



Notes on the Ineffectiveness of the Biopsychosocial Model for Treating Myalgic Encephalomyelitis

The Biopsychosocial Model

Background:

Myalgic Encephalomyelitis (ME) has been documented in the medical literature from 1934. The Wallis description of ME (not Chronic Fatigue Syndrome, known as CFS - see below) was in 1957.

Sir Donald Acheson's (a former UK Chief Medical Officer) major review of ME was in 1959.

In 1962, the distinguished neurologist Lord Brain included it in the standard textbook of neurology.

ME has been formally classified by the World Health Organisation as a neurological disorder in the International Classification of Diseases (ICD) since 1969 (ICD-8: Vol I: code 323, page 158; Vol II (Code Index) page 173).

ME remains classified in the current ICD as a neurological disorder (ICD 10. G.93.3).

Chronic Fatigue Syndrome (CFS) is listed in ICD-10 as a term by which ME is also known, as is the term Postviral Fatigue Syndrome (PVFS). The term "CFIDS", or Chronic Fatigue and Immune Dysfunction Syndrome, is used by some groups in the US. [1]

BIOPSYCHOSOCIAL MODEL:

- The Biopsychosocial (BPS) model was developed by Professor Sir Mansel Aylward (who was chief medical officer for the Department for Work and Pensions (DWP) and Dr Gordon Waddell, an orthopaedic surgeon. Aylward later went on to become head of Cardiff University's Centre for Psychosocial and Disability Research, a group backed by the USA insurance company giant Unum.
- The biopsychosocial model states that illnesses are part biological, part mental, part social. In practice it is often the psychological elements that are emphasised. Thus, the "biopsychosocial" model of ME is that a patient may have originally had a virus but after that, symptoms are not primarily the result of an ongoing disease process at all. Instead, patients simply have "dysfunctional" or "false" illness beliefs and thus adopt the "sick role". Spending too much time in bed is the reason they have physical abnormalities, as they become deconditioned due to "exercise avoidance", and it is assumed that symptoms are reversible by the patient's own efforts.

Invest in ME Research – BPS Model Flaws

- These psychosocial explanatory models for fatigue and ME/CFS and fatigue in general are the rationale for the combination of cognitive behavioural therapy (CBT) and graded exercise therapy (GET). In the BPS view, the patient can 'recover' by adjusting dysfunctional beliefs and behaviour and reversing deconditioning, which are proposed to be the maintaining factors in ME/CFS. CBT is aimed at eliminating psychogenic maintaining factors, for example, illness beliefs, unhelpful, anxiety-provoking thoughts and kinesiphobia ('fear of movement'); CBT challenges the negative cognitions and dysfunctional beliefs of the patients. CBT is indissolubly attached with GET, a rehabilitative approach of graded increase in activity to address deconditioning [2]
- Fatigue and impairment are considered to be the end result of behavioural (psycho/sociogenic) factors only.
- The BPS theories for ME are increasingly being challenged as not only flawed, but also as harmful to patients [3].
- Indeed, since the BPS model has been used by successive UK governments to ideologise their welfare benefits policies in order to reduce costs this use of BPS is linked to deleterious effects on the health of sick people and an increase in suicides amongst claimants of welfare. Statistics released by the UK Department for Work and Pensions (DWP) revealed that during the period December 2011 and February 2014 2,380 people died after their claim for employment and support allowance (ESA) ended because a work capability assessment (WCA) found they were found fit for work [4].
- Professor Tom Shakespeare and Professor Nicholas Watson, and fellow academic Ola Abu Alghaib, concluded that the biopsychosocial model of health (BPS) "does not represent evidence-based policy" [5].
- The flagship trial for the BPS model in the UK (The PACE Trial) [6] has been proven to be flawed [7], possibly fraudulent [8] and a complete waste of tax payers' money
- Reanalysis of PACE Trial results by Matthees et al (once the data was forced to be released from the authors following a legal challenge) states - "This re-analysis demonstrates that the previously reported recovery rates were inflated by an average of **four-fold**." [9]
- The PACE Trial is now used as an example of how not to perform research – and it is widely seen as flawed and is ridiculed. Several articles by David Tuller academic coordinator of the concurrent masters degree program in public health and journalism at the University of California, Berkeley, have exposed these flaws and demonstrated that the PACE Trial cannot be considered valid [10]
- In USA major organisations and agencies have downgraded support for using CBT and GET for ME

The USA Agency for Healthcare Research and Quality (AHRQ) downgraded CBT and GET [11]

The USA CDC is not recommending CBT/GET [12].

- The Finnish agency Valvira recently removed recommendation to use CBT and GET for ME [13].
- The European AGREE Instrument governs guideline development (Appraisal of Guidelines Research and Evaluation Instrument) [14] with which agencies are obliged to comply in the formulation of Guidelines is specific: “The health benefits, side effects and risks should be considered when formulating the recommendations” and give equal weight to three main sources of data: “evidence-based” medicine, usually deemed to be random controlled trials (RCTs); the opinion and experience of physicians with expertise in the area, and the opinion and experience of the patient group for whom the Guideline is intended.
- It must be noted now that any agency that recommends use of CBT and GET for ME will find themselves possibly open to litigation when the effects of these psychiatric theories cause harm to patients.

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