ME: The rise and fall of a media sensation

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ABSTRACT

ME (also known as chronic fatigue syndrome), a medical disorder of unknown aetiology, generated considerable media attention in the late 1980s and during the 1990s. Patients insisted they suffered from an organic disease, while certain lay and medical commentators construed the condition variously as an effect of female hysteria; as a form of depression manifesting itself in physical form; and most famously, as 'yuppie flu', an affliction of stressed young professionals. This article documents the origins of the controversy, explores the principal constructions of ME that arose amongst commentators and the assumptions that underlay them, and traces the differing fate of the diverse constructions in subsequent years.

Introduction

The late 1980s saw the very public commencement of a controversy about the nature of a contested medical condition, ME. Patients vehemently insisted that they were the innocent victims of an unexplained incapacitating organic disease, while many medical practitioners and social commentators interpreted the symptoms, from a variety of perspectives, as psychological or self-inflicted. The disorder was widely termed 'yuppie flu'. Twenty years on, however, ME, though still prevalent and still controversial, no longer hits the headlines; and, notably, it is no longer construed as a symptom of a pathogenic society.

This retrospective was prompted by the realisation of how media coverage of the condition has altered, and how certain constructions have waned. However, the reasons for this change are not obvious. In particular, recent economic events have highlighted the extent to which greedy city high-fliers, formerly seen as prime candidates for ME, still abound. Concerns about combining motherhood with work - apparent in some discourses on ME – endure (Carvel, 2008). A diagnostic marker for the disorder continues to elude researchers (ME Association, 2007). The preconditions for much of the furore about ME thus still appear to be in place – but certain aspects of the furore have subsided. These considerations led me to ask why the debate arose when it did, in the form it did, and in what respects it has since been transformed.

In an attempt to throw some light on these issues, I examine the various constructions of ME at the height of the controversy, and the assumptions underlying them. I focus on the pronouncements of those who construed the condition in ways not envisaged or favoured by many patients, rather than those of patients and their sympathisers; it is the constructions propounded by the former, rather than the latter, that, after an initial period, dominated the media coverage. The pervasive 'yuppie flu' construction plainly arose from its social context, and I go on to consider what, socially, may have changed as it ceased to be prevalent. I begin with a brief account of the way in which ME first entered the public domain.

The emergence of ME

On 1 June, 1986, the Observer newspaper carried a feature entitled 'A disease doctors don't recognise'. The author, Sue Finlay, wrote of her disabling illness, which she named as Myalgic Encephalomyelitis (ME) or post-viral fatigue syndrome. (It is now also widely
known as chronic fatigue syndrome, or CFS.) She described her symptoms - exhaustion, extreme muscle weakness, joint pains, mood disturbances, deteriorating eyesight, vague stomach problems - and related her long and frustrating search for a diagnosis, and thereafter for medical help. She claimed that thousands of people in Britain shared her predicament, enduring years of physical misery while doctors ascribed their problems to ‘nerves’. Readers were invited to write to the Observer for a factsheet; over 14,000 people responded, and a year later, Sue Finlay was receiving over 200 enquiries a week (Observer, 2 August, 1987). It was the beginning of a publicity campaign which would make ME a household name, and in the course of which it would become the subject of heated controversy about its nature and significance.

The debate about ME in this country was not new, although the issue had attracted little attention for many years. In 1955, an epidemic swept through the Royal Free Hospital in north London, affecting nearly 300 people, mainly nursing staff, some of whom appear never to have fully recovered (Ramsay, 1986). Although they could not isolate the organism causing the symptoms, doctors were certain that they were dealing with an infectious disease. A subsequent editorial in the Lancet (1956) reviewed a number of apparently similar outbreaks, distinguishing the symptoms from those of known viral conditions such as poliomyelitis, as well as from those of hysteria. It proposed the name ‘benign myalgic encephalomyelitis’ (‘benign’ denoting absence of fatalities) for the newly identified syndrome. In a comparison of 14 episodes of paralytic illness in various parts of the world, beginning with an outbreak in Los Angeles in 1934, Acheson (1959) provisionally endorsed the Lancet’s conclusions. He considered at some length (ibid.: 589-591) the possibility that these epidemics might be due to hysteria, but dismissed this as improbable on a number of grounds, including similarities in the symptomatology and course of the illness across many types of community.

However, two British psychiatrists later reviewed the records of the Royal Free patients, and in 1970 published two papers in the British Medical Journal arguing that the supposed viral epidemic was in fact an episode of mass hysteria (McEvedy and Beard, 1970a; 1970b). Pointing to the high proportion of female nurses amongst those affected, they suggested that this type of condition often proliferated when large numbers of women were cloistered together. This view rapidly became medical orthodoxy. Despite the foundation in 1976 of the ME Association, a charity for the support of sufferers, and despite apparently similar outbreaks in the UK in 1974 and 1980 (Bell, 1991: 96), the disorder lapsed into obscurity.

Within months of Sue Finlay’s 1986 article, however, publicity about ME began to abound. A new patients’ pressure group (the ME Action Campaign, later renamed Action for ME) was formed, with Sue Finlay as one of the trustees, and the navigator Clare Francis, herself diagnosed with ME, as president. The ME Association - despite its lack of involvement in the publicity drive - reported a trebling of its membership within a year (Blackman, 1988).

At first, much of the media coverage was sympathetic, with ME reported as a serious, neglected disease caused by the persistence of a virus in the body. Before long, however, medical practitioners and journalists began to propose explanations of ME in terms of the personality of the sufferer. The term ‘yuppie flu’ became widespread - linking the condition no longer to gender, but to class. (This term originated in the USA, where an epidemic in an opulent area of Nevada in 1985 provoked a similar debate about the aetiology of the symptoms (Bell, 1991: 7)). The disagreements in the mass media were mirrored by those in medical publications; indeed, some of them involved the same protagonists using the same arguments.

In the controversy of the 1980s and ’90s, the topic of epidemics of ME was often sidelined. Broadly, two types of account of the genesis of ME as organic disorder have prevailed (Cooper, 1997: 189). The first attributes the condition to persistent viral infection: it is considered an endemic disease subject to outbreaks of epidemic prevalence (Ramsay,
A contending account is that, although ME may be triggered by a virus, its underlying cause is a damaged immune system. The latter explanation allows for the preponderance of sporadic cases, which later came to constitute the majority of those diagnosed with the condition (Aronowitz, 1992: 161), and it underlies many of the constructions of ME widespread in the media in the 1980s and 1990s. However, Dr Melvin Ramsay (1989: 20), who treated the victims of the 1955 outbreak, inveighed against immunological views of ME, demanding to know how 200 nurses at the Royal Free Hospital could have developed abnormalities of their immune system within three months. Whether the Royal Free nurses of the 1950s were afflicted by a disorder of the same aetiology as the patients of the 1980s, 1990s and 2000s – or indeed, whether the symptoms of the latter all result from the same underlying pathology - remains uncertain.

Background and identification of data

My interest in constructions of ME stems from my experiences as a sufferer, diagnosed in 1987. Since then, I have participated in patients' self-help groups, and I have been a member of two principal ME charities: Action for ME, and the ME Association.

From 1989, Action for ME collected press reports through a press cuttings agency, Durrant's, their search term being 'ME'. They offered a selection of these to members, and this has been my main source in documenting press coverage between 1986 and 1993. (My recent attempts to ascertain the proportion of their collection distributed, and their selection criteria, failed after such a long interval of time.) I added cuttings that I gathered myself, or that were donated by friends. 164 cuttings were consulted covering the period 1986 to 1993, 153 of which relate to the period 1988 to 1993 – by which date the main constructions of ME were well established. I collected later press reports less consistently. I have further relied on the videotape, again provided by Action for ME, of television programmes transmitted during 1988; subsequent programmes are also referred to in the text. All material relates to the United Kingdom only.

This material cannot be claimed as comprehensive or strictly representative. However, I believe that it covers the range of popular discourses surrounding ME in the UK – a view supported by my contacts with patients' groups and my perusal of the ME charities' literature: the journal of Action for ME carried frequent reviews of press reporting of ME.

I occasionally refer to writings on the disorder in the medical press and in academic contexts where these had a clear influence on popular constructions of the condition in the UK. Notably, in describing and discussing the assumptions underlying influential psychiatric constructions of ME, I have drawn on accounts in the medical press (e.g. Butler et al. 1991) and in the ME charities' journals (Chalder and Butler, 1989). While these do surface in press reports, their basis is clarified more fully elsewhere.

I have excluded the contentious issue of children believed by their parents to have ME, but diagnosed by health professionals as suffering from psychoneurotic disorders. The ensuing debate generated discrete discourses, with stigmatising constructions of parents as well as patients, which require separate examination.

Finally, even with more comprehensive documentation of reporting in the early years, it would be difficult to measure past against present media interest. The spread of the internet makes comparisons between the extent of coverage now and 20 years ago extremely problematic, and arguably meaningless. There are now online versions of newspapers that differ from the printed versions, and that incorporate readers' comments, as well as an untold amount of information with no printed equivalent.

This reservation will become relevant when I discuss the fate of constructions of ME later in the paper. But I first proceed to examine these constructions as they arose in the late 1980s and early 1990s.
Constructions of ME after 1986

Discourses on ME are diverse, and sometimes mutually contradictory. Preoccupations about the robustness of the human frame, and its fitness for lifestyles characteristic of the (changing) modern world co-exist with others relating to specifically feminine frailty and invalidism. But there are similarities of theme. Certainly, some issues are conspicuously absent from all the discourses on ME. Amongst these are sexuality and the fear of contagion\[1\] - the latter perhaps surprisingly since ME was originally specified as a disease occurring principally in epidemics. While the reason for these absences can only be surmised, it seems possible that the AIDS pandemic, a matter of intense concern at the time, had so completely appropriated all available meanings surrounding these two topics that other medical conditions were bound to be construed in different terms, expressing other social anxieties.

ME personality – a gender issue?

Accounts of ME, in the 1980s and 1990s as later, consistently stress the preponderance of women sufferers (e.g. Dawes and Downing, 1989: 20; Hall, 1991; Cooper, 1997: 192-194; CFS/ME Working Group, 2002, Annex 5). However, estimates of the ratio of women to men vary, and difficulties bedevil attempts to ascertain it (Mechanic, 1993: 329-332). It is clearly impossible to specify the true gender distribution of a condition for which no firm diagnostic criteria exist. Further, men and women who experience the same symptoms may react to them and describe them differently; and even similar reports may not elicit the same response or diagnosis. Whatever the 'true' gender distribution of ME, however, certain dominant discourses have construed it as a disorder of femininity. As already noted, the first well-publicised theory about ME personality was propounded by psychiatrists McEvedy and Beard (1970a; 1970b). For them, being a woman is a sufficient condition for having an ME personality; particularly vulnerable are those living at close quarters with other women.

The characterisation of ME as hysteria did not endure (David, 1991: 981), and it is, in any case, difficult to see how an account in terms of mass hysteria could apply in a situation where most sufferers did not become ill in the course of an epidemic. However, McEvedy repeated his views, virtually unchanged, in a television programme in 1988 (Horizon, BBC2, 27 June, 1988). Women, he argued, have a tendency to identify with other sick women, and a lower threshold for feeling ill and manifesting symptoms than do men.

Other accounts also construe ME in terms of a pathogenic femininity. Richmond (1989), in an article entitled 'Myalgic encephalomyelitis, Princess Aurora, and the wandering womb' places ME in a long line of supposedly organic, but actually fictitious, diseases of the past. As is apparent from the title, images of female invalidism and hypochondria abound in her account of ME, which she sees as a construct enabling patients to avail themselves of a

\[1\]An exception is a press report in Today (Pope 1990) entitled 'Yuppie flu from single handshake' - the only 'scare story' about contagion (from a supposed viral infection) I have found.
glamorous diagnosis, and private doctors to make a profit. 'Then as now,' she states, after a foray into the bile and vapours of the eighteenth century, 'ladies suffering from the vapours retired to their boudoirs. Taken from the French word bouder, to sulk, a boudoir is a lady's sulking room... A typically environmentally sensitive princess could not sleep when a pea was placed under 15 mattresses...' (ibid.: 1296). It beggars belief that Richmond is an influential medical journalist, and this contribution to the debate is scientifically legitimated by its publication in the British Medical Journal. Richmond (1992) repeats her views in the popular press, though in somewhat less flowery terms.

A further 'scientific' opinion is that of neurologist Peter Hudgson, who claimed in a television interview (in a tone of contempt for his ME patients of both sexes that cannot be conveyed in writing) that four fifths or more of the ME sufferers who consulted him were women with unsatisfactory marriages and difficult children with thwarted ambitions (Frontline, Channel 4, 25 July, 1993). Hudgson did not explain why similarly frustrated men might be less likely to develop similar symptoms. The same omission is evident in many more sober accounts of ME reporting the high proportion of female patients. One account which does attempt to explain the preponderance of women is that of American medical anthropologist Norma Ware (1993: 66), cited in the British press (Woodham, 1993), who argues that women under the influence of feminism have sought to 'have it all', and have overcommitted themselves in the effort to achieve a successful career and a fulfilling family life.

However, not all discourses on ME construe it as an effect of a pathogenic femininity. Indeed, certain constructions of the disorder as an outcome of overactivity actually seem to posit what might be thought of as a type of feminisation as a remedy for its symptoms. Within such discourses, excessive ambition needs to be tempered by gentleness and patience, conventionally feminine qualities. I now turn to these discourses, and to the assumptions implicit within them.

ME as 'yuppie flu'

The construction of ME as an affliction of busy and ambitious people in a work-obsessed society is – or was during the period under review - perhaps the best-known popular understanding of the condition. It may have been fuelled by the accounts of patients themselves, anxious to rebut aspersions of malingering by emphasising their dynamism before the onset of illness. It is particularly evident in the press coverage in the early years of reporting. Walsh (1987), writing in the Sunday Express, refers to 'twentieth century burnout'; in a six-page article in the Telegraph magazine, Askwith (1989) quotes Dr Audrey Livingstone-Booth, director of the Stress Syndrome Foundation, as claiming that people are 'becoming immunosuppressed as a result of an obsession with achievement, work and material advancement', with their stressed bodies producing a noxious admixture of adrenaline and various steroids. A similar length feature in the Observer magazine (Bryan and Melville, 1989), on the following day, suggests that many people with ME were previously high achievers. An article in the magazine Here's Health (McKenna, 1990: 14) states that 'sufferers seem to be ‘achievers’ who have run down their immune system by overwork and stress, allowing viruses to take hold'. While it is occasionally specified that busy people of all classes and ages are at risk (e.g.Walsh, 1987), most accounts emphasise the dangers to professional people. Thus, in the Daily Telegraph, Wookey (1988) tells us that 'young energetic executives seem to suffer severely', and Rowe (1989) refers in Today to 'stressed city high-fliers'. The other category of people singled out as prone to ME are athletes (e.g. Harris, 1989). While many of these accounts are sympathetic to ME sufferers, presenting them as hard-working people afflicted by serious disabling symptoms of organic aetiology, it may be that some journalists are expressing, or at least relying on in their readership, a degree of Schadenfreude, a desire to see city high-fliers fall flat on their faces.
This characterisation of ME personality and lifestyle is also apparent in the theory that ME is an effect of hyperventilation, or overbreathing. In this version of the 'yuppie flu' construction, sympathy for the sufferer morphs into contempt. The theory, based on the claim that a change in breathing lowers the level of carbon dioxide in the blood, inducing malfunction in muscles and other organs, was publicised in an article on the front page of the Sunday Times (Hodgkinson, 1988); the title, predictably maddening to sufferers, was 'Yuppie flu' is all in the mind, say doctors'. The doctors concerned were cardiologists Peter Nixon and Stuart Rosen, who expounded their views in the same issue of the Sunday Times, and whose proposed method of treatment was a period of sleep induced by heavy sedation, followed by breathing retraining.

The notion that the symptoms of ME result from hyperventilation produced by anxiety originates in the writings of McEvedy and Beard (1970b: 13). The essentials of this new version of an old idea emerge from the press report just mentioned. 'All the (ME patients) we have seen here,' explains Rosen, 'have four-star abilities with five-star ambitions. They have above-average intelligence, high levels of drive, lots of enthusiasm; but they are not quite the superman or superwoman they need to be to achieve their ambition.' A severe viral infection, he believes, can trigger the health crisis, but it is not the root cause. With the disregard for logic and coherence that characterises so many pronouncements about ME, Rosen adds that his patients have ranged from an old lady whose illness began when she was pushed out of a bus queue, to a woman who survived torture in a South American prison, but became ill when she learned that her daughter had married a fascist. How either of these classification of five-star ambitions hampered by four-star abilities is not clear.

Rosen's colleague, Peter Nixon, adds more soberly that 'overbreathing is a symptom of fear or panic, that can be experienced when people who demand a lot of themselves are falling short in their achievements'. A subsequent paper in the medical press, of which Rosen and Nixon are amongst the co-authors, draws analogies between alleged stages of ME and those of battle-weariness, and speculates as to whether hyperventilation due to anxiety and effort may be the natural penalty for violating the boundaries of physiological tolerance (Rosen et al. 1990: 763-764).

In a later television interview, Hodgkinson (Frontline, Channel 4, 25 July, 1993) defended his use of the term 'yuppie flu' in his Sunday Times report. He explained that yuppies in the 1980s went all out for material success, becoming ill when their goals were frustrated; they had 'one foot on the accelerator and one foot on the brake', and suffered a crisis leading to deep exhaustion and despair. As suggested above, there is an implication, albeit unstated, that ME sufferers are unpleasant, pushy people, who have got their just deserts. The preponderance of female sufferers appears to be forgotten here: it is not plausible that most of the high-powered people to whom Hodgkinson refers were women.

‘Yuppie flu’: social or individual pathology?

In considering the account of ME as the outcome of 1980s ambition and overactivity, the issue arises of whether this construction attributes blame to individual 'yuppies', or to economic and social conditions that promote a pathogenic lifestyle. In addressing this question in relation to ME, it is interesting to draw parallels with another disorder at one time constituted (also by cardiologists) as uncertainly poised between a driven personality and an achievement-orientated society, namely coronary heart disease (CHD).

Studies conducted in the USA from the late 1950s (fallaciously) present the typical CHD victim as characterised by the 'type A behaviour pattern' (TABP). The features of this pattern include competitiveness and addiction to high stress careers (Helman, 1992: 31-32). CHD is, then, like Hodgkinson's account of ME, construed as a disease of overambitious, middle-class people ultimately defeated by the pressures of a fast-moving, achievement-obsessed society (ibid.: 35). Considerable ambiguity exists in the literature on CHD as to whether TABP is a
In the literature, heart disease comes as nemesis, as a punishment for overconformity to the norms of competitive capitalism (ibid.: 52). The same fate, according to the model of Hodgkinson, Nixon and Rosen, befalls the overbreathing yuppie flu victim of the Thatcherite 1980s. The analogy between the construction of the two diseases is reinforced by the accounts of the subsequent fate of the sufferer: the type A heart attack survivor returns to the community chastened, and is thereafter encouraged to be less competitive and impatient (ibid.: 50). This prescription is similar to that sometimes advocated for the recovering ME patient. Ware (1993: 67) argues that the illness frequently acts as a catalyst for an ultimately beneficial change of lifestyle, in which 'perpetual motion' is replaced by relaxation, caring for others, simplicity and calm – a view echoed by Woodham (1993) in the Independent on Sunday. Jacques (1996) – a former ME sufferer - concurs with Ware in attributing ME to an increasingly pressurised lifestyle - and moreover, implicitly characterises his solution as a kind of feminisation in his description of 1980s attitudes to work as 'machismo'.

As with CHD, the emphasis in this construction appears to fall more on the sufferer's state of mind than on social factors. Indeed, it appears to be ambition and addiction to work (largely the preserve, of course, of middle-class people with interesting jobs and good career prospects), rather than hard work itself, which is deemed pathogenic. The proposed remedy for both disorders is not social transformation the moral re-education of the sick person.

However, the construction of the CHD sufferer differs from that of the ME sufferer in one important respect: the latter emerges as meriting ridicule. First, ME patients are often depicted as failures in terms of worldly success as well as health: they lack the capacity to make good despite all efforts, whereas no such slur is cast on the abilities of type A personalities with CHD. Second, their illness is only apparently serious: the incapacitating nature of the symptoms belies the triviality of the cause. By contrast, CHD victims have a life-threatening disease. Analogies between ME and the 'effort syndrome' found in wartime exhaustion (Rosen et al., 1990: 763) further highlight the silliness of patients whose panic and hyperventilation has been induced not by the terrors of battle, but by everyday stresses. Indeed, according to this construction, ME scarcely qualifies as an illness at all: sound sleep will bring recovery.

ME as learned helplessness

Meanwhile, again to the displeasure of patient groups, psychiatrists were propounding views of ME – or chronic fatigue syndrome, as they preferred to call it - as depression manifesting itself in physical form (Stuttaford, 1993; Wessely, 1993). Wessely, a controversial and influential figure who today remains the bugbear of many patients, construes ME primarily as learned helplessness. He and his adherents argue that, although a virus may trigger the disorder, persistent symptoms are due to cognitive distortions and lack of activity. In the course of an initial minor illness, patients are said to develop dysfunctional beliefs about the nature of their condition and the dangers of taking exercise - beliefs reinforced by the fact that physical deterioration resulting from excessive rest makes any sporadic attempts at activity tiring and painful. The result is 'a vicious circle of symptoms, avoidance, fatigue, demoralisation and depression' (Butler et al.,1991). Treatment - cognitive behaviour therapy (CBT), sometimes accompanied by antidepressants - is aimed at modifying unhelpful cognitions (Chalder and Butler, 1989: 17), while activity is slowly increased by means of graded exercise therapy (GET), strengthening muscles weakened by prolonged disuse.

Accounts of this treatment offered by its proponents are striking in the emphasis placed on introducing predictability into the pattern of rest and activity – as though disordered bodies, predominantly female, need to be disciplined. Thus, long intervals of rest may be allowed, at
least initially, but these must be for a set period, and at set times (Chalder and Butler, 1989: 17; Butler et al., 1991: 154). Emphasis is also placed on the importance of completing a preplanned activity regardless of symptoms. This regulation of activity stands in stark contrast to that proposed by ME patients and their organisations, who advise sufferers to avoid straining at their limits; to 'listen to their bodies'; and to tailor their lifestyle to their reduced capacity. According to the advocates of CBT, however, the belief that the illness is long-term, and requires an adaptation of lifestyle, needs to be countered.

Wessely further speculates about the social context of ME. In a well-known paper, Old wine in new bottles: neurasthenia and 'ME' (1990), as well as in the press (Wessely, 1993), he draws analogies between neurasthenia patients in the late nineteenth century and ME patients in the 1980s. (Richmond (1992) makes the same comparison.) Both conditions, he argues, are characterised by fatiguability, with a host of other mental and physical symptoms (Wessely, 1990: 36-37); and neurasthenia was, like ME, regarded as an outcome of the pace of modern life and of the drive to succeed, rather than of work itself (ibid.: 43). Like ME patients, neurasthenics allegedly claimed lack of sympathy from the medical profession and - by contrast with hysterics - stressed their eagerness to collaborate with their medical advisers, and to return to normality (ibid.: 39-40).

For Wessely, the long interval between the demise of neurasthenia and the emergence of ME denotes neither a relaxation in the pace of life during that period, nor changes in the classification of symptoms at different times. Instead, he claims that what in the psychiatric literature is termed 'distress' (Wessely, 1990: 43; David, 1991: 181) manifests itself in culturally sanctioned ways, varying with changes in attitudes to work and material success (Wessely, 1990: 50). He concedes that his account is incomplete in that the social processes governing what he terms the 'creation' of such illnesses remain obscure.

But it is not only social processes that Wessely's account leaves untheorised: the individual's distress also remains unexplained, and in particular, there is no suggestion that certain social attitudes or arrangements might give rise to more distress than others. While the 'yuppie flu' construction of ME does, however ambivalently, link the prevalence of the condition to its social context, the construction of ME as psychiatric illness construes it as social only in the form it takes.

What became of the headlines?

ME first made news in the late 1980s because activists worked hard to ensure its prominence. In particular, Clare Francis, president of Action for ME, campaigning unremittingly for recognition of the disease, securing repeated media interviews (e.g. Francis, 1988a; 1988b; Right to Reply, Channel 4, 11 June, 1988). But, albeit with exceptions (e.g. Hawkes, 1992), the reportage soon took a turn they neither expected nor welcomed. It appears that a determined and initially successful publicity campaign by sufferers was hijacked by a variety of parties with their own agenda. In an exploration of their waxing and waning, the various discourses on ME require separate examination.

The involvement of psychiatrists and psychologists, once the debate was underway, can arguably be explained by professional self-interest, given the high profile of the condition and the large number of sufferers. (The same could be claimed of Drs Nixon and Rosen.) The psychiatric construction has changed little over time; its associated treatments, CBT and GET, are offered in various hospital departments and claimed as effective by their adherents (e.g. Quarmby et al., 2006). They remain bitterly contested, with some patients claiming that GET can be harmful, and many demanding that efforts focus instead on discovering the organic basis of their symptoms (ME and CBT, BBC Radio 4, 7 November, 2007; ME Association, 2009).

The discourses of the late 1980s foregrounding women's proneness to pathology display an inconsistent mixture of the old and the new, legitimated by the preponderance of women
amongst diagnosed ME patients. These do appear to have undergone a change. Well-established constructions of women as hysterical, suggestible, and vulnerable to psychosomatic symptoms have hopefully now become less common; they are not in evidence in the current psychiatric literature on ME. And while discussion continues about women's increased representation in the workforce, and their attempts to 'have it all', anxieties now centre on the possible ill-effects on family life where long and inflexible hours are the norm, and fathers do not share responsibility equally (Carvel, 2008). So far as I am aware, concerns about working mothers are - for unknown reasons - no longer linked to their supposed propensity to become ill with ME or any other condition.

In considering the reasons for the rise – and subsequent fall – of 'yuppie flu' constructions, it is useful to examine the account offered by Martin Jacques (1996), former editor of Marxism Today. This was late for a construction of this particular kind – although 1996 saw heated debate about ME with the transmission of an angry television programme (Rantzen Report - ME: The Secret Epidemic, BBC 1, 5 August, 1996) and the publication of a psychiatrically-dominated report (Royal Colleges of Physicians, Psychiatrists and General Practitioners, 1996). In a long Guardian feature, Jacques relates his own experiences of suffering and recovery from the disorder. He spells out what he sees as the pathogenic features of the 1980s, citing increased intensity of work, decline of certainty and rise of insecurity, and the transformed condition of the middle class. He argues that it was not surprising that under these circumstances new diseases that were simultaneously stress-related and physical should emerge.

Admittedly, social inequality – a growing feature of the 1980s – may impair health (Wilkinson and Pickett, 2009). Nonetheless, Jacques's claim seems vastly overblown. Within living memory, for instance, sections of Europe were devastated and British cities blitzed. One might ask why the victims of these events did not develop ME. What about concentration camp survivors? The inhabitants of Darfur? In the light of these catastrophes, it appears implausible that life in peacetime for prosperous young people should have been so unprecedentedly stressful as to generate a new disease. One wonders why those who reflected and reported on the lifestyle and health of their contemporaries were so panic-stricken and, in a sense, so self-pitying.

It is beyond the scope of this article to explore the preconditions for 'moral panics' and other forms of social disquiet, and why these may sometimes express themselves as fear of specific illnesses. But it is not inconceivable that social disruption in supposedly 'normal' times might on occasion cause almost as much disorientation as upheaval at times when normality is no longer expected. Certainly, British society under Thatcher underwent radical and rapid change – although there is no objective evidence of a resulting increase in the incidence of ME. Journalists, both reflecting and generating unease, may have been particularly conscious of the shifting culture: Rupert Murdoch’s confrontational move of his titles to Wapping in 1986, soon followed by most of the press, would - though aimed at the printing unions rather than themselves - have made them sharply aware of a more ruthless ethos. By linking their concerns to the proliferation of an allegedly new physical disorder, these commentators could claim emerging social changes not just as distasteful, but also as pathogenic. 1986 also saw the Big Bang, the deregulation of the stock exchange. This was, of course, also the year of Sue Finlay’s Observer article that brought ME to prominence.

Legacies of Thatcherism persist: large numbers of City (and Canary Wharf) high-fliers remain. But attitudes towards them soon altered dramatically. Peter Mandelson famously stated after New Labour’s accession to power in 1997 that the new government was 'seriously relaxed about people getting very, very rich'. Forms of competitiveness and greed that arose with the advent of Thatcher in 1979, and that evoked alarm in the years that followed, ceased to attract much comment. The economic crisis that began in 2008 has raised fresh questions about their desirability, but 'yuppies' - a term now more or less fallen into disuse – are no longer thought to embody an unnatural lifestyle deemed to generate bodily disorder.
Conclusion

By 1998, the ME charities were welcoming - Action for ME warmly (Tolley, 1998); the ME Association (1998) with more caution – of a widely reported statement by the Chief Medical Officer describing ME as a debilitating and distressing 'real medical condition'. An ensuing report (CFS/ME Working Group, 2002) gave a voice to patients, acknowledged the contribution of their organisations, and highlighted the prevalence, severity and chronicity of ME. It disappointed some patients by its alleged failure to sufficiently stress the need for research into the aetiology and pathogenesis of the disorder, as well as by its endorsement of CBT as a useful, if not curative, strategy; but constructions of ME in terms of feminine hysteria or Thatcherite hyperactivity had clearly been relegated to the past.

With the reservations noted earlier, it seems fair to suggest that media interest in ME has waned. Reports and sufferers' accounts still occasionally appear, usually taking the organicity and seriousness of the disorder for granted (e.g. Gould, 2008; Kahn-Harris, 2008). Notably, the Mail Online produces a fairly steady stream of (often confused and ill-informed) reportage (e.g. Lantin, 2007; Edwards, 2008). But an unsubstantiated theory about the aetiology of ME would not now occupy the front page and an entire inside page of a major newspaper (Hodgkinson, 1988); nor would ME now be the subject of six-page weekend colour supplement features (Askwith, 1989; Bryan and Melville, 1989).

Sontag (1991: 5) suggests in relation to TB and cancer that illnesses will be encumbered by the trappings of metaphor for as long as they are not understood and not curable. It seems, however, that ME, once so powerfully construed as a symbol of the social ills of its age, has shed its metaphoric connotations. It is regarded either as a predominantly psychiatric condition to be addressed by management techniques; or, perhaps increasingly, as a poorly understood organic complaint that is just one more dreary and meaningless chronic illness amongst others.

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