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Letter to the Editor

Sharpe *et al.*'s (2009) study 'Neurology out-patients with symptoms unexplained by disease: illness beliefs and financial benefits predict 1-year outcome' presents in declarative statements three interdependent socio-psychological factors as indicative of poor outcome after 1 year of illness: illness beliefs, non-attribution to psychological causes and financial factors.

Whilst patients may be happy to engage with a biopsychosocial model it is the lack of available biological explanations that may well lead to poor outcome rather than illness beliefs *per se*. Terms such as 'functional weakness' and 'software error' are semantically vague and as Stone acknowledges elsewhere (see: www.neurosymbols.org 'family and work') may well need to be re-worded in unhelpful psychological terms as 'conversion disorder' on official documents. For patients the biological is important as it provides social legitimacy for a physical illness and an objective entity that they can fight to overcome. Vuilleumier *et al.*'s (2001) study of hysterical paralysis showed poor recovery dictated by the level of activation in the contralateral caudate and

thalamus. Yet this study attempts no physiological or objective reassessment of patients. Instead it relies on subjective self-reported assessment. Objective assessment by an experienced physiotherapist or occupational therapist may well produce a different SF-12 score. As such, reported improvement or failure to improve may be merely the result of a cognitive compliance to the demands of the physician or indeed the breakdown and nihilism when faced with a discourse devoid of physical explanations. Kanaan *et al.* (2009) suggests that neurologists often decide within a few minutes of meeting a patient whether an organic explanation will be forthcoming. Do we assume patients are unaware of this through subsequent manner and rapport? What might the effect of this be on patient morale and presentation, especially those struggling with distressing symptoms?

Rather than work towards a therapeutic relationship of mutual trust and respect Sharpe *et al.* state that their data lends 'support to the idea that interventions which change these variables [*i.e. state benefits or opposition to physician imposed psychological explanations of physical symptoms*] may improve the outcome for this patient group'. Have Sharpe and colleagues considered how patients may interpret the fiscal side of this intervention?

In denying a correlation between SF-12 scored disability and receipt of benefit, Sharpe *et al.* inadvertently infer that patients with 'symptoms unexplained by disease' are guilty of benefit fraud. The DWP does not use SF-12 to allocate benefits such as disability living allowance (DLA) or incapacity benefit. It is therefore erroneous to use data as the authors do to state that: 'Illness beliefs and financial benefits are more useful in predicting poor outcome than the number of symptoms, disability and distress.' They also fail to assess the monetary value of any benefit with regard to severity of disability or map this against socio-economic status.

That there is a link has been noted by Rosato & Reilly (2006) who in contrast to Sharpe *et al.* correlate level of benefit with degree of disability. Indeed some studies of families with disabled children have shown that disability benefits actually improve social inclusion and in the long term allow independence within the family unit (Preston, 2005).

Of particular note from Preston's study is the improvement in mental health amongst DLA claimants with money spent on cinema trips, social activities as well as contributing to basic costs such as transport.

Sharpe *et al.* conceivably present a situation in which the most vulnerable within a population are further excluded from society. For the fact remains that in all patient groups socio-economic status is a greater predictor of ill health than the receipt of

health-related benefits *per se*. Furthermore, by denigrating a patient's own perceptions of their illness they deny the therapeutic partnership by which any disease may be overcome, irrespective of aetiology.

Declaration of Interest

The author is a full-time teacher and patient misdiagnosed with 'multiple functional symptoms', found after 5 years to have 'systemic autonomic failure' and hereditary spastic paraplegia by consultants Yiannakou, Gorman and Newton. Condition improved with baclofen, midodrine and sacral nerve implant.

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