

The Model of the Myth?

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In case members of the ME community find it helpful, attention is drawn to three important items.

In 'The myth of the biopsychosocial model', N McLaren exposes once and for all the myth upon which the so-called biopsychosocial model of illness so favoured by Wessely School psychiatrists depends (Australian and New Zealand Journal of Psychiatry, March 2006;40:277).

McLaren comments on a recent paper by advocates of the biopsychosocial model who suggest that cases with complex medical, psychological and social interactions require more services and who lament the fact that orthodox medical services tend not to address such issues adequately (ref: Operationalisation of biopsychosocial case complexity in general health care. De Jonge P et al. Australian and New Zealand Journal of Psychiatry 2005;39:795-799).

McLaren does not beat about the bush, pointing out that De Jonge et al (and psychiatrists in general) have made a mistake in crediting Engel as author of the biopsychosocial model of disease, when Engel did not write any such model. All Engel did was to plead for a more considerate type of medicine.

McLaren notes that Australasian psychiatry seems to have mistaken Engel's call for a more considerate model with an assumed existence of such a model. To quote McLaren:

Nothing (Engel) wrote constituted a coherent series of propositions that generated testable predictions relating to the unseen mechanisms by which mind and body interact, ie. a scientific model for psychiatry.

McLaren concludes: Science is conducted according to rules, one of which states that people cannot believe just what they like. We are compelled to adjust our ideas according to the evidence, yet the frequent defences of Engel's mythical model indicate little awareness of the discipline required to advance the science of psychiatry. Instead of an objective neutrality, we see an inexplicable partiality that serves only to retard model development in psychiatry.

Perhaps Professor Peter White (editor of Biopsychosocial Medicine: An integrated approach to understanding illness [OUP 2005] who is currently principal investigator in the Medical Research Council PACE trials of this model) -- as well as other Wessely School members -- are unaware that the model they so fervently espouse is based not on a legitimate model by Engel after all, but simply on a myth? (For information on White's book, see Proof Positive? on Co-Cure ACT: 2nd September 2005).

The ME community may like to know that McLaren presented a paper entitled 'The biopsychosocial model and scientific fraud' at the annual congress of RANZCP in May 2004, which is available from the author at Northern Psychiatric Services, Darwin, Northern Territory, Australia.

The second item of importance is a letter sent on 17th January 2006 from Susanna Agardy to Chris Clark, CEO of Action for ME, in which Agardy perfectly exemplifies the non-mythical issues:

Referring to the Research Summit on CFS/ME arranged by Action for ME in conjunction with the MRC that is scheduled to take place in April 2006, Agardy goes straight for the jugular:

It appears that the Summit will be dominated by psychiatrists and others who adhere to their views about CFS/ME. I hope you will ask the psychiatrists why they are so keen to be involved in ME/CFS. Psychiatry has spectacularly failed to alleviate the problems of mental illness. Certainly, its effectiveness is not nearly commensurate with the power and prestige the profession seems to enjoy.

What we see is that, rather than trying to improve their skills in the area of supposed expertise, some (psychiatrists) are increasingly encroaching upon and appropriating physical illnesses, among them CFS/ME, in which they have no expertise.

Some psychiatrists act as if the large body of evidence of the physical abnormalities in CFS/ME did not exist and pass the illness off as some kind of belief disorder.

Psychiatry is replete with examples of the abandonment of humanity, ethics and common sense.

Why should psychiatrists self-generated aura of infallibility in judging the human condition be accepted? Where is the evidence to back up this claim?

While you have such an excellent opportunity, I'd like you to ask the psychiatrists how they propose to treat ME/CFS phenomena such as low blood volume, cardiac insufficiency, lack of perfusion to areas of the brain, various immune and neurological abnormalities, channelopathy, Low Molecular Weight RNaseL, many deficiencies eg. of potassium, infections with mycoplasma and viruses, to name a few. As you would know, there is well-researched evidence for all of these and more. How do psychiatrists address these serious problems? How do they manage to ignore the evidence for them and to prescribe treatments which are contraindicated? Is this ethical?

You might also ask, in the interests of clear, unambiguous research, how they get the positive results for CFS/ME people in GET studies. You could ask why the Oxford criteria are repeatedly used for selection of subjects, when these criteria do not even include post-exertional malaise that is the distinguishing feature of CFS/ME.

The use of the Oxford criteria invites an unknown number of subjects to participate who very likely have idiopathic fatigue. The results are then passed off as applying to ME/CFS people and widely imposed on us.

The conclusions of these flawed studies acquire the status of self-evident truth by merely being repeated uncritically, ad infinitum.

In the interests of your constituency, the CFS/ME community, I hope you will ask these questions and bring back the responses to you membership .

If the Summit goes ahead, about which there is now some doubt, the ME community will require an appropriate response from Chris Clark to this most reasonable request.

The third item dates from March 2005 and is also by Susanna Agardy (see Does Graded Exercise Therapy improve post-exertional malaise in CFS? Co-Cure RES: 30th March 2005). It is a damning indictment of the selection of participants for studies that are intended to support current psychiatric management regimes for those with ME/CFS:

People with CFS/ME are being increasingly urged to exercise to improve functioning. In (an) Editorial (Med J Aust 2004;180:437-438) the problem of post-exertional malaise is acknowledged: the cardinal phenomenon in CFS is characterised by a marked and prolonged exacerbation of symptoms following minor physical activity . As people with this problem know, this exacerbation is often delayed and brings into play many symptoms.

Three studies, two of them British and one Australian, have been cited as providing evidence for the benefits of GET. To what extent can the results of these studies be generalised to people with post-exertional malaise?

Two of the studies, which are often quoted, show no evidence of directly addressing post-exertional malaise and do not even mention it (refs: Randomised controlled trial of patient education to encourage graded exercise in chronic fatigue syndrome. Powell P, Bentall RP, Nye FJ et al. BMJ 2001;322:1-5; Randomised controlled trial of graded exercise in patients with the chronic fatigue syndrome. Fulcher KY, White PD. BMJ 1997;314:1647-1652).

These studies used the Oxford criteria of 1991 (but) the syndrome definition in the Oxford criteria does not include post-exertional malaise (and) there is no requirement to include subjects who have this problem. The amorphous and confusing term chronic fatigue fails to do justice to the phenomenon of post-exertional malaise. These studies leave themselves open to the interpretation that some subjects did not suffer from post-exertional malaise to begin with.

These studies do not justify claims which imply that graded exercise assists in overcoming the effects of post-exertional malaise because they subscribe to the belief system which dictates that most of the limitations (of those with ME/CFS) reside within their dysfunctional belief systems.

Where selection of subjects ignores and excludes post-exertional malaise (as with the use of the Oxford criteria), the experimenters belief system is perpetuated and remains unchallenged.

For GET studies to have credibility for sufferers of post-exertional malaise they need to demonstrate that the subjects suffered from this problem before and not after the study. This would mean using the Canadian criteria.

While there is any ambiguity about this crucial issue, people with post-exertional malaise cannot but reject the generalisations from these studies .

Is it not bizarre that certain psychiatrists --- most notably those of the Wessely School --- persist in their belief that they alone have the undisputed right to demand a level of evidence-based proof that ME/CFS is not an aberrant belief as they assert, when their

own biopsychosocial belief system that perpetuates such an aberrant belief about the nature of ME/CFS has been exposed as being nothing but a myth?

See Also:

21st March 2006

More on the Myth?

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