

A SHORT SUMMARY OF THE PSYCHIATRIC PARADIGM OF ME/CFS

By Angela Kennedy

This document provides a brief, critical overview of identified themes within the approaches to ME/CFS, that have been promoted extensively by a vociferous group of doctors and others known colloquially as the ‘Wessely School’, after Simon Wessely, a psychiatrist who has had a key role in facilitating the emergence of the notion that ME/CFS is a psychological disorder (Hansard, cited in Marshall et al, 2001).

Unfortunately for ME/CFS sufferers themselves, the ideas espoused by this group have been accepted uncritically by many others, even though there are fundamental theoretical, methodological and ethical problems with their approach, which have caused endangerment and disenfranchisement to ME/CFS sufferers worldwide, as well as further, unnecessary, suffering.

Their approach, theoretical assumptions and apparent beliefs, as delineated below, I have termed the ‘psychiatric paradigm’. This is not meant to imply that all psychiatrists, psychologists and other mental health professionals subscribe to a ‘psychiatric paradigm’ of ME/CFS, as proposed by the ‘Wessely School’. As will be demonstrated, some psychiatrists have critiqued the notions espoused by the ‘Wessely School’. Dutton (1992), has used the word ‘paradigm’ in connection with depression/somatization explanations for ‘CFS’. I am therefore using the term ‘psychiatric paradigm’ to describe the psychiatric causation explanations for the disease ME/CFS, espoused by those such as Simon Wessely, and various others.

The main problems of the Psychiatric paradigm can be summarised as follows:

1. Refusal to recognise ME/CFS as a neurological illness

Proponents of the psychiatric paradigm do not appear to subscribe to the WHO ICD-10 classification of Myalgic Encephalomyelitis/chronic Fatigue Syndrome as a neurological disease (for example, see David and Wessely, 1993). This is further illustrated, for example by Wessely’s own comment (1994), that: “I will argue that ME is simply a belief, the belief that one has an illness called ME”.

Another example of this position was illustrated, for example, when proponents of the psychiatric paradigm unilaterally (and incorrectly) represented the term Chronic Fatigue Syndrome as being classified as a mental disorder in the ICD-10, and advised the British government that this mis-classification was in order, until the British Government was corrected by the Countess of Mar during a House of Lords debate in 2004, with confirmation by the World Health Organisation. **(Footnote 1)**

The refusal to recognise that ME/CFS is a neurological illness is in direct contradiction to a very large body of international research/clinical literature illustrating the neurological and other

physiological evidence as to the organic basis of this disease. **(Footnote 2)** Such literature, especially where it prevents a fundamental challenge to the psychiatric paradigm, has been consistently ignored in the Wessely's School's own literature, and frequent quoting of the work of the prime proponents of the psychiatric paradigm instead occurs regularly within this literature (for example, as discussed in Marshall et al, 2001. Also see discussion surrounding the continuing failure to engage with the Canadian Myalgic Encephalomyelitis/Chronic Fatigue Syndrome Case Definition and Treatment Protocols (Carruthers 2003), for example, in Kennedy and Bryant, 2004).

2. Confused, Inconsistent Notions of 'Psychosomatic' Illness

Instead of accepting either the WHO's neurological classification, or the evidence of organic disease presented by the international research and clinical literature, proponents of the psychiatric paradigm continue to assert the notion that the 'illness' is caused and/or perpetuated by 'psychological' or 'behavioural' factors. This idea manifests itself in a number of ways, often used interchangeably and confusingly, where various discursive categories of 'psychosomatic' illness are assigned to ME/CFS sufferers within the literature supporting the psychiatric paradigm, implying that various mental, behavioural, or emotional processes, not organic processes of disease in the body, are the causes of their ill health. In this context, ME/CFS sufferers are often constructed as the authors of their own misfortune (McWhinnie et al, 1997), seen as either a conscious or unconscious process (Kennedy, 2004 (a)). Such categories identified in the literature of the psychiatric paradigm include:

- Imaginary (the illness or symptoms are deemed not 'real', but imagined);
- Malingering (the 'sufferer' is implied as lying about the extent or even the existence of their illness, in order to receive financial or other benefits, including social or familial attention. Sometimes this can be implied to be occurring on an 'unconscious' level, i.e. 'lying to one's self');
- Hypochondria (the 'sufferer' is deemed to have odd or 'aberrant' or 'irrational' illness beliefs, for example, believing they need to rest, when they 'should' be exercising, even though exertion may have serious adverse implications for ME/CFS sufferers, and the idea that such concerns are 'irrational' are highly subjective and contested, as described in Kennedy 2004 (b);
- Personality disorders, often interspersed with notions of 'character flaw'.
- Functional (a disturbance of the function of an organ mediated by emotional tension);
- Structural (a physical structure disturbance mediated by emotional tension).

The last two Categories are used within the context of the psychiatric paradigm, usually to imply a unidirectional relationship between the mind and body (psychological problems are attributed

by proponents as CAUSES of the illness, and not considered as EFFECTS of chronic, serious illness),

privileging the mind's effect on the body without considering the body's effect on the mind, therefore frequently manifesting as an example of the cultural myth of 'mind over matter'. (Wendell, 1996)

A seventh Category, 'Holistic', an approach to any state of the body taking into consideration psychological factors in physical conditions and physical factors in psychological conditions as described by Bartol and Eakes, (1995) for example, an approach endorsed by the World Health Organisation, has been, so far, conspicuous by its absence in the deliberations on ME/CFS by proponents of the psychiatric paradigm.

Often, within the literature of the psychiatric paradigm, the first six categories (but in particular the first FOUR categories) identified above are used concurrently, interchangeably, and confusingly. Frequent examples of this tendency in the literature are evident in the examples of text collated in Hooper (2004) and Marshall and Williams, (1996, 1999). (**Footnote 3**)

The various discursive categories of 'psychosomatic' illness, which have been broadly described above, can have many descriptive terms applied to them, which are also used interchangeably and confusingly within the literature of the psychiatric paradigm and applied to ME/CFS sufferers. Such descriptions include: 'psychosomatic' 'Functional Somatic Syndrome' 'somatization' 'hysteria' 'conversion disorder' and 'psychogenic'.

3. Failure to differentiate psychological problems found in chronic illnesses from psychiatric illness per se.

Proponents of the Psychiatric Paradigm consistently fail to clearly demarcate the differences in any 'anxiety' or 'depression' or other emotional/psychological problems that might be diagnosed in some (by no means all) ME/CFS sufferers (Dutton, 1992). This has the effect of incorrectly attributing such problems as the causes or perpetuating factors of 'CFS'. So, for example, they frequently fail to demarcate the possible types of anxiety or depression that might be found in ME/CFS (certainly not always), e.g. as delineated by Stein (2001):

- “1. grief due to loss of health, social connections, family support, financial capability, career and uncertainty re (sic) all of these;
2. change in mood/cognition as part of the physical disorder of CFS (similar to mood change in MS or Parkinson's disease);
3. comorbid depressive disorder and
4. mood change due to medication or food or withdrawal from either of these.”

It is significant that, while psychiatrists such as Stein are concerned with the impact on quality of life of serious illness such as ME/CFS (as exemplified in this comment):

“Grief is not a disorder. It is a normal developmental process which enables people to deal with overwhelming loss. It is an understandable reaction to a serious, uncertain, stigmatizing and

chronic disorder. Grief is therefore common during the initial post diagnostic period and may recur each time there are new changes in health or life situation.”

such considerations are not deliberated or considered within the vast majority of the literature advocating the psychiatric paradigm. This indicates that the high figures of ‘co-morbid anxiety and depression’ in ‘CFS’ claimed frequently by proponents of the psychiatric paradigm are untenable: firstly because of the heterogeneity of patient samples in research conducted under the auspices of the psychiatric paradigm (discussed later in this paper), but also, in regard to the issue of psychological problems, because proponents of the psychiatric paradigm fail to differentiate normal grief or fear reactions to chronic illness, neurologically mediated mental disturbances, and other environmentally-mediated mental disturbances such as, for example, reactions to medication or hypoglycaemia due to lack of food (all of which may be transitory), from anxiety and depressive disorders that might be present independent of the illness of ME/CFS (the ‘co-morbid’ or even ‘pre-morbid’ (Dutton, 1992) disorders), and place them under a catch-all category of ‘co-morbid’ psychological disorder.

4. Flawed research design

Within their research projects, proponents of the psychiatric paradigm consistently fail to demarcate ME/CFS from other disorders involving ‘fatigue’, some of which may have a psychological component (Jason et al, 1997), such as idiopathic chronic fatigue (classified by the WHO as ICD-10 F48, a psychiatric disorder), depression, Fibromyalgia (Classified by the WHO as a Soft Tissue Disorder), ‘burnout’ and indeed ANY ‘fatigue state’, none of which are ME/CFS. They then generalise any results from a highly heterogeneous sample which may NOT apply to those who are ME/CFS sufferers (Caruthers et al, 2003, Jason et al, 1997). In light of their theoretical assumptions regarding CBT/GET, and the dangers associated with those treatments to ME/CFS G93.3 sufferers, they are therefore placing such sufferers at risk (see Kennedy & Bryant, 2004, and point 7 below).

Significantly, their research has failed to include Seriously Affected Sufferers to date, and yet their generalisations are applied to this group also. They also sometimes exclude patients with cardinal symptoms of ME/CFS in their samples, for example, sleep disorder in Fulcher and White, (1997) yet continue to generalise, within their literature, any ‘successes’ of their proposed ‘treatments’ (especially Cognitive Behavioural Therapy and ‘Graded Exercise/Activity’ regimes, discussed below) to all patients (for example, even those with sleep disorders).

The continued use of criteria such as the Oxford Criteria by some in particular, presents a major methodological problems which proponents of the psychiatric paradigm continue to ignore. The Oxford criteria exclusion definition actually prevents a patient with an organic brain disease from entering into research trials utilising the criteria. ME/CFS ICD-10 G93.3 **is actually** an organic brain disease as listed by the WHO and this classification is agreed by the UK Government. What is more, most ME/CFS sufferers will exhibit signs and symptoms of organic brain disease, and especially those seriously affected. By the logic of the Oxford Criteria, they should be excluded. This anomaly is one of the major flaws of the Oxford Criteria, yet these

criteria continue to be used by proponents of the psychiatric paradigm, for example, in the ongoing PACE Trial (Kennedy and Bryant, 2004, Bryant 2004).

5. Fatigue as a trivialising term

Proponents of the psychiatric paradigm consistently fail to discuss the problem of the issue of ‘fatigue’ as applies to ME/CFS sufferers, thereby incorrectly presenting ‘fatigue’ as merely ‘tiredness’, despite the evidence that the word ‘fatigue’ is inadequate to describe the physical abnormalities (both signs and symptoms) that occur in ME/CFS. In the same context, they fail to acknowledge that ‘fatigue’ (which might mean tiredness, drowsiness, exhaustion, disturbed level of consciousness, weakness, paralysis, or feelings of malaise, depending on how certain illnesses are experienced or linguistically constructed by individuals) is present in MOST organic illnesses, acute and chronic. Indeed: “Fatigue is both a normal and a pathological feature of everyday life’ (Hyde 1992: 11).

Proponents of the psychiatric paradigm, in their literature, tend to associate ‘fatigue’ with a psychological state, ignoring the physiological reasons that may contribute to the bodily symptoms in ME/CFS, with the effect that these become generalised, and often trivialised, as ‘fatigue’. As Hyde also points out, to place such an emphasis on such a generalised, unspecific, indefinable and immeasurable term as ‘fatigue’, present in both healthy patients and those with both organic and psychological illness, the elimination of hundreds of other diseases are necessitated. This logistical flaw results in only the most limited investigation being encouraged for ME/CFS patients, and NOT in areas that might yield definitive results, such as certain brain scans (as discussed and referenced in Hyde et al, 1992, Marshall et al, 2001, Carruthers et al, 2003).

Particularly relevant to ME/CFS sufferers also is the problem also identified by Hyde (1992: 11-12):

‘...taking the fatigue as the flagship symptom of a disease not only bestows the disease with a certain Rip Van Winkle humour, but removes the urgency of the fact that most ME/CFS symptoms are in effect CNS symptoms.’

In this context the ramifications of such serious, disabling symptoms as found in ME/CFS are both trivialised and ignored. The problem is compounded by the frequent tendency, by proponents of the psychiatric paradigm themselves and taken up uncritically by others, to use, incorrectly, the term ‘chronic fatigue’ instead of and interchangeably with ‘chronic fatigue syndrome’, even though both terms denote completely different diseases. Chronic Fatigue Syndrome is described in the WHO ICD-10 as synonymous with (therefore merely another name for) the neurological disease ME, while chronic fatigue is assigned a different category of illness in the ICD-10 (Psychiatric). This incorrect practice of using the terms ‘chronic fatigue’ and ‘chronic fatigue syndrome’ interchangeably and confusingly has a direct relationship to the research design flaws delineated in point 4 of this document, and the actions described in point 1.

6. Promotion of Cognitive Behavioural Therapy as ‘cure’ for a neurological illness

They promote the use of Cognitive Behavioural Therapy, NOT as a strategy of coping with one’s illness, but as a ‘cure’ for ME/CFS, (which, it must be remembered, has been both classified and consistently demonstrated as a neurological illness) believing that the multi-system physiological abnormalities (manifesting as symptoms) can be improved to the point of ‘recovery’, merely by challenging the illness beliefs and behaviour of the sufferer (see for example, Sharpe, 1996: 248, Stulemeijer et al, 2004). Their rationale for the use of CBT is as a ‘cure’ for a neurological illness that they do not even recognise, an illogical position unheard of in regard to medical approaches to any other neurological or other organic illness.

7. Promotion of Graded Exercise despite the evidence of risk

They promote ‘Graded Exercise/Activity Therapy’ (GET or GAT) regimes, even though their own research in this area has been criticised for the high drop out rate of patient samples, and the patients excluded from such trials (Carruthers et al, 2003, Kennedy and Bryant, 2004). In promoting GET or GAT, they continue to ignore the documented harmful effects and therefore potential dangers of ‘Graded Exercise/’Activity’ for ME/CFS sufferers, for example as demonstrated in Van de Sande (2004) Carruthers et al (2003) 25% Group (2004) Shepherd (2001) Action for ME (2001)

8. Cultivation of a ‘Culture of Ignorance’

Proponents of the Psychiatric Paradigm frequently and illogically describe ME/CFS as ‘Medically Unexplained’ (see for example, Rief and Sharpe, 2004). Ironically, they then promote a state of ‘cultivated ignorance’ about patient signs and symptoms, by discouraging all but the most limited of biomedical investigations/treatments for ME/CFS sufferers (as demonstrated in Montague and Hooper, 2001).

9. Prejudicial Descriptions of Patients

Within their literature, proponents of the Psychiatric Paradigm consistently discursively construct ME/CFS sufferers as mentally, socially, and emotionally deviant (**footnote 4**) in various ways, applying their own subjective moral judgements and thymic categories of dysphoria (**footnote 5**), which frequently appear prejudicial, onto sufferers. Examples of these are comprehensively documented in, for example, Hooper (2004) and Marshall and Williams, (1996, 1999), and discussed in Kennedy, 2004 (a).

10. Lack of reflexivity or epistemological and methodological insight

There is a marked lack of the reflexivity or critical self reflection by proponents of the psychiatric paradigm that would be normally be expected in such literature, in order to identify potential theoretical problems in research, (Harding, 1987) and therefore this epistemological problem, identified as a problem to be addressed in the social sciences, (Brunskell, 1998) and

therefore much more frequently considered within those disciplines, remains un-addressed by proponents of the psychiatric paradigm within their literature.

The above problem is confirmed when considering another methodological criticism to be made of research conducted by proponents of psychiatric paradigm. Much of their studies involves quantitative method. The potential problem with any quantitative approach is that qualitative factors, those which are subjective, for example, bodily experiences such as pain, exhaustion, emotions, are measured quantitatively, but the parameters for measurement are constructed within the context of the researcher's own assumptions. So, when research subjects (or patients) are questioned, they have to comply with answering a set of closed questions, which are constructed according to the researcher's agenda (and possibly ideological assumptions), leaving no room for qualitative clarification by the patient/research subject.

An example of this phenomenon within the psychiatric paradigm include the use of the 'SPHERE' checklist (Hickie et al, 1996). In this method, a number of closed questions (requiring a YES or NO answer) are put to the patient. Answers in the positive to any of these questions can lead to a diagnosis (from either researcher or clinician) of psychiatric disorder. Ironically, the majority of the questions relate to bodily symptoms that will be experienced in MANY organic illnesses, and will be specifically experienced by ME/CFS sufferers, and which can be explained as resulting from Central Nervous System dysfunction, (Hyde and Jain, 1992) for example. The symptoms include: head pain, irritability, poor memory, pains in limbs, muscle pain after activity, fatigue, emotional lability, fainting, nausea, arms and legs feeling heavy, flatulence and abdominal distension, pyrexia, back pain, hypersonic, post-exertional malaise, sore throats, numbness or tingling sensations, muscle weakness, Diarrhoea or constipation, sleeping difficulties, dizziness, fatigue even at rest, difficulties with concentration, and aphasia.

If a researcher (or doctor) assumes that ME/CFS is a psychological or behavioural disorder, they will diagnose a sufferer of the above symptoms as mentally ill, even though such symptoms indicate a high level of physical dysfunction and suffering, and are entirely consistent with Central Nervous System Dysfunction as discussed, for example, in Hyde et al, 1992. The WHO ICD-10 neurological classification of ME/CFS is based on the large amount of research indicating neurological dysfunction.

This specific way that the personal subjective bias of a researcher or doctor will influence the diagnosing of somatization disorder in this way is discussed in Jason et al (1997), and demonstrated in Johnson et al (1996). As Stein (2001) also states:

"It is a mistake to use screening instruments such as the Beck Depression Inventory, the General Health Questionnaire or the SPHERE to diagnose mental illness in persons with undiagnosed somatic complaints including those with CFS because of the unstated, unproven and incorrect assumption that the somatic complaints are of psychological origin."

The construction of YES/NO-type or other closed-answer questions, and the expression of apparently ideological assumptions as mathematical data, can be very simplistic ways of attempting to measure human experience, and, as has been demonstrated above, subject to

skewed results, based on the biases of the researcher. In the case of the psychiatric paradigm, the often demonstrably prejudicial value judgements as illustrated by, for example, key members of the Wessely School, immediately raises doubts about any claims to objectivity inherent in their research literature, and this problem is compounded by their lack of critical self-reflection, even though faced with critique of the value judgements expressed within their literature (for examples of these see Hooper, 2004, and Marshall and Williams, 1996, 1999), and the continuing protests by ME/CFS sufferers about the damage to health and welfare caused by such assumptions.

Does the Psychiatric Paradigm result in failure of care?

The approaches towards ‘treatment’ of sufferers of ME/CFS, by proponents of the psychiatric paradigm are in stark contrast to the care plan advocated by psychiatrists such as Stein (2001) :

“The treatment of psychological symptoms in CFS is fourfold:

1. treat the physical illness,
2. actively advocate for the patient’s health, mental health and economic needs,
3. offer or refer for psychotherapy to support the patient’s grieving process and encourage the formation of sustainable values and expectations and
4. use low dose psychotropics for those in whom anxiety or depression symptoms are disabling and/ or are interfering significantly with quality of life.”

The psychiatric paradigm as proposed by Wessely et al fails to achieve the above exemplar because:

(a). They do not accept the demonstrated organic, neurological nature of ME/CFS, despite the large body of evidence that demonstrates this, preferring to maintain that it is caused or perpetuated by psychological, social, emotional and behavioural factors. In line with this position, they discourage all but the most limited of biomedical investigations/treatments for ME/CFS sufferers, and, ironically, discouraging those investigations in which strongest evidence of organic pathology are being delivered (Hooper et al, 2001, Marshall et al, 2001).

(b) They are involved in discursive constructions of ME/CFS sufferers as social and mental deviants, therefore contributing to a stigmatization of sufferers, leading to social exclusion, and material and social inequalities (as described, for example, in Michell, 2004, Hyde et al, 1992, p 25-37, TYMES Trust, 2003, Jason, 2000).

There is also evidence to show that key members of the ‘Wessely School’ are involved in denying benefits and pensions to ME/CFS sufferers. (e.g. Walker, 2003)

Uncritical acceptance of the psychiatric paradigm has led to the forced incarceration of ME/CFS children, against their own and their parents’ wishes, and enforced exercise regimes and psychiatric treatment (Mar, 2001, TYMES Trust, 2003, Michell, 2004) There is also evidence of

personal involvement of key proponents of the psychiatric paradigm in such treatment of ME/CFS child sufferers (Walker, 2003).

(c) They promote Cognitive Behavioural Therapy (CBT) in their literature, but frequently ignore the other available forms of psychological support strategies for ME/CFS sufferers (if needed). Indeed, they do not promote CBT as a support strategy, but as a 'cure' for ME/CFS, (a neurological illness) believing that the multi-system physiological abnormalities (manifesting as symptoms) can be improved to the point of 'recovery', merely by challenging the illness beliefs and behaviour of the sufferer. Their rationale for the use of CBT is as a 'cure' for a neurological illness that they do not even recognise, a position unheard of in regard to any other neurological or other organic illness.

(d) They fail to differentiate between the different forms of psychological problems that might (though not always) be faced by ME/CFS sufferers, implying ANY psychological problem is a CAUSE rather than EFFECT of the illness. This leads to a conspicuous lack of commitment to promoting ways of offering psychological and social support for the impact on quality of life caused by this chronic illness.

The contrasts between Stein's model of care, and the positions adopted and the actions taken by proponents of the psychiatric paradigm, demonstrates a failure of care of ME/CFS sufferers on the part of the latter, and this failure has specific adverse affects upon the health and welfare of such patients.

Effects of the Psychiatric Paradigm on ME/CFS sufferers

Documented iatrogenic effects, on patients, resulting from the Psychiatric Paradigm of ME/CFS, include:

1. Lack of medical investigation of physical abnormalities.
2. Lack of appropriate bio-medical treatment and support (**Footnote 6**)
3. Denial of benefits, insurance or pension payments to sufferers, even though the extent of their disabilities would, with regard to other organic illnesses, entitle such sufferers to these.
4. Hostility and/or lack of empathy from many in the medical profession, families, communities and society at large, who frequently believe that the illness is a result of social, mental and behavioural deviance.
5. Social Exclusion, and other material and social inequalities resulting from the above and from lack of social, welfare and financial support associated with the belief that this illness is a result of deviance.
6. Forced treatment of patients, including forced incarceration of both children and adults.
7. Continued distress at not having one's physical suffering and limitations believed.
8. Adverse impact on quality of life to such a degree that some ME/CFS sufferers have committed suicide. (**Footnote 7**)
9. Increased Post exertional malaise following Graded Exercise/Activity Regimes, which have been reported as reducing functional ability levels and increasing symptom severity (see point 7 for references).

Conclusion

This document has provided only a brief summary of the psychiatric paradigm and the fundamental flaws to be found within. The range and depth of problems with this paradigm raises serious issues of validity and reliability.

A full discussion of the philosophical problem of how the mind and body is to be considered in medicine is outside the scope of this document. However, it is important to remember that assumptions around 'psychosomatic illness' promoted within the psychiatric paradigm have been heavily critiqued (for example, Webster, 1995), are unverifiable at present (Stein, 2004, Dalen, 2003), and may remain so indefinitely.

Crucially, the lack of clarity of concepts demonstrated within the psychiatric paradigm, the refusal to accept the problems with and lack of proof of their own speculative hypotheses, evidence that regularly disproves the psychiatric paradigm and, most importantly, their refusal to acknowledge the prejudicial judgements made about ME/CFS sufferers within the psychiatric paradigm and the iatrogenic suffering this has caused (and continues to), has rendered the theoretical position of this paradigm untenable.

As the proponents of this paradigm continue to promote such flawed concepts, within their own literature, and in advice to government and other parties, even though they have been made aware of these flaws and the critically adverse impact they have on ME/CFS sufferers, on many occasions, it is impossible to reach any conclusion other than that such continued actions represent a clear breach of medical ethics: primarily, a fundamental abrogation of duty to patients suffering from this disease.

In light of the considerable theoretical, methodological and ethical problems identified within the psychiatric paradigm, and the endangerment and disenfranchisement to ME/CFS sufferers these continue to cause, a review of all 'bio- psychosocial' approaches to ME/CFS adopted in health and social policies, globally, is necessary as a matter of urgency.

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FOOTNOTES

1. See Marshall et al, 2001, for an account of this. Also see:

See Hansard:

<http://www.publications.parliament.uk/pa/ld199697/ldhansrd/pdvn/lds04/text/40311w05.htm>

Also see 'WHO Geneva Headquarters, classification information ME/CFS' Available on the One Click Website:

http://www.theoneclickgroup.co.uk/documents/ME-CFS_docs/

2. An indication of the extensive body of evidence supporting the recognition of ME/CFS as a neurological disease, in line with its classification as such by the WHO ICD-10, and the multi-systemic physiological abnormalities presenting as part of the disease can be found in documents and publications such as Montague and Hooper (2001) Marshall, Williams and Hooper (2001), Hyde et al (1992) Carruthers et al (2003) and the Journal of Chronic Fatigue Syndrome. It must be noted, however, that such references, and evidence, contained in these documents, are by no means exhaustive.

3. These themes, and others, have been identified as part of a research project into the writings of the psychiatric paradigm that I am currently undertaking (summarised in Kennedy, 2004), using social science research techniques of narrative, linguistic, textual and discourse analysis.

4. Deviance is defined as being or doing outside cultural norms (Macdonald and Plummer, 1997, p.208). Labels of deviance are not 'natural'; they are socially constructed, i.e. by the culture we live in. Crime is an example of 'deviance', though not all criminals are considered deviant (for example, those committing petty crimes such as using the telephone at work for personal calls). 'Deviance' usually involves moral value judgements of 'badness' (see footnote below) being applied to an act, or, more worryingly, a person. The extensive quotes collated in Hooper's and Williams' documents demonstrate a frequent categorisation of ME/CFS sufferers as being outside social norms in terms, not of having a disability, but of the frequent implication that their illness is the result of character flaws or morally inappropriate ('deviant') behaviour such as malingering or hypochondria (Kennedy 2004 (a)).

5. The term THYMIC CATEGORIES (Martin and Ringham, 2000) refers to the linguistic categorisation of subjects or objects as 'good' or 'bad', that can be identified when conducting discourse analysis on produced texts. Thymic categories are constructed by two poles, of euphoria (good or pleasant feelings) and dysphoria (bad or unpleasant feelings), corresponding to evaluations of goodness or badness. Such characteristics are a feature of all discourses, including academic and medical. My concern in this respect regards the way in which observable dysphoric categories are frequently applied to the behaviour, thoughts, actions and characters of ME/CFS patients within the literature of proponents of the psychiatric paradigm, with a corresponding absence of euphoric categories. The observable, overall effect of such linguistic constructions is that of an author's consistent evaluation of ME/CFS patients and their feelings, beliefs, actions and characters as 'bad'.

6. For example, the proposed 'CFS/ME' centres in Britain will only provide CBT/GET 'treatments' as a matter of course, and there has been no evidence of provision of, for example, SPECT or other brains scans which have been shown to provide clear evidence of

brain dysfunction in a high majority of ME/CFS patients (Hyde et al, 1992, Carruthers et al, 2003, Marshall et al, 2001). Nor is there any apparent system for referral to neurological, immunological or endocrinological specialists for either diagnosis or treatment of this neurological disease. See for example the 'Harrow and Hillingdon Bid', available on the One click Website:

http://www.theoneclickgroup.co.uk/documents/ME-CFS_docs/

7. The Suicide Register was organised by Sheila Barry after her 27 year old daughter, an ME/CFS sufferer, committed suicide (See Walker, 2003: vii).

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