu. This document states: “The clinical syndrome loosely defined as Neurasthenia exists as a mental health problem. It also says: “Irrespective of the current lack of evidence base, the suffering of patients should be acknowledged” but it then seems to undermine the validity of the “Technical Report” itself

because it states bluntly: “Objective evidence-based data is presently not available to enable (the) inclusion (of neurasthenia) into current nosology”.

Despite the acknowledged lack of objective evidence about the very existence of neurasthenia, the WPA “Technical Report” aims to re-instate neurasthenia within modern medicine as a biopsychosocial disorder. It details “predisposing factors”, “personality factors”, “belief systems” and “social factors” as components, all of which will be familiar to those members of the ME community who have knowledge of the so-called “independent” 2002 Report of the Chief Medical Officer’s Working Group on “CFS/ME”. The treatment is said to be physical rehabilitation and cognitive behavioural strategies. On page 22 of the “Technical Report” on neurasthenia, chronic fatigue syndrome / myalgic encephalomyelitis is specifically named as one presentation of neurasthenia.

The WPA Neurasthenia project was supported by an unrestricted educational grant from the pharmaceutical company Pfizer.

Moving on to 2005, in a book entitled Somatoform Disorders (Volume 9), edited by Mario Maj et al and published by John Wiley & Sons, Chichester (ISBN 13978-0-470-01612-1), Wessely and his co-psychiatrist Michael Sharpe contributed chapter 5, which is called “Chronic Fatigue and Neurasthenia: A Review”. Although the title refers to “chronic fatigue”, it starts by announcing: “This chapter reviews current knowledge about chronic fatigue syndrome (CFS) and neurasthenia”, which immediately reveals not only a telling lack of scientific rigour, but also the underlying agenda of the Wessely School.

For someone who in 2000 placed on public record his intention to withdraw from involvement in “CFS/ME”, Wessely’s continued in-depth involvement would seem to indicate that his public statements should be treated with caution, because some five years after announcing his intention to withdraw, Wessely’s efforts to achieve his aim to eradicate ME and to secure the re-classification of “CFS” as a biopsychosocial disorder seem unremitting.

In their 2005 chapter, Sharpe and Wessely clearly persist in their belief that ME/CFS is a biopsychosocial disorder. So that readers may judge for themselves, a few quotations are provided here. Following their chapter, there are 15 invited “Commentaries” on it from others in the field of mental health. Given the available international literature on ME/CFS, the pre-supposition and lack of knowledge about ME/CFS both in the chapter itself and even more strikingly in some of these “Commentaries” defy belief.

Quotations from Chapter 5

“Is CFS an ‘organic’ or ‘psychogenic’ disorder? The extreme organic position argues that CFS will eventually (be) found to be as firmly based in disease pathology as any other medical condition. An extreme psychogenic view would be that CFS is a ‘pseudo-disease’. In clinical practice, an extreme organic position encourages patients to engage in an often endless search for a doctor who will find the pathology”.

“The proper use of the DSM-IV axes allows the patient to be given both a medical (Axis III) and a psychiatric (Axis I) diagnosis. We need a classification that avoids two diagnoses being given for the same symptoms. This is a task for the authors of the forthcoming DSM-V”.

“The term CFS subsumed a multitude of previous terms (which) include myalgic encephalomyelitis and post-viral fatigue syndrome, as well as neurasthenia”.

“It was found that requiring multiple somatic symptoms as well as fatigue and using strict psychiatric exclusions made the condition very rare”.

“In clinical practice, many but not all patients with CFS can be given a psychiatric diagnosis. Most will meet the criteria for a depressive or anxiety disorder. The others are likely to meet DSM-IV criteria for a somatoform disorder or merit an ICD-10 diagnosis of neurasthenia”.

“Ninety-five percent of those seen in a UK CFS clinic also fulfilled the criteria for neurasthenia”.

“Few modern epidemiological studies have looked specifically at neurasthenia”.

(Note: this may be because in Commentary 5.15, Edmond Chiu states: “The controversy over the existence of neurasthenia as a clinical syndrome is exemplified by the fact that it has been removed from the DSM-IV classification”, whilst in Commentary 5.4, Renee Taylor states: “With neurasthenia, the syndrome was regarded as non-existent for nearly a century”. It may be worth noting that “neurasthenia” originally referred to “neuro” meaning relating to nerve cells or fibres and “asthenia” meaning lacking in strength [ie. a lack of physical stamina] but was distorted by psychiatrists to denote a lack of “mental” stamina. It is this construed “psychosocial” ascription that has prevailed).

“Our hypothesis is that fatigue syndromes are universal, but that culture is important in understanding the transition from symptoms to disability. Where there is considerable concern about concepts such as immune dysfunction, viral persistence, and environmental toxicity, there may be greater likelihood of symptom persistence and severe disability”.

“Poor outcome in CFS is predicted by longer illness duration and also by a strong belief in physical causes”.

“The precise aetiology of CFS remains unknown. A wide range of factors has been proposed. These factors will be discussed under the headings of predisposing, precipitating and perpetuating factors”.

“A variety of immune changes have been reported in patients with CFS but the direction of causality is unclear. The hypothesis that CFS is associated with immune activation remains unproven”.

“There are no proven pathologic or biochemical abnormalities of muscle or muscle metabolism other than those associated with deconditioning. Deconditioning offers a potential biological explanation for exercise-induced fatigue and also provides a rationale for treatment using graded activity”.

“CFS is a disorder of effort perception”.

“Abnormal perception of sleep has also been found in CFS”.

“A repeated observation has been a tendency to low blood cortisol and a poor cortisol response to stress. It is unclear whether this is merely a consequence of inactivity”.

“Orthostatic intolerance and postural orthostatic tachycardia syndrome have been reported in CFS. However, postural hypotension occurs after prolonged inactivity”.

(Note: these authors continue to confuse postural hypotension with orthostatic hypotension; the two are not the same).

“There is evidence of more widespread cerebral activation in CFS than controls when performing a fatiguing task. These functional brain imaging findings must be regarded as preliminary”.

(Note: the same tactics of dismissal have been a Wessely School hall-mark for many years, for example: “It is premature to claim unique neuroimaging abnormalities in the chronic fatigue syndrome” [ref: JNNP 1996:60:471-473]; dismissal of MRI findings: “Findings of abnormalities require careful interpretation and may reveal ‘abnormalities’ of little consequence”; dismissal of SPET findings: “Studies to date have used inconsistent case definitions (and) poor resolution scanners. Any interpretation must await independent replication”; dismissal of neuroimaging techniques in ME/CFS: “There is no justification for their use” [ref: Chronic Fatigue Syndrome: Joint Royal Colleges’ Report (CR54), RCP Publication Unit, 1996]. This contrasts with the evidence of Dr DC Costa of the Institute of Nuclear Medicine at UCL Medical School, London, the foremost ME researcher in nuclear medicine in the UK, who also in 1996 ---at the AGM of the UK ME Association --- showed that hypo-perfusion of the mid-brain is the main characteristic apparent on neuroimaging in ME, and that it is more severe in ME than in AIDS encephalitis, or indeed in any other brain disease he had examined since 1985).

“A systematic review of prognostic studies in CFS found that strong attribution (to a physical disease) predicted a poorer outcome. It may be because such an attribution may lead to non-participation in potentially effective psychological and behavioural treatment”.

“The belief that activity is damaging may be a critical psychological target for effective rehabilitation”.

“Another potentially important coping behaviour is the focusing of attention on symptoms (which is) associated with greater perceived symptom intensity. It offers another target for treatment”.

“Whatever the biological aspects of CFS, cognitive-behavioural models assume that the symptoms are perpetuated by psychological, behavioural and social factors. Biological factors are assumed to be largely reversible”.

(Note: is not “assumption” an admission that the CBT management model is hypothesis-based and experimental? Wessely himself is on record elsewhere as confirming that CBT does not work for all ME/CFS patients).

“Immunological and viral tests are generally unhelpful as routine investigations”.

“The under-diagnosis of psychiatric disorders is particularly common”.

“The mainstay of therapy continues to be antidepressant drugs”.

“There are a variety of types of CBT. Here we refer to a type of rehabilitation that aims to achieve both graded increases in activity and changes in unhelpful beliefs”.

“It is desirable that all patients should have a trial of rehabilitative treatment”.

“Many physicians are reluctant to accept chronic disability in these patients, perhaps because they do not regard these conditions as true diseases”.

(Note: one must ask who has worked so tirelessly to bring about this reprehensible state of affairs?)

Quotations from the Commentaries on the Review

Unsurprisingly, there is glowing praise for Wessely and Sharpe’s Review, for example: “Sharpe and Wessely eloquently delineate the consensus surrounding CFS” (Commentary 5.1 by Kurt Kroenke from Indiana University); “The scholarly review by Sharpe and Wessely” (Commentary 5.3 by Bedirhan Ustun from WHO, Geneva); “This timely and erudite review by Sharpe and Wessely” (Commentary 5.4 by Renee R Taylor from the Department of Occupational Therapy, University of Illinois, Chicago); “ The sensible treatment plan outlined by Sharpe and Wessely” (Commentary 5.5 by James L Levenson from the Department of Psychiatry, Virginia Commonwealth University School of Medicine); “Sharpe and Wessely offer us a comprehensive and timely overview of the most important aspects of diagnosis, aetiology and management” (Commentary 5.9 by Petros Skapiniakis and Venetsanos Mavreas from the Department of Psychiatry, University of Ioannina, Greece); “Sharpe and Wessely are to be commended for their thorough and balanced approach in their review of the current evidence” (Commentary 5.10 by Jonathan R Price from the University of Oxford Department of Psychiatry, Oxford, UK); “The authoritative and comprehensive review by Sharpe and Wessely demonstrates an excellent example of the confluence of psychological, social and biological models for understanding health complaints” (Commentary 5.12 by Vikram Patel from London School of Hygiene and Tropical Medicine); “The importance of cultural factors has been shown by Sharpe and Wessely in their comprehensive and authoritative review” (Commentary 5.13 by Marco Appolinario and Sandra Fortes from the Federal University of Rio de Janeiro, Brazil).

Commentary 5.1 (Kurt Kroenke, Indiana)

“Simple laboratory testing recommended by the authors typically has low yield but is inexpensive and reassuring. More costly work-ups (eg. immune function, cardiopulmonary testing) may still not guide treatment in an evidence-based manner”.

Commentary 5.2 (Stefan Priebel, Newnham Unit for Mental Health, London)

“Patients’ experience and presentation of symptoms is likely to be influenced by social expectations and cultural factors. It has been argued that the incapacity to fulfil a societal role is a primary characteristic of CFS. Patients express their distress in terms of conventional symptoms and insist on the disorder being a medical illness. Their frequent insistence on physical causes has been identified as an obstacle to successful treatment. More than any other disorders, CFS tends to raise the question amongst clinicians as to whether it

really exists. Many clinicians doubt that CFS is a disorder in its own right and not just a consequence of psychiatric disorder”.

Commentary 5.3 (Bedirhan Ustun, WHO, Geneva)

“Persons who suffer from this condition see themselves as ‘sick’. Doctors may not agree on this ‘disease’ status. Many pension systems do not accept this as a form of chronic disability. Wide-spectrum antidepressants are unsurprisingly effective”.

Commentary 5.5 (James Levenson, Virginia, USA)

Levenson’s Commentary is entitled “Chronic Fatigue Syndrome as a Paradigm for Psychosomatic Medicine”.

“In another era, William Osler said: ‘He who knows syphilis knows medicine’. As Sharpe and Wessely illustrate in their review of CFS, one could well now claim: ‘He or she who knows CFS knows psychosomatic medicine’, and I mean psychosomatic medicine to encompass functional disorders, unexplained medical symptoms and the somatoform disorders. The psychosomatic approach is exemplified when Sharpe and Wessely state that ‘a combination of environmental factors and individual vulnerability initiates a series of social, psychological and biological processes that leads to the development of CFS’. Although CFS is a relatively young concept, one can see in its history the recapitulation of many of the mistakes that have occurred in psychosomatic medicine – over-interpreting endocrine or immune changes of ambiguous significance and causal direction, and searching fruitlessly for specific explanatory lesions”.

(Note: Mary Schweitzer has pointed out that whilst people perceive the term “ME” to be lost in history, research conducted under that name (and the knowledge and experience thereby obtained) is lost to patients, researchers, medical practitioners and the public in general [ref: [Melvin Ramsay and “CFS”](#): Co-Cure NOT, MED, ACT, 17th March 2006]. Levenson’s Commentary seems to be a classic illustration of this loss and of the consequent ignorance that surrounds ME/CFS as well as of the failure to keep up-to-date with biomedical science).

Commentary 5.6 (Gordon Parker, University of New South Wales, Australia)

“The field is more likely to advance by abandoning pseudo-diagnoses such as CFS and neurasthenia”.

Commentary 5.7 (Sing Lee, Hong Kong and Arthur Kleinman, Harvard University, Boston)

“CFS has demonstrated an overall fate that is not substantively different from that of its historical ally neurasthenia. If there is any difference at all, it would be the rapidity with which the condition dies out in response to professional and social forces that dictate whether an illness should be considered real or legitimate. These forces include the hegemony of the psychocentric DSM classification and the pharmaceutical authentication of disease categories. The evidence seems persuasive that we should ‘bring the body back to the DSM’.

But to do this is to reverse complex political and economic factors that create and sustain the DSM. Our guess is that this will not happen until a substantial redistribution of power takes place in international psychiatry. By leaving out a large body of information about chronic

fatigue, Sharpe and Wessely's review may yet be another demonstration of research that marginalizes most human beings".

(Note: here is the clearest possible confirmation of how disease status is now determined, namely by "pharmaceutical authentication of disease categories". It is interesting to note Lee and Kleinman's observation that in their Review, Sharpe and Wessely have left out a "large body of information" and that the resultant review may marginalize "most human beings". Some, at least, seem to be aware of what is going on).

Commentary 5.8 (Anne Farmer, Institute of Psychiatry, London and Tom Fowler, Cardiff Medical School)

"Clinics specialising in the assessment and management of chronic fatigue (*sic*) have been slowly established around the United Kingdom over the past 10 years. Prompt assessment and ready access to CBT and graded exercise approaches carefully described in Sharpe and Wessely's review will hopefully ensure that fewer patients develop severe intractable symptoms or acquire intransigent attitudes associated with poor outcome".

Commentary 5.9 (Petros Skapiniakis and Venetsanos Mavreas, University of Ioannina, Greece)

"The core symptom of fatigue is very common in the general population. In our view, future revision of the definition of CFS should concentrate on defining better the core symptom of severe fatigue and eliminate the multiple symptoms".

(Note: the core symptom in Ramsay's ME (also classified in ICD-10 as "CFS") is not "fatigue". It is very different from "fatigue": it is post-exertional fatigability. This means that on even minimal sustained exertion, muscles become excruciatingly painful, tremble like jelly and become temporarily outside volitional control to the extent that, for example, it is simply not possible to walk upstairs because of incapacitating exhaustion and vice-like pain, together with profound malaise (which means the person is unable to function independently). The second core feature of ME/CFS is the rapid fluctuation and variability of symptoms. If the multiple physical symptoms that characterise ME/CFS are removed from the case definition, then "CFS/ME" will be deemed to be no different from any other psychiatric or idiosyncratic "fatigue" and Wessely School psychiatrists will have obtained their objective of "eradicating" ME).

Commentary 5.10 (Jonathan Price, University of Oxford Department of Psychiatry)

"Sharpe and Wessely do not shirk from wholeheartedly embracing the biopsychosocial perspective, in which a person's social and psychological context is a key factor in their illness and recovery. Psychiatrists are excited by the burgeoning evidence for the relevance of psychological interventions in a wide range of disorders. Isn't it good news that, according to the cognitive-behavioural model, biological factors are only partly responsible for the illness, or largely reversible. The key message is that CFS is not a fixed, unalterable disease, lying outside the patient's control. Rather, CFS is reversible by the patient's own efforts. It therefore seems surprising that many CFS patients are reluctant to embrace a biopsychosocial approach to their management".

(Note: If the “biopsychosocial” approach worked and did not result in serious relapse, and if the biological factors were “largely reversible”, there would be no long-term sufferers from ME/CFS because patients are desperate to regain their health and independence. The GMC recently criticised and struck off a doctor for practising outside his area of expertise. If psychiatrists attempt to claim dominion over “ a wide range of disorders”, they might be at similar risk because it is not possible for them to be experts in such complex fields as vascular biology or gene expression that are known to be disrupted in ME/CFS. Wessely himself stated at his Gresham College lecture on 25th January 2006 that he did not understand immunology).

Commentary 5.11 (Winfried Rief, University of Marburg, Germany)

“These patients tend to over-interpret the relevance of physical perceptions (and) focus attention on their bodily processes. There is currently no evidence to differentiate the various (functional somatic) syndromes in patients with multiple physically unexplained symptoms. (This) conclusion has significant implications for the management and treatment of these patients. Treatment approaches should not focus on single symptoms but on the perception of bodily processes in general”.

Commentary 5.12 (Vikram Patel, London School of Hygiene and Tropical Medicine)

“It seems apparent, though, that fatigue, the defining symptom of neurasthenia, is a culturally sanctioned expression of distress. Sharpe and Wessely rightly say that cultural factors play a major role in the experience of fatigue”.

Commentary 5.13 (Marco Appolinario and Sandra Fortes, Federal University of Brazil)

“The importance of cultural factors has been shown by Sharpe and Wessely. Although these patients seek medical attention, their symptoms are rather an expression of being upset and a way of getting sympathy and help from other people”.

Commentary 5.14 (Ruud Vermeulen, Amsterdam)

(Note: The author of this Commentary stands out as being the only one to be aware of scientific developments in ME/CFS. It is refreshing to read Vermeulen’s informed view that since fatigue is not the disease, it should not be the target of the therapy).

“Promising developments in research on CFS were published and presented in the last 2 years. New developments in testing of cytokines, oxidative stress, heart rate variability and gene expression response to stress and exercise in these patients open new opportunities for objective criteria. Proton magnetic resonance spectroscopy showed in CFS patients an abnormal phospholipid metabolism in the cell membranes of the occipital cortex, with release of choline, likely due to oxidative stress. Okada et al reported a bilateral reduction in grey matter volume in the prefrontal cortex in CFS patients. The volume reduction in the right prefrontal cortex paralleled the severity of the fatigue. This may explain the full recovery rate of only 5% in CFS patients. These studies are all pointing at an immune disturbance in the brain. We should realise that since fatigue is not the disease, it should not be the target of the therapy”.

Conclusion

With the single exception of Vermeulen's contribution, the ignorance and, it has to be said, the arrogance of some of these contributors is incomprehensible. How can such gross distortion of the published international biomedical evidence on ME/CFS proliferate unchallenged?

The Wessely and Sharpe review cannot by any standards be described as a "comprehensive overview" because the authors ignore so much published evidence of established multi-system pathology in ME/CFS. There is simply no mention of distressing symptoms such as true vertigo, ataxia, neuromuscular inco-ordination, cardiac insufficiency, respiratory dysfunction, pancreatic insufficiency, parasympathetic enteropathy, vasculitis, hair loss, mouth ulcers etc. Why not? How can these psychiatrists not address the existence of such obvious pathology and focus only on "fatigue"? Research of great consequence that they have ignored has found increased expression of genes involved in immune, neuronal and mitochondrial function. Also ignored is the research that demonstrates oxidative stress, abnormal acetylcholine metabolism and increased neutrophil apoptosis (ie. the biochemical, vascular, brain and muscle abnormalities that have been shown in ME/CFS), all of which predated the 2005 chapter.

There is no consideration by Sharpe and Wessely or by 14 of their chosen 15 commentators of the possibility that the expression of multiple symptomatology in ME/CFS may indeed be the consequence of multiple organ dysfunction; instead, these psychiatrists are supremely confident that their own assumptions must prevail over the evidence that shows them to be wrong.

Many international non-psychiatrist researchers have demonstrated that patients with ME/CFS do suffer from such multiple symptoms and that these can be shown by relevant testing, but such is the stranglehold of the Wessely School that these tests are not permitted to be carried out in the UK.

Does not the persistent, deliberate rejection and dismissal of the international evidence amount not just to professional insult and negligence, but to iatrogenic abuse of very sick and vulnerable people? By virtue of orchestrating the refusal and denial of both State and medical insurance benefits necessary for basic survival, by creating a rampant culture of disbelief about the very existence of ME/CFS throughout the NHS and Government departments and by the imposition of inappropriate management regimes, Wessely School psychiatrists seem to be depriving ME/CFS sufferers of their basic human rights.

The last word must go to Australian psychiatrist Jock McLaren: "A Medline search of the word 'biopsychosocial' yielded nearly four hundred references, not one of them critical. Indeed, the Journal of Psychosomatics now uses the terms 'psychosomatic' and 'biopsychosocial' interchangeably. In its present form (it) is so seriously flawed that its continued use in psychiatry is not justified. In a word, the officially-endorsed biopsychosocial model is pure humbug because it does not exist. Psychiatrists have long attempted to convince the general public, the funding bodies and, most significantly, the younger generations of students and psychiatrists that the profession has articulated a rational model which grants it special and unique knowledge of the aetiology of mental disorder. It is my view that we are guilty of the grossest intellectual neglect or of outright scientific fraud. I believe there is a serious risk psychiatry as we know it will no longer exist in as little as fifteen years" (ref: The Biopsychosocial Model and Scientific Fraud. N McLaren. May 2004; available from the author at jockmcl@octa4.net.au).

If this were to be so, there are many who would rejoice.

See Also:

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