Mind over body?

Can people think themselves sick? This is what psychiatrist **Simon Wessely** explores. His research into the causes of conditions like chronic fatigue syndrome and Gulf war syndrome have led to hate mail, yet far from dismissing these illnesses as imaginary, Wessely has spent his career developing treatments for them. **Clare Wilson** asks what it's like to be disliked by people you're trying to help

How might most of us experience the effects of the mind on the body?
In an average week you probably experience numerous examples of how what's going on around you affects your subjective health. Most people instinctively know that when bad things happen, they affect your body. You can't sleep, you feel anxious, you've got butterflies in your stomach… you feel awful.

When does that turn into an illness?
Such symptoms only become a problem when people get trapped in excessively narrow explanations for illness – when they exclude any broader consideration of the many reasons why we feel the way we do. This is where the internet can do real harm. And sometimes people fall into the hands of charlatans who give them bogus explanations.

Is that how chronic fatigue syndrome can start?
Often there is an organic trigger like glandular fever. That's the start, and usually most people get over it, albeit after some weeks or months. But others can get trapped in vicious circles of monitoring their symptoms, restricting their activities beyond what is necessary and getting frustrated or demoralised. This causes more symptoms, more concerns and more physical changes, so much so that what started it all off is no longer what is keeping it going.

One of the enigmas is why certain infections, like glandular fever, have an increased likelihood of triggering chronic fatigue syndrome (CFS), while others, such as influenza, do not. We also don't know why people who have had depression are twice as likely to develop CFS. I get cross with people who want to explain one and not the other. Some people take too psychiatric a view of CFS and ignore the infective trigger, whereas others want to think only about the infection.

So how do you treat CFS?
The first thing you have to do is engage people. I see them for 2 hours, which enables me to take a proper history to ensure I understand their symptoms and how the illness is affecting them. This helps people to open up, as they can see I am interested in their problems and taking them seriously.

With many people I genuinely do not know why they are ill. Or if I do, if they had glandular fever five years ago, say, I tell them there is nothing I can do about the original trigger. What makes a difference is what happens next. Then we get on to the practical stuff, such as finding out how people deal with the condition. Are there things they are doing that may not be the best for recovery? Then I recommend cognitive behavioural therapy and tailored programmes of gradually increasing activity levels.

How successful is your treatment of CFS?
Roughly a third of people completely recover and a third show good improvement. About a third we can't do much for.

What about those people who have such severe CFS they are bedridden?
In that kind of disability, psychological factors are important and I don't care how unpopular that statement makes me. We also have to consider what those years of inactivity have done to their muscles. People know that if you break your leg, when you take the plaster off there's nothing much left. If you've been in a wheelchair for some years, the laws of physiology haven't stopped.

Your most cited paper claims that conditions such as CFS, irritable bowel syndrome and fibromyalgia are all the same illness.
If you ask people with irritable bowel syndrome whether they suffer from fatigue, they all say yes. It's just gastroenterologists don't ask that question. Likewise, if you talk to someone with CFS, you find that nearly all of them have gut problems. If you systematically interview people with these illnesses, you find that a big proportion of these so-called discrete syndromes have a large overlap with the others. You have to think that we have got the classifications wrong.

So do you think these syndrome labels are arbitrary?
Each country has different syndromes. They don't have CFS in France; they have a strange one, spasmophilia, where a person has unexplained convulsions. In Sweden they have dental amalgam syndrome, which hasn't really caught on here. In Germany they believe low blood pressure is bad.

Where does Gulf war syndrome fit in?
I'd read about people with Gulf war syndrome in newspapers. They looked incredibly like my CFS patients except they were in uniform. Behind them was an interesting scientific conundrum calling out for epidemiological research. Someone had to ask: "What are the rates of illness in those we sent to the Gulf compared with those we haven't?" And that's what we did. We showed that serving in the Gulf had definitely affected the health of a proportion of those personnel, even though this was not a new "syndrome".

PROFILE
Simon Wessely trained in epidemiology at the London School of Hygiene and Tropical Medicine and psychiatry at Maudsley Hospital in London. He founded the Chronic Fatigue Syndrome Research and Treatment Unit at King's College London and the first specialist NHS clinic for CFS at what is now King's College Hospital. He now focuses on military health and terrorism psychology, and is an adviser to the UK's Home Office and Ministry of Defence.


KCH

Simon Wessely believes that our mindset can exacerbate certain illnesses

Is looking into Gulf war syndrome how you came to focus on military health?
Yes. I like dealing with military personnel – I admire what they do. Looking back on my career, it is military research that has given me the most straightforward pleasure, and the satisfaction of knowing we have had a positive impact on policy.

What kind of input has your team had on military policy?
We have provided information on rates of psychiatric disorders in troops. For example, alcohol is a bigger problem than post-traumatic stress disorder (PTSD). We've shown that extending operational tour length has a bad effect on people's morale and mental health. We also did a comprehensive review of prior research into PTSD and concluded that psychological debriefing after a traumatic incident doesn't help. Normal soldiers need to keep away from people like me – psychiatrists and counsellors.

"Alcohol is a bigger problem than post-traumatic stress disorder in troops"

Your recent research is on people who claim that mobile phones make them ill. What's going on there?
My colleague James Rubin and I showed that people who believe they are sensitive to mobile phones aren't able to tell the difference between sham and real phone signals. So are these people all making it up? Of course not. They've got themselves into a situation where a mobile phone triggers symptoms, but it doesn't do so through electromagnetic radiation.

What is it like to receive hate mail?
There have been times when it has been pretty unpleasant. But it goes with the territory. I'm not targeted by my own patients. If I ever thought that my patients or peer group thought I was a bad person, I would be worried. What matters is that the research we do is good quality. That's what you stand or fall by. n