

Social and Cultural Aspects of Chronic Fatigue Syndrome

Simon Wessely

Patients with chronic exhaustion after minimal effort for which a medical explanation is lacking are not new. In the past they have been labelled as suffering from neurasthenia, neurocirculatory asthenia, nervous exhaustion, effort syndrome and others (1), but in recent years many will acquire the label of chronic fatigue syndrome [CFS] or fibromyalgia.

The literature of CFS is expanding rapidly. Specialist reviews have appeared concerning virology, immunology, psychiatry, epidemiology and treatment. This paper will consider the wider social and cultural aspects of the condition. There has been a tendency to neglect these aspects of CFS in favor of biomedical explanations, in the hope that some new discovery arising out of immunology or virology will explain the enigma of CFS. I shall argue that an understanding of the cultural background to CFS is equally pertinent.

A word of caution is in order given the controversial subject of this paper. There are two aspects to CFS. The first is an operationally-defined condition, that can be measured and studied. We and other groups are making progress in determining the epidemiology of CFS in primary care using the conventional methods of epidemiological research. However, such research will not shed light on the second problem of CFS. This is the

Simon Wessely, MA, BM, BCh, MSc, MD, MRCP, MRCPsych, is Senior Lecturer in Psychological Medicine, King's College Hospital Medical School and Institute of Psychiatry and Consultant Psychiatrist, King's College and Maudsley Hospital, Denmark Hill, London, United Kingdom SE5 9RS.

[Haworth co-indexing entry note]: "Social and Cultural Aspects of Chronic Fatigue Syndrome." Wessely, Simon. Co-published simultaneously in the *Journal of Musculoskeletal Pain* (The Haworth Medical Press, an imprint of The Haworth Press, Inc.) Vol. 3, No. 2, 1995, pp. 111-122; and: *Fibromyalgia, Chronic Fatigue Syndrome, and Repetitive Strain Injury: Current Concepts in Diagnosis, Management, Disability, and Health Economics* (ed: Andrew Chalmers et al.) The Haworth Medical Press, an imprint of The Haworth Press, Inc., 1995, pp. 111-122. Multiple copies of this article/chapter may be purchased from The Haworth Document Delivery Center [1-800-3-HAWORTH; 9:00 a.m. - 5:00 p.m. (EST)].

© 1995 by The Haworth Press, Inc. All rights reserved.

111

belief, whether self- or doctor-generated, that one is suffering from an illness with that label. Thus, patients are appearing in increasing numbers who believe, often with passion and conviction, that they suffer from chronic fatigue and immune deficiency syndrome (CFIDS) in the USA, or myalgic encephalomyelitis (ME) in the United Kingdom. I have argued the importance of distinguishing these two distinct themes (2). Our group will present data showing that many of those who fulfil criteria for CFS in the community who are not seeking help attribute their illness to other causes. On the other hand, many of those who do believe that they have the condition do not fulfil the criteria.

As an epidemiologist, I know that a person has CFS only if they fulfil operational criteria. As an observer of the social scene, I also know that ME or CFIDS is defined by the sufferers themselves. Hence, for this paper, a person has ME or CFIDS simply if that is what they believe is wrong with them. Untold confusion has arisen from the failure to distinguish between an operationally-defined epidemiological construct and a social belief system. This essay concerns the latter and not the former.

PSYCHIATRIC DISORDER AND CFS

Wherever CFS patients are studied, and however they are studied, psychological morbidity is conspicuous by its presence. It is a matter of regret that each generation of physicians appears to need to discover this afresh, and that such observations continue to inspire the same futile "organic versus psychological" polemics (1). Once again, numerous studies confirm that the majority of those seen in specialist centers and primary care with a chief complaint of chronic fatigue fulfill operational criteria for a psychiatric disorder. The consequence of physical disease cannot alone account for the clinical features of CFS (3,4).

These findings do not mean that psychiatric disorder causes CFS, or that CFS and psychiatric disorder are one and the same. One must not forget that psychiatric disorder in general, and depression in particular, are heterogenous concepts. The possibility that both CFS and psychiatric disorder have a common origin in disturbances of cerebral function now attracts considerable attention (5), and some evidence is emerging of neurobiological differences between the subgroup of CFS patients without depression and both normal and depressed controls.

A more appropriate conclusion is that the current acrimonious debate over the relationship between CFS and psychiatric disorder based solely on comparisons of operational criteria is unhelpful. Chronic fatigue syndrome and psychiatric disorder go together. It is inevitable because of the way both concepts have been constructed, the similarities of the criteria

and the measures used to define them. Operational criteria will be unable to make a complete distinction between CFS and psychiatric disorders. To understand these differences once must turn to the role of social and cultural factors.

A flavor of these differences comes from the popular literature on chronic fatigue syndrome. Take the issue of personality and vulnerability to CFS. Sufferers are often characterized as perfectionists and over-achievers. One sufferer told the journalist that “until my symptoms started I gave 120% to every aspect of my life.” Hence when she picked up an infection, “instead of resting I just carried on” (6). Sufferers are particularly prone to be overactive, unlikely to take things easy, “the last people to take time off work for no good reason” (7). “It seemed like a bad bout of flu from which [as usual] I did not allow myself proper time to recover” (8). Sufferers “work until they drop, whilst everyone else creeps to bed with the slightest headache or sniffle . . . lazy people don’t get ME” (9).

The cultural purpose of these stereotypes is to separate CFS from another stereotype—those patients who do none of these things—by implication those who do take time off work for no good reason, who do creep to bed with the slightest sniffle—psychiatric patients. The current President of the ME Association stated that one of the distinctive differences between ME sufferers and depressives is that those with ME are highly-motivated achievers, “they almost have too much will power, whereas depressives have virtually none” (10). If psychiatric disorder is seen in these Victorian terms, it is not surprising that it is something to avoid. Hence the descriptions of overachieving, duty-driven victims of CFS is one strategy for countering any suggestion of a psychological origin to symptoms.

THE SEARCH FOR VALIDATION

At the heart of CFS is the rejection of any form of psychological causation or treatment. In the first newsletter of the ME Action Campaign, Claire Francis, the President of the Campaign and without doubt the most famous sufferer from CFS in Britain, wrote that “psychiatry is the dustbin of the medical profession” (11). Hence few sufferers come anywhere near a psychiatrist. Being referred to a psychiatrist is “being blackballed” (12), “being imprisoned for a crime I didn’t do” (13), or being on trial (14). Courtroom analogies are apt, since the atmosphere surrounding CFS is now an adversarial one, accompanied by a rhetoric of struggle and injustice—a typical headline is, “Justice for the neglected and maligned sufferers of ME” (15). Others speak of bitterness, anger, and hate. The accusation is not just that the sufferer is guilty of being depressed, or of having a

psychiatric disorder, but of not being ill at all—of having an imaginary disease.

Here is another tragedy of CFS. Many doctors do indeed equate psychological disorder with unreal disorder. The reluctance to accept suffering perceived as of psychological origin as genuine, is shared, and often initiated, by the medical profession. A doctor agreed that it is important that psychiatric patients are separated from ME because “some neurotic patients devalue the tales of genuine sufferers” (16). Another is quoted as telling a medical conference that “ME is an imaginary disease . . . for which the best treatment is psychiatric” (17). A recent article on chronic Lyme disease talked about the difficulties faced by patients in their dealing with doctors—“some were even considered malingerers. Many were referred to psychiatrists when their medical physicians lost faith in the validity of their patients’ complaints” (18). Doctors thus share many of the prejudices of the CFS sufferer—psychiatrists treat imaginary, malingered or non-existent diseases.

The consequences of this lack of validation are many and grievous. One sufferer was refused sickness insurance benefit because his policy excluded depression, of which he had a past history. His claim to be now suffering from ME was rejected, although he was informed that this decision would be changed if a test for ME were to be developed and he tested positive (19). Hence sufferers cannot literally afford to be depressed. It is the search for validation that underlies the drive to find a test for CFS, and the rejoicing that greets each such claim. As one sufferer wrote, “the difference between a crazed neurotic and a seriously ill person is simply a test” (20). These views are understandable, since in the absence of acceptable tests or physical signs, onlookers find it harder to accept the reality of distress. The patient rarely looks sick. Sufferer after sufferer note how outsiders make comments, such as “well, you don’t look sick—you look great” (21). “My skin is clear and tanned. I don’t have a plaster cast on a broken leg . . . people say ‘you look so well’ ” (22).

Similar observations have been made concerning chronic pain. Both fatigue and pain are private experiences to which no one else has access. In an insightful paper, aptly called “The Pilgrimage of Pain,” Reid and colleagues (23) noted the problems encountered by RSI sufferers in their search for validity—endlessly shuttling between the company doctor accusing them of malingering, and the trade union doctor with an equal and opposite aversion to recognizing any psychological distress at all. Without a test, not just the CFS patient, but also the fibromyalgia and RSI sufferer, exist on the margins of sickness and disability.

*WHY A VIRUS
[OR IMMUNE DEFECT, OR ALLERGY . . .]?*

Why have there been such efforts to find a microbiological cause of CFS, and so many mutually exclusive claims of success over the years? It is true that many patients give a history of an initial “viral” illness. Nevertheless, with the exception of recent work demonstrating beyond doubt that the Epstein-Barr virus is indeed associated with a true post-infectious fatigue syndrome (24), proof that CFS is associated with either a post or persistent viral state is far from compelling.

One reason, beyond the scope of this paper, is methodological. Of more relevance are the social and cultural factors. The concept of an external agent is a familiar one for both doctor and patient. The external nature of the attribution made by the chronically fatigued patient seen in hospital practice has certain consequences, irrespective of its accuracy. External attribution may protect the patient from the stigma of being labelled psychiatrically disordered—“the victim of a germ infection is therefore blameless” (25). In the context of CFS “to attribute the continuing symptoms to persistence of a “physical” disease is a mechanism that carries the least threat to a person’s self-esteem” (26). The absence of guilt and the preservation of self-esteem, even in the presence of mood disorder, has been noted in post-infectious fatigue syndromes (27).

What the many popular explanations have in common is that they are external to the patient, and are not accompanied by accusations of moral weakness or blame (28). CFS has been claimed to be due to viruses, electromagnetic radiation, geopathic stress, dental amalgam, candida, food allergy, pesticides, antibiotics, immunization and so on. This is well caught in the media writing on CFS. A newspaper headline expressed this view in its clearest form : “Virus research doctors finally prove shirkers really are sick” (29), while a Times piece was titled, “Fatigue blamed on virus: Malingering disease proved genuine” (30). A recent review of a self-help book noted “an infection is respectable. It has none of the stigma of a psychologically induced illness, which implies weakness or lack of moral fibre” (31). It is also a popular explanation for disease in the English-speaking world. Finally, the rise of HIV has meant that the concept of a deadly virus that affects the immune system is now one deeply embedded in popular consciousness. Direct analogies between AIDS and CFS are common—the name adopted by the most vigorous of the campaigning organizations in the USA—the Chronic Fatigue and Immune Deficiency Syndrome—is a conscious attempt to draw upon the experience of AIDS.

DOES IT MATTER?

At present the prognosis for those who have acquired, by whatever means, the label of CFS or its local equivalents, is poor. Behan and Behan (32), who have perhaps the most extensive experience of CFS in this country, wrote that “most cases do not improve, give up their work and become permanent invalids, incapacitated by excessive fatigue and myalgia,” confirmed by systematic follow-ups of those referred to an immunology or an infectious disease clinic (33,34). The main association of poor prognosis was the strength of belief in an exclusively physical cause for symptoms (34,35).

Much of the current information on CFS may also adversely influence prognosis. Current literature on CFS is frequently gloomy in tone, with a tendency to use “worst case” examples for publicity purposes. The first President of the ME Association and its first medical advisor used the same words—the disease has “an alarming tendency to chronicity” (36,37). Those who champion the disease often insist that an essential clinical feature of the disease is “a prolonged relapsing course lasting years or decades” (38). Newspapers and magazines frequently call the disease incurable. How much is this perception based on clinical reality, and how much does it influence that reality?

The climate of opinion and controversy surrounding CFS means that the sufferer is frequently caught in a trap. The treatments suggested by a model of CFS as a unitary condition, the sole consequence of a single physical agent, are straightforward, simple to explain, free of stigma and moral implications. As yet, few appear to work. On the other hand, other strategies, based on a more complex model, involving either psychological or behavioral interventions, are far from value-free. All of this is magnified in the light of the controversy surrounding CFS. In this climate accepting any treatment other than those based on the single disease/external agent model is fraught with difficulty. The hostility towards psychological distress, perceived as it is as synonymous with low moral fiber and blame, permeates treatment and outcome. Psychiatrists are seen as having little or no role in the management of CFS. In the CFS literature, often the good psychiatrist is the one who finds nothing wrong and declares the sufferer psychologically normal.

REST AND THE TREATMENT OF CFS

At present, the mainstay of management in CFS is rest. A nurse with CFS advises others, “Always remember, until an exciting medical an-

nouncement is made, that there is no one drug to cure ME. The only cure is rest and keeping the affected parts of the body rigid so as to improve the body's defenses" (39). Similar sentiments were expressed in a magazine—"the only hope is that one day some substance will be isolated that has the power to zap the ME virus," and until then "the most doctors can do is to advise patients to rest, and wait for the ME to go away" (40). The familiar Victorian metaphor of the supply and demand of energy reappears frequently—"use energy at a slower rate than you make it" (41). The treatment frequently comes back to that mainstay of the Victorian approach to neurasthenia, the rest cure. An American self-help book heads a section with the title "Rest, Rest and More Rest" (42), and discusses "Aggressive rest therapy," as does an English self-help title (43).

Although there is no doubting the good faith behind such advice, its long-term wisdom is open to question, and is at odds with most medical teaching. Despite this, rest is one part of the spectrum of avoidance behaviors that characterize much of the popular management of chronic fatigue syndrome. A frequent theme is the need to avoid various agents, ranging from immunizations and pollution to a variety of foods and even sunlight that may affect the illness. In its most extreme form CFS overlaps with such Western cultural syndromes as multiple chemical sensitivity or total allergy syndrome, where lives are ruined by fearful anticipation and avoidance of most forms of environmental stimulation.

Why is rest so popular? One reason is that it appears to work. Rest is an effective short-term strategy for dealing with acute fatigue, particularly after acute infection, which is so often the trigger for chronic fatigue syndrome. For most subjects, such rest is only used as a short-term coping strategy, and the vast majority are able to resume normal activity. However, recovery from viral infection is almost certainly normally distributed, and some may experience a prolonged, and inexplicable, period of ill health. Attempts to resume previous levels of activity may continue to be difficult during this period, and result in a resurgence of symptoms.

Many have noted that many chronic sufferers initially adopted a vigorous program of exercise—there are numerous anecdotal reports of chronic sufferers with a previous history of an abrupt return to dramatic physical activity. There are several reasons for this. First, this author's experience is that CFS patients seen in the clinic are frequently particularly fit and athletic. Such patients would be at risk of rapid physical deconditioning after a period of enforced rest. Furthermore, personality and lifestyle factors may also suggest that the same people are also likely to adopt overly aggressive early attempts at exercise. I have already discussed the popular stereotype reinforced by the CFS organizations that sufferers are particu-

larly prone to be overactive, unlikely to take things easy and so on [vide supra]. Many have tried to “exercise away” their fatigue, and hence carried out activity that might be excessive in the light of their current, but not previous, fitness.

What are the consequences? They need little elaboration to the audience of this paper. One general practitioner who is a sufferer and author of a popular self-help guide has written “prolonged bed rest . . . should be advised with great care in the long-term cases, who may then become trapped in a vicious circle of immobility and weakness, and become almost bedridden” (7). The consequences of lack of physical activity, and the changes in the neuromuscular system that result, have been known to clinicians for many years and will not be elaborated in detail. Rest as a coping strategy is thus of short-term benefit to those with acute fatigue syndromes, but in the long-term is harmful.

THE SOCIAL PURPOSE OF CFS

One purpose of CFS is to give legitimacy to distress that would otherwise be unacceptable to the patient, relative, employer, doctor and insurer. This has many benefits. I have pointed out how badly doctors can treat the patient perceived to have a psychological origin to their distress. This can be avoided when the label of CFS is seen to indicate a physical, and hence, blameless, etiology.

The second purpose may be to allow the sufferer to make necessary changes in their life without stigma. The self-help literature on CFS is equally full of wide-ranging suggestions for changes in lifestyle. A typical book (44) includes not only the usual advice on diet, rest, exercise, candida, stress and work, but also sections on the power of prayer, attitudes, the need to love oneself, and a section discussing the relative merits of holidays in the mountains or the Mediterranean, just as the neurasthenia texts discussed the merits of the different European spas.

Sufferers are urged to alter their lifestyle by placing their own personal well-being, comfort and happiness at the center of their concern. A sufferer must accept an inability to live at the same pace as previously, but this can lead to moral and spiritual benefits. Self-worth is “not measured by being busy, earning money or even being good at anything” (45). Of the patients studied by Norma Ware in Boston, nearly half had undergone a transformation of lifestyles as a result of CFS, which they declared to be painful, but ultimately positive (21). In this country, an actor told a newspaper that ME had “been like a gift, as though it was sent to sort my life out . . . My life has taken a completely different direction” (46). One

American sufferer found that CFS led her to consider “better ways to feel, think and relate” and to address the chronic stresses of her life, which were responsible for the depletion of her immune system (47). Another sufferer wrote that as a result of ME, “I have tried to use the time positively to make changes I accept were overdue,” going on to describe reassessment of work, relationships and so on (48). A doctor with ME became a changed woman, seeing “a value in going for a walk on her own. She feels no guilt about enjoying herself or taking time off to relax” (49).

As well as permitting changes to lifestyle, CFS serves as a conduit for social concerns, expressed via the metaphor of illness (2). Neurasthenia was frequently blamed on the unwelcome features of contemporary life (1). Contemporaries such as George Beard blamed the unwelcome intrusion of modern technology and business practice for the rise of the new disease of nervous exhaustion. Others blamed neurasthenia on the “dust, and whistling, noisy pandemonium, smoke and bad air of the city” (50). Neurasthenia texts struck a balance between the language of the current scientific discourse, and concerns and language that were meaningful to the lay reader. Much of this was conveyed by metaphors. These could be drawn from business life and commerce—“The strenuous man of business knows well the significance of an overdraft in his bank account, and does not treat it so lightly as an overdraft on his nerve center balance” (51) or alternatively, from popular science—“the storage battery has been discharged rapidly or for too long a time” (52). Similarly, the modern CFS “sufferer should treat her energy resources as if they were money in the bank, and be careful not to overdraw” (53). Alternatively, they must have batteries that are either flat (54), unable to hold their charge (45), or in need of recharging (55).

An individual’s responsibility for neurasthenia then and CFS now is thus restricted to the relatively blameless [and indeed praiseworthy] habit of overwork, of struggling on beyond the limits of what is physiologically tolerable. If overwork summarizes the individual’s role in acquiring CFS, that of society is summarized by “overload.” According to Beard (56), the unwelcome features of contemporary life which caused neurasthenia did so by creating an “overload,” or “overloaded system.” The same concepts have surfaced in the context of CFS/ME. Articles are frequently entitled “the ME Generation”—one began with the question “What is modern life doing to us?” (57). Another popular magazine suggests that “ME is very much a disease of our time—an attack on the immune system exacerbated by stress, pressure and the demands of twentieth century life” (58). ME is “an overload disease unique to this century” (59). Nowadays, the overload is due to pesticides, allergies, chemicals, neurotoxins, anti-

biotics, over-refined diet, pollution, electromagnetic radiation, candida and so on. CFS is due to the "sickness of the planet" (59).

Will CFS go the same way as neurasthenia? I suspect not, for three reasons. First, the rise of modern neurobiological research has meant that previous boundaries between psychiatric and physical disease are dissolving, although not as rapidly as one would like. There is every prospect of new insights being gained into fundamental central mechanisms underlying CFS. Second, once an agnostic, I am inclined to believe that an entity called CFS can be located in the community, although I suspect that, like fibromyalgia, it will be the arbitrary end of a spectrum of fatigue and exhaustion. Finally, the changes in the relationship between the modern patient and doctor have been so profound, with the balance shifting from the former to the latter, that academic arguments about the status of CFS are becoming overtaken by events. Whether it exists or not, it is here to stay.

REFERENCES

1. Wessely S: The history of chronic fatigue syndrome. *Chronic Fatigue Syndrome*. Edited by S Straus. New York; Mark Dekker, 1994, pp. 41-82.
2. Wessely S: Neurasthenia and chronic fatigue syndrome: theory and practice. *Transcultural Psychiatric Review* 31: 173-209, 1994.
3. Wood G, Bentall R, Gopfert M, Edwards R: A comparative psychiatric assessment of patients with chronic fatigue syndrome and muscle disease. *Psychological Medicine* 21: 619-628, 1991.
4. Katon W, Buchwald D, Simon G, Russo J, Mease P: Psychiatric illness in chronic fatigue syndrome. *J General Internal Medicine* 6: 277-285, 1991.
5. Bearn J, Wessely S: The neurobiology of chronic fatigue syndrome. *Eur J Clinical Investigation* 24: 79-90, 1994.
6. Macdonald K: Why perfectionists are most at risk from ME. *Daily Mail* Sept 28th 1993.
7. Shepherd C: *Living with ME: a Self-Help Guide*. London, Heinemann, 1989.
8. Roeber J: Industry of Anxiety. *Vogue*, August 1989, 178-179.
9. Bragg P: Kilroy was here. *Interaction* 3, Autumn 1989, 503.
10. Dowsett E: quoted in Stacey S. "Tired and Tested." *Harpers & Queen*, Oct 1990.
11. Francis C: A Beginning. *Interaction* 1, 1988.
12. Conant S: *Living With Chronic Fatigue*. Taylor; Dallas; 1990.
13. Gardner K: *Interaction* 1; Winter 1988.
14. Hartnell L: *British Medical Journal* 10th June 1989; 1577-1578.
15. Field E: Justice for the neglected and maligned sufferers of ME. *Guardian*, 7th August 1990.

16. Timbs O: Postviral puzzle. *Observer*, 2nd August 1987.
17. Herbert V: cited in Steincamp J. *Overload: Beating M.E.* Fontana, London, 1989, p. 5.
18. Burrascano J: The overdiagnosis of Lyme Disease. *J Am Med Assoc* 270:2682, 1993.
19. Stopp C: ME sufferers forced to battle with insurers. *Independent* on Sunday 27th June 1993.
20. Jeffries T: *The Mile High Staircase*. Auckland, Hodder & Stoughton, 1982.
21. Ware N: Society, mind and body in chronic fatigue syndrome: an anthropological view. *Chronic fatigue syndrome*. Edited by A Kleinman, S Straus. Wiley, Chichester (CIBA Foundation Symposium 173); 1993, pp. 62-82.
22. Berrett J: Condemned to live a lonely life. *Guardian* July 6th 1991.
23. Reid J, Ewan C, Lowy E: Pilgrimage of pain: the illness experiences of women with repetition strain injury and the search for credibility. *Social Science Med* 32:601-612, 1991.
24. White P, Thomas J, Amess J, Grover S, Kangro H, Clare A: A fatigue syndrome following infectious mononucleosis: 1: the existence of the syndrome. Submitted.
25. Helman C: Feed a cold and starve a fever. *Culture, Medicine & Psychiatry* 7; 107-137, 1978.
26. Katz B, Andiman W: Chronic Fatigue Syndrome. *J Pediatrics* 113; 944-947, 1978.
27. Imboden J, Canter A, Cluff L: Brucellosis.III. Psychologic aspects of delayed convalescence. *Arch Intern Med* 103: 406-414, 1959.
28. Abbey S: Somatization, illness attribution and the sociocultural psychiatry of chronic fatigue syndrome. *Chronic fatigue syndrome*. Edited by A Kleinman, S Straus. Wiley, Chichester (CIBA Foundation Symposium 173); pp. 238-261.
29. Hodgkinson N: Virus research doctors finally prove shirkers really are sick. *Sunday Times*, 25th January 1987.
30. Anon. *The Times*, Jan 2 1988.
31. Seagrove J: The ME Generation. *Guardian* May 19 1989.
32. Behan P, Behan W: The Postviral Fatigue Syndrome. *CRC Critical Reviews in Neurobiology* 42: 157-178, 1988.
33. Hinds G, McCluskey D: A retrospective study of the chronic fatigue syndrome. *Proc R Coll Physicians Edin* 23:10-14, 1993.
34. Sharpe M, Hawton K, Seagroatt V, Pasvol G: Follow up of patients with fatigue presenting to an infectious diseases clinic. *Br Med J* 305:347-352, 1992.
35. Wilson A, Hickie I, Lloyd A, Hadzi-Pavlovic D, Boughton C, Dwyer J, Wakefield D: Longitudinal study of the outcome of chronic fatigue syndrome. *Br Med J* 308: 756-760, 1994.
36. Ramsay M: Introduction to Shepherd, C. *Living with ME; A Self Help Guide*. Heinemann, London, 1989.
37. Smith D: Myalgic encephalomyelitis. 1989 Members Reference Book. Royal College of General Practitioners: Sabre Crown Publishing, London, 1989, pp. 247-250.

122 *Fibromyalgia, Chronic Fatigue Syndrome, and Repetitive Strain Injury*

38. Dowsett E, Welsby P: Conversation piece. *Postgrad Med J* 68:63-65, 1992.
39. Dainty E. M.E. and I: *Nursing Standard* 84: 49-50, 1988.
40. Hodgkinson L: M.E.—the mystery disease. *Women's Journal*, November 1988.
41. Holford N: ME. Report of the Assistant Masters and Mistresses Association, Sept 1989, 12-13.
42. Feiden K: *Hope and Help for Chronic Fatigue Syndrome*. Prentice Hall, New York, 1990.
43. Franklin M, Sullivan J: *The New Mystery Fatigue Epidemic*. M.E. What is it? Have you got it? How to get better. Century, London, 1989.
44. Dawes B, Downing D: *Why M.E.? A Guide to Combatting Post-Viral Illness*. Grafton, London, 1989.
45. MacIntyre A: *ME: Post-Viral Fatigue Syndrome: How to Live with It*. London, Unwin; 1989.
46. My battle with “devil” illness, by Bergerac star Sean; *Daily Mail*, 8 Sept 1990.
47. D Patrick Miller. My healing journey through chronic fatigue. *Yoga Journal* Nov/Dec 1992.
48. Berrett J: Condemned to live a lonely life. *Guardian* July 6th 1991.
49. When the drive band snaps. *Hampstead and Highgate Gazette*, August 5th, 1988.
50. Ely T: Neurasthenia as modified by modern conditions, and their prevention. *Journal American Medical Association* 47; 1816-1819, 1906.
51. Hughes C: *Psychiatry and Neurology in the Medical Press*. *Alienist and Neurologist* 27: 452-460, 1906.
52. Pershing H: The treatment of neurasthenia. *Medical News* 84:637-640, 1904.
53. “Postviral Fatigue Syndrome.” In: *The Manual of Family Health*. Royal College of Nursing. Little, Brown: London, 1992; pp. 489-490.
54. Stacey S: *Tired and Tested*. Harpers & Queen, Oct 1990.
55. Millenson J: ME: An Alternative View. *Interaction* 9, Spring 1992.
56. Beard G: *American Nervousness*. New York: G.P. Putnam's, 1881.
57. The ME Generation. *Sunday Telegraph Weekend Magazine*, Jan 22nd 1989.
58. Flett K: Why M.E.? *Arena*, March 1990.
59. Steincamp J: *Overload: Beating M.E*. Fontana, London, 1989.
60. The Internal Athlete. *MS*. Volume II, No 6. May/June 1992.