

## UNUM UNITED?

Eileen Marshall    Margaret Williams

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On 10<sup>th</sup> October (World Mental Health Awareness Day) UK Health Secretary Alan Johnson MP announced that £170 million a year will be released to provide cognitive behavioural therapy (CBT) across the board for mental illnesses in England, to be delivered by the recruitment of 3,600 “therapists”, and that 900,000 people who suffer from depression and anxiety in particular will benefit (“More funds for talking therapies”. BBC News, 10<sup>th</sup> October 2007). Lord Layard (the “happiness tsar” who supports this policy) said on BBC Radio 4 midnight news that he is delighted, because CBT is “*state of the art treatment*” and that “*half of the patients will be completely cured*”.

Do patients in the UK who have been diagnosed with myalgic encephalomyelitis (ME) / chronic fatigue syndrome (CFS) fall into the category of “mental illness”?

According to Wessely School psychiatrists and the Medical Research Council (MRC), they do.

The Wessely School and the MRC persistently refuse to accept the World Health Organisation classification of ME/CFS as a neurological disorder and seem to have little regard for accuracy of diagnosis or for the catastrophic consequences of misdiagnosis.

On 12<sup>th</sup> December 1998, “Disability Now” reported that Dr Nigel Speight, a consultant paediatrician with extensive experience of ME/CFS, went on record saying he feared the old idea that ME/CFS is not a real condition, only a state of mind, was still at work. Despite the biomedical evidence that has emerged since then, it seems that the Wessely School continues to believe that ME/CFS is simply a state of mind.

What neurological disorder has ever been cured by a course of CBT? Where is the evidence? Even the Wessely School proponents of CBT concede that “*few patients regard themselves as cured after treatment*” (Anthony W Clare, Peter D White. In: Psychological Medicine (in) Clinical Medicine, Ed: Kumar and Clark. Saunders, 2005, p/b).

Despite this, it has been confirmed that the only NHS provision for those with ME/CFS is to remain psychiatric: on 9<sup>th</sup> October 2007, Hansard recorded that in answer to the question asking what plans the Government has to provide support for those affected by CFS, Ann Keen, Parliamentary Under-Secretary of State at the Department of Health, replied: “*We have no current Government plans to provide support for further specialist national health service centres for those living with CFS*”.

In the BBC “PM” programme on 11<sup>th</sup> October 2007, clinical psychologist Oliver James said claims about the efficacy of CBT were a bare-faced lie on the part of the Department of Health, and that even if patients did improve, after 18 months they were all back to where they were before.

According to the Conference Report “M.E./CFS research summit workshop” produced by Action for ME, of the AfME / MRC joint Summit held in November 2006, Peter White said that the UK leads the world in behavioural interventions for ME/CFS.

Why are behavioural interventions even on the agenda for a disease described by Professor Nancy Klimas from Miami at the same Summit as having an increase in class II antigens HLADR4, DR5, DQ3, (HLA antigens are responsible for the immune system being activated to detect and eradicate foreign bodies) and an immune response that has persistently shifted to the Th2 system (so the Th1 system does not function properly), which means that the Th2 cytokines activate B-cells, which in turn results in the production of auto-antibodies which can trigger autoimmune disease, as well as profound allergic reactions?

Put another way, how can behavioural interventions such as re-educating the mind to believe that ME/CFS does not exist as an organic disorder possibly be effective in restoring the immune system dysregulation (including the chronic immune activation) that is characteristically seen in ME/CFS? Such mind-changing “interventions” are not the same as providing support and help in managing a life-shattering disease.

Could it be that Wessely School psychiatrists do not understand immunology? Certainly, on his own admission, Simon Wessely does not understand immunology: he stated this at his Gresham College lecture on 25<sup>th</sup> January 2006 (“Something old, something new, something borrowed, something blue: the true story of Gulf War Syndrome”).

If the “biopsychosocial” approach worked and did not result in serious relapse, and if the biological factors seen in ME/CFS were “*largely reversible*” (as claimed by Wessely and Sharpe in their chapter “Chronic Fatigue and Neurasthenia: A Review” in *Somatoform Disorders*, Volume 9, edited by Mario Maj et al, John Wylie & Sons, 2005), there would be no long-term sufferers from ME/CFS because patients are desperate to regain their health and independence. 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 more extracts from that chapter, see [http://www.meactionuk.org.uk/More\\_on\\_the\\_Myth.htm](http://www.meactionuk.org.uk/More_on_the_Myth.htm)

The GMC recently criticised and struck off a doctor for practising outside his area of expertise. It is not possible for psychiatrists who have not undertaken post-graduate training to be experts in such complex fields as immunology, vascular biology or gene

expression that are known to be disrupted in ME/CFS, so why do they regard and promote themselves as experts in this disorder?

Stephan (or Stefan) Priebe from the Unit for Social and Community Psychiatry at Barts and The London School of Medicine and colleague and collaborator of Professor Peter White is well-known for his view about CBT: “(Patients’) *frequent insistence on physical causes for the fatigue has been identified as an obstacle to successful treatment*”. In other words, non-recovery after a course of CBT is the patients’ own fault, rather than the fact that the nature of the disorder precludes recovery following a course of brain-washing techniques.

Priebe has equally clear views about the value of diagnosis: “*The criterion for a diagnosis is not whether it does or does not exist in reality, but whether it is useful*” (Stephan Priebe, (In): Somatoform Disorders, Volume 9, page 289. Ed: Mario Maj et al; John Wylie & Sons, 2005).

A diagnosis is certainly useful for the medical insurance industry, if not for the patient, because a diagnosis of a mental disorder means the insurance company has either no – or greatly reduced – liability for the payment of benefits. The same exclusions apply to eligibility for certain state benefits in England.

The principal beneficiaries of a correct diagnosis used to be the patient but not, it seems, any longer: since the corporate take-over of medicine and the NHS by the multi-national conglomerate, the principal beneficiary of “diagnosis” is the conglomerate, in which the medical insurance company Unum is a world player.

In his Annual Report for 2007, entitled “Mind over Matter – Exploring the issues of Mental Ill Health”, the Chief Medical Officer of Unum (Professor Michael O’Donnell) says: “*With mental ill health problems now accounting for around 30% of all our claims, and 40% of claims for Incapacity Benefit, now is the time to consider what we, as employers, can do about the problem (because) this represents one million incapacity claims for mental and behavioural disorders. Cognitive Behavioural Therapy (CBT) has the best evidence base for effectiveness. In last year’s Chief Medical Officer’s Report (Rehabilitation – Keeping people in work), Professors Gordon Waddell and Kim Burton pointed out that a high proportion of people who have been off work for longer than six months suffer from what are referred to as common health problems in (which) subjective symptoms predominate (and) it is as much psychosocial as biological issues that obstruct recovery. It is for this reason that I have asked Dr Chris Bass and Professor Simon Wessely to contribute to this year’s report. I asked them to write on what many others as well as me believe to be obstacles to recovery. They are both known for their firm beliefs. Dr Bass applauds the response of the insurance industry. Professor Wessely has written on collusion (and he) points out that this can be part of the therapeutic process*”.

Was O’Donnell being sardonic in paraphrasing Wessely’s article in terms: “*Problems can occur when doctors have a financial interest in their clients remaining unwell*”?

It is noted that O'Donnell's particular listed interests include "*the biopsychosocial model of incapacity*".

O'Donnell refers to the "*firm beliefs*" of Bass and Wessely; others might refer to those beliefs not as "firm" but as fanatical. Whatever the adjective, that is all they are – beliefs. The elective ignoring of the scientific evidence that discredits those beliefs is astounding.

As far as ME/CFS is concerned, it defies credibility that a policy that is to be rolled out nationwide at such considerable cost should be predicated on the unproven beliefs of a small group of psychiatrists whose contempt and disdain for their patients with ME/CFS seems virtually tangible (see below). How can such beliefs spread like a virus throughout the UK, when there is so much published evidence demonstrating that such beliefs bear no relationship to scientific reality and are not supported by the international evidence that ME/CFS is a multi-system organic disorder of devastating impact?

Unum, however, seems happy to continue to ignore this evidence, and in what seems to be an attempt to portray the company as enjoying an impeccable reputation, the document proclaims: "*Unum Limited is authorised and regulated by the Financial Services Authority*", as though this were a badge of honour.

Currently, regulation by the Financial Services Authority (FSA) is little to boast about: as reported in the UK media, on 9<sup>th</sup> October 2007 Sir Callum McCarthy, Head of the FSA, appeared before a House of Commons Treasury Select Committee and was stringently criticised for the failure of the FSA to notice that the bank with the most risky financing model in the UK (Northern Rock) was a disaster waiting to happen. Media commentators were unimpressed by Sir Callum's failure to acknowledge the FSA's own shortcomings and the resultant credit crunch, and by his attempts to pass the buck as a distraction from the FSA's own failure by his focusing on the now-frosty relations between the discredited tripartite system of financial control (Comment, Tom Stevenson, Daily Telegraph, 10<sup>th</sup> October 2007).

This being so, Unum's proud proclamation that it is regulated by the FSA might not amount to much at all.

Importantly for the UK ME/CFS community, the Unum Report provides yet more proof of the incestuous relationship between Wessely School psychiatrists and the insurance industry, a relationship that the parliamentarians who produced the Gibson Inquiry Report of November 2006 were particularly troubled about: "*Given the vested interest private medical insurance companies have in ensuring (ME/CFS) remains classified as a psychosocial illness, there is a blatant conflict of interest here. The Group finds this to be an area for serious concern and recommends a full investigation by the appropriate standards body*".

For some reason, the Wessely School and its Unum backers remain impervious to and immune from any such investigation.

The reports of Dr Bass and Professor Wessely are briefly considered here.

Dr Chris Bass was formerly at King's College Hospital, London, but is now a Consultant in Liaison Psychiatry at the John Radcliffe Hospital, Oxford. Between 1993 and 1997 he was Chairman of the Liaison Psychiatry Section at the Royal College of Psychiatrists. His listed areas of research and clinical interest include patients with persistent medically unexplained physical symptoms and patients with fabricated illnesses. He has edited or co-edited five books since 1990.

His article in the 2007 Unum Report is titled "The Interface between Psychiatric and Physical Disorders" and begins by bemoaning what Bass calls the firewall that he says continues to exist between psychological and physical disorders and services, alleging that the purchasers of healthcare operate as if the firewall was a permanent fixture. Bass then goes on to talk about the "*problematic word 'psychosomatic'*".

*"Most physicians are not trained to recognise patients with concurrent physical and psychiatric illness, nor do they realise the impact emotional problems have on the clinical, functional and economic outcomes for these patients".*

*"UK newspapers found that the word 'psychosomatic' had a perjorative meaning (imaginary or 'made-up'). Clearly more needs to be done to educate the media to make it attractive to patients".*

*"In the last decade high quality research has demonstrated the key role of psychosocial factors in disorders that have previously been conceptualised as 'medical', such as Chronic Fatigue Syndrome (CFS)".*

It is notable that the National Institute for Health and Clinical Excellence (NICE) in its recent Guideline on "CFS/ME" classified the psychosocial model of ME/CFS as just one hypothesis among many.

*"These so-called 'somatoform disorders' are the third most common cause of workplace absence, which has forced the government and insurance companies to sit up and take notice".*

*"Recent figures have revealed that 70% of individuals in receipt of Incapacity Benefit have non-organic disorders, which in my opinion represents a failure of not only the medical model but also the training of doctors".*

*"Hadler, (a rheumatologist) has pointed out that the key difficulty with fibromyalgia lies in framing the problem as biomedical. Similar processes occur in patients with CFS".*

*"These patients with nonorganic complaints are overrepresented in the clinics of alternative practitioners, where they are often provided with explanations for their symptoms that re-inforce a 'somatic' ailment where none exists. Patients do not need*

*more complementary practitioners peddling non-evidence based medicine treatments – doctors need to be better trained. Regrettably, most physicians continue to be oblivious to the role of **illness perception and beliefs** in these disorders”.*

*“Of course, patients do not like to be informed that psychosocial factors are more important than physical ones”.*

*“Another gross anomaly is the provision of funding of services for patients with ‘non-organic’ disability. What is particularly galling is that the purchasers of healthcare do not appear to understand basic facts”.*

*“In a recent article, a rheumatologist suggested that by 2050, ‘neurotropic blockers will put an end to the problem of fibromyalgia and myalgic encephalomyelitis’. **This is the medical model run riot, and it does not bode well**”.*

Does the potential development of “neurotropic” blockers open up the possibility of targeted therapeutic interventions, which indeed may not bode well for psychiatrists who deny the existence of the need for such interventions?

Perhaps intentionally, Bass failed to provide the reference for this article from a rheumatologist and has so far failed to respond to several polite emails requesting its provenance.

At this juncture, it may be prudent to reflect on what seems to be the inescapable condescension, complacency and arrogance that permeate this article in the Unum Report: the certainty with which Bass asserts **“This is the medical model run riot”** seems to indicate a disturbing conviction that his own beliefs about fibromyalgia and ME/CFS are the only correct beliefs. In psychiatry, there is a term for people who believe implicitly that they alone are right in the face of evidence that they are wrong.

Bass continues:

*“My impression (carrying out insurance medical exams for the last 10 years) is that some orthopaedic surgeons, rheumatologists and occupational physicians have become aware of the key importance of psychosocial factors in the maintenance of these disorders”.*

Is Bass claiming that orthopaedic sequelae (including those that are iatrogenic) are psychosocial? Perhaps he believes that the existence of chronic disorders such as rheumatoid arthritis and lupus are psychosocial also?

This seems to be another example of the Wessely School’s attempts at social engineering, whereby these psychiatrists are intent on discrediting medical disorders and claiming that all illness is simply a behaviour.

To quote once again Peter White’s Preface to the book he edited (“[Biopsychosocial Medicine: An integrated approach to understanding illness](#)” OUP 2005):

*“Some people believe that medicine is currently travelling up a ‘blind alley’ (and) this ‘blind alley’ is the biomedical approach to healthcare. The biomedical model assumes that ill-health and disability is directly caused by diseases and their pathological processes (but) there is an alternative approach.....the biopsychosocial approach is one that incorporates thoughts, feelings, behaviour, their social context and their interactions with pathophysiology”.*

Might such a view ultimately lead to the denial of the organic pathoetiology of all medical disorders and impute on-going disease to an attitude of mind? Even to consider such a possibility is retrogressive in the extreme, and therefore dangerous. For Bass to be promoting this view in the 2007 Unum Report bodes ill indeed for those with disorders for which medicine has not yet discovered the cause or the cure.

Bass finishes his article by referring to a book which he asserts *“has been the cause of much cheer”* but which others have referred to as *“one of the worst in existence and a shameful display of ignorance on the part of its author”* (see *“The Mental Health Movement: Persecution of Patients?”* M.Hooper et al, available at [http://www.meactionuk.org.uk/SELECT\\_CTTEE\\_FINAL\\_VERSION.htm](http://www.meactionuk.org.uk/SELECT_CTTEE_FINAL_VERSION.htm) ).

The book in question is *“Whiplash and Other Useful Illnesses”* by Andrew Malleon, who was born and brought up in England but who is now a psychiatrist with Toronto University Health Network; he is also psychiatric consultant to the Canadian Government Occupational Health and Safety Agency and has done medico-legal work for over 15 years.

Bass states with apparent satisfaction: *“Malleon’s masterly book (2002) has raised the profile of some of the issues raised in this paper”.*

For the avoidance of doubt, what Malleon actually said in his book is this:

*“Somatizers had dropped neurasthenia like a hot brick. Fatigued somatizers needed a new diagnosis (so) they developed “chronic fatigue syndrome” (CFS) in North America and “myalgic encephalomyelitis” (ME) in the United Kingdom. Chronic fatigue syndrome has gone from strength to strength. At the end of the 1980s, conventional medicine focused on the acquired immunodeficiency syndrome of AIDS. AIDS left its victims in a chronic state of exhaustion. In the typical way that fashionable illnesses have of acquiring serious-sounding pathology, CFS quickly incorporated this concept. The chronically fatigued promptly renamed their illness “chronic fatigue and immune dysfunction syndrome (CFIDS), a condition satisfactorily endowed with all the pathological glamour of AIDS, but respectable.*

*“Victims of CFS and ME, like the neurasthenics before them, are mostly young to middle-aged women from the middle and professional classes. Epidemics of ME, CFS (and) environmental hypersensitivity do not occur in the industrially underdeveloped countries. Fashions and affluence go together.*

*“I have used the word ‘victim’ to designate the sufferers of fashionable illnesses. I have done so deliberately, because these sufferers are quick to adopt the victim role. They often see themselves being harmed by members of the medical profession who inflexibly refuse to recognize the validity of their suffering.*

*“As well-educated members of the middle and professional classes, these victims are often vocal advocates for their own anguish. Victims aim much of their copious literature at the unbelieving doctors and their callous disregard for such illnesses (because) in order to provide compensation or support, insurance companies and government social services require medical validation of the illness.*

*“Some doctors, perhaps out of a sense of scientific integrity, out of bloody-mindedness, or even, as the claimants for fashionable illnesses sometimes maintain, because of payments from insurance companies, refuse to validate these pseudo-illnesses”.*

It seems that in his contribution to the Unum 2007 Report, Bass has served his Unum paymasters well and there is no need to be concerned about the impecunious sick who suffer from ME/CFS and whose benefit payments Unum continues to dispute and deny.

Simon Wessely is Professor of Epidemiological and Liaison Psychiatry at the Institute of Psychiatry, King’s College, London and Honorary Consultant Psychiatrist at King’s and Maudsley Hospitals. He is also Director of the King’s Centre for Military Health Research Unit at King’s College, London. His research interests include chronic fatigue syndrome. He has published over 500 papers.

Wessely’s article in the Unum Report is entitled “Why and When do Doctors Collude with Patients?”. It starts by affirming that doctors do indeed collude with patients, sometimes out of self-interest, but more commonly in the genuine belief that to do so is in the best interests of patients, because **“what the patient doesn’t know won’t hurt”**.

Does such a view indicate that paternalism in medicine remains alive and well in the UK? How does such a view accord with the Government’s “Expert Patient” initiative, which requires a partnership approach to the management of chronic illness throughout the entire NHS? (“The Expert Patient: A New Approach to Chronic Disease Management for the 21<sup>st</sup> Century”, published by The Department of Health, reference 25216 1p 10k Sep 01).

Wessely does not mention the terms ME or CFS specifically, but instead says:

*“Sometimes a little collusion can go a long way. Take the example of hysteria. Despite being so often described as on the decline, it is instead ‘alive and kicking’. Slater’s view that a diagnosis of hysteria merely reflected ignorance, and that most cases would turn out to have diagnosable disease if they were properly investigated or followed up for long enough, has been repeatedly disproved”.*



(Whilst favoured by psychiatrists, such an assertion is not universally accepted by other medical disciplines).

*“So when the scans, EEGs and nerve conduction tests are back, and the diagnosis clear, what happens next? Does our ethically trained doctor share this information with the patient? ‘Sir/Madam, there is no neurological reason why you cannot walk. You have what psychiatrists call conversion disorder, but everyone else calls hysteria’. You can bet your bottom dollar that they do not.*

*“In another study nearly every UK neurologist admitted seeing patients for whom the diagnosis of hysteria and/or conversion disorder was appropriate, but hardly any used that label in front of the patient.*

*“In one of those papers one wishes one had written oneself, Stone et al (the et al included Wessely’s colleague Michael Sharpe) showed the importance of labels (“What should we say to patients with symptoms unexplained by disease? The ‘number needed to offend’”. *BMJ Dec 21<sup>st</sup>, 2002*). You have to tell 43 patients who cannot walk that they have multiple sclerosis before one becomes offended, a mere 9 if you say it’s ‘functional’ but two is sufficient if you call it hysteria. Let’s hear it for collusion.*

*“Using labels can trigger a battle of diagnosis, from which the patient themselves is the loser, determined to prove the doctor wrong in the only way possible -- by staying ill.*

*“Finding a label that will not offend the patient whilst enabling them to engage in sensible treatment can be a good strategy. I know a number of neurologists who manage patients whom others might call somatising under a variety of labels such as fibromyalgia.*

*“Whatever your problem, several establishments near the modern Harley Street have the solution. Every test they do is always positive. They replace hormones that don’t need replacing – giving thyroxine to people with normal thyroid function is currently popular. These medical entrepreneurs have a talent for converting the latest scares into opportunities.*

*“We don’t see much hypoglycaemia these days, and chronic brucellosis has gone the way of all flesh, but candida, food allergy and multiple chemical sensitivity continue to flourish”.*

Wessely’s disdain for suffering humanity is inescapable, and his assertion about brucellosis is curious in the light of what is to be found about brucellosis on PubMed documenting Britain’s biological weapons research programme (EA Willis: *Med Confl Surviv.*2003 Oct-Dec; 19(4):285-302).

Wessely continues:

*“The exact label is not the issue – what is important is that they provide an explanation for the stresses, strains and symptoms of life that avoids any of the possible self-blame, stigma and guilt of those diagnoses that more conventionally minded doctors use.*

*“Perhaps it is just too painful to realise that the kindly, polite, charming doctor with the smart consulting room, the latest gadgets, and the utter conviction that he or she really does understand the cause of your problems is really giving you things you don’t need for problems you don’t have.*

*“The swings that you gain on having your complaints listened to are lost on the roundabouts of continuing ill-health and dependency on doctors.*

*“I doubt there are few occasions in which doctors are more pressurised to collude with their patients (than) when the latter pushes across the desk a form that needs to be signed. If I don’t sign, the chances are they will complain, so it’s anything for the quiet life.*

*“ So doctors collude with their patients all the time. It’s not such a bad thing after all”.*

What has happened to respect for the sick and the suffering? What has happened to compassion? What has happened to truth?

Dictatorships are advancing in prosperous societies and are marked by excessive preoccupation with productivity and profit, to the detriment of the weak (in this case, those with ME/CFS). This “freedom” of the strong becomes a factor in the destruction of the weak, because it no longer recognises and respects the truth and shuts out even the most obvious evidence of an objective truth.

On 11<sup>th</sup> October 2007 a BBC 2 documentary entitled “The Ministry of Truth” revealed that many senior Members of Parliament not only think that there is no need for legislation requiring them not to tell lies in their capacity as an MP and as a Minister of State, but are actually opposed to any such requirement. It seems that many of our senior MPs believe that the honesty and accountability of our democratically-elected representatives are up for grabs.

The programme reminded viewers that it was Peter Mandelson MP, one-time Golden Boy of New Labour, who said: “*Our job is to create the truth*”.

It has been shown to be the case that New Labour thinkers are indeed preoccupied with “*the construction of the truth*”. Their portrayal of ME/CFS as a mental disorder is but one example.

The imposition of State-approved “truth” will lead to total control of the individual by the State and its officers, with resultant suppression of everything and everyone who refuses to follow State ideology.

Was it not to prevent such repression that two World Wars were fought? Yet here we are in the UK, walking blindfold into such repression, this time within our own nation.

Francis Wheen, in his chapter "The demolition merchants of reality" said: "*Even verifiable facts can acquire the dangerous potency of myth in an intellectual climate where equal validity is granted to any interpretation, however perverse. When facts are transmuted into myth for political purposes, they can become lies. The fractured logic of post-modernism leads to the conclusion that any perception of 'reality' is as valid as another*" ("How Mumbo-Jumbo Conquered the World: A Short History of Modern Delusions". Harper Perennial, 2004).

The demolition merchants of ME/CFS have turned the facts about ME/CFS into myth.

Why do the charities that are tasked with supporting those with ME/CFS not wake up and take effective action before it finally becomes too late?

It was Francis Bacon (1560 – 1626), one time barrister and member of Grays Inn, Member of Parliament, Solicitor General, Lord Chancellor and Viscount St Alban, who in his Essay "Of Truth", wrote: "*What is truth, said jesting Pilate, and would not stay for an answer*".