

**Eileen Marshall and Margaret Williams' response to Michael Sharpe
about UNUM**

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Eileen Marshall and Margaret Williams note that, although Co-cure states it is not a discussion list, Mike Sharpe has been offered the right of reply to our post on his involvement with UNUM and cognitive behavioural therapy: in his post of 24 April 2003 he states his belief that the post was “systematically biased” and was “aimed at portraying myself and my colleagues as hostile to patients” and he states “This is wrong and offensive”.

We would simply point out that the ME/CFS community believes that the way in which the seriousness of ME/CFS and the way that the clear evidence of the organic nature of it have been methodically ignored since the 1980s by psychiatrists including Mike Sharpe and Simon Wessely and their followers is what is “wrong and offensive”.

We also believe that it is this group of psychiatrists who have been and continue to be “systematically biased” in their determined refusal to acknowledge the ever-growing evidence of an organic pathoaetiology.

As far as Sharpe's support for such patients is concerned, his published works speak for themselves. We can state this with certainty as we are very familiar with the relevant literature. Those who are unfamiliar with his work may find enlightenment in the document “Quotable quotes on ME/CFS from Dr Michael Sharpe” dated 12 May 2001 which can be viewed at www.meactionuk.org.uk/Quotes_from_Mike_Sharpe.htm

So that readers may form their own opinion, here are just a few illustrations of Mike Sharpe's beliefs about this quite devastating physical disorder (which the CMO has equated with multiple sclerosis and motor neurone disease and for which Mike Sharpe expressed his disapproval):

“Psychiatric management may be defined as the treatment of the mentally ill....Personality factors (attitudes, beliefs and thoughts) and behaviour have been shown to perpetuate disability...these ‘dysfunctional’ cognitions include the belief that recovery from the illness is not under personal control...it has been suggested that dysfunctional

cognitions and maladaptive behaviour perpetuate the disability that comprises CFS...Even if shown to be beneficial, such (immunological) treatment is unlikely to be feasible on a wide scale because of cost....The aim (of cognitive behavioural therapy) is to show that the patient can regain control of their lives ...There is evidence that psychiatric treatment can reduce disability in CFS. In some patients it can be ‘curative’ ” (ref: Psychiatric management of PVFS. M Sharpe. British Medical Bulletin 1991;47:4:989-1005).

“(Patients’) higher levels of depression serve to reinforce the now widely current notion that such patients may be suffering from a depressive illness”.

(ref: Fluctuations in perceived energy and mood among patients with chronic fatigue syndrome. C Wood, M Sharpe et al JRSM 1992;85:195-198)

“In clinical practice, no additional tests, including laboratory tests and neuro-imaging studies, can be recommended.....We consider a mental state examination to be the minimal acceptable level of assessment....The exclusion of persons (with psychiatric disorders) would substantially hinder efforts to clarify the role that psychiatric disorders have in fatiguing illness”.

(ref: The Chronic Fatigue Syndrome: A Comprehensive Approach to its definition and Study. K Fukuda, S Straus, M Sharpe et al Ann Int Med 1994;121:12:953-959)

[Note that this is the “1994 CDC” criteria].

“Evidence for the superiority of new ways of thinking about such patients is growing. These new treatments, often referred to as cognitive behavioural therapies, take a new approach (which) is in keeping with the evidence that the perpetuation of unexplained somatic symptoms is best understood in terms of psychological factors (such as misinterpretation of bodily sensations and unhelpful coping behaviour”.

(ref: Treating medically unexplained symptoms. EDITORIAL (Editor’s Choice).

Richard Mayou and Michael Sharpe. BMJ 1997;3:15:561-562)

“The only treatment strategies of proven efficacy are cognitive behavioural ones. The clinical problem we address is the management of the patient with a BELIEF that he/she has a fatiguing illness such as CFS or ME. The patients who cause the greatest clinical difficulty are those with strong beliefs. The majority of patients believe that their symptoms are the result of an organic disease process. Many doctors believe the converse....Beliefs are targets for therapeutic intervention....Abnormal physical signs should not be accepted as compatible with a diagnosis of CFS...Perpetuating factors (include) reinforcement of sick role by mother and doctor”.

(ref: Chronic Fatigue Syndrome: A Practical Guide to Assessment and Management.

Sharpe M, Wessely S et al Gen Hosp Psychiatry 1997;19:3:185-199)

“The label of CFS avoids the connotations of pseudo-disease diagnoses such as ME...Patients’ beliefs and behaviour are often a prominent part of the clinical presentation...CFS may serve as a culturally defined function which allows a socially acceptable expression of distress...psychiatric assessment is recommended in EVERY CASE (and) few laboratory investigations are necessary”.

(ref: Chronic fatigue syndrome and occupational health. A Mountstephen and M Sharpe. Occup Med 1997;4:217-227)

“CBT helps patients to re-evaluate their beliefs (and) encourages them to change their behaviour. Change in the belief is an important factor in recovery”.

(ref: Cognitive Behaviour Therapy. Michael Sharpe. (In): A Research Portfolio on Chronic Fatigue. Ed. Robin Fox for The Linbury Trust. pub. The Royal Society of Medicine 1998)

“In my lecture this evening, I would like to talk to you about ME, also known as CFS. We know that in the majority of cases CFS can be effectively treated (with CBT). I shall argue that patients themselves have played a part in denying themselves this type of treatment...reinforcement of unhelpful illness beliefs can have an unhelpful effect on patients’ attitude and coping”.

(ref: ME. What do we know (real physical illness or all in the mind?). Lecture given by Michael Sharpe in October 1999, hosted by the University of Strathclyde)

“Psychosocial factors are important in CFS....The belief that there is no treatment is incorrect...correcting misconceptions about the disease process and avoiding unnecessary investigations all help patients....The problem of communication between doctors and insurance or benefit agency personnel were discussed throughout the meeting, which was an excellent first step towards improved links between the Royal College and doctors working in insurance and benefit agencies”.

(ref: Insurance Medicine: Chronic fatigue syndrome and its management. Dr Michael Sharpe. Conference Raporteur: Ian Cox, Chief Medical Officer, Prudential UK JRCF 2000;34:394-396)

There is a vast literature in similar vein by these psychiatrists and readers are strongly urged to access it and read it for themselves.