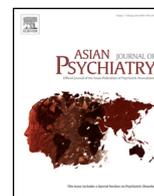




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journal homepage: www.elsevier.com/locate/ajp**Myalgic Encephalomyelitis, chronic fatigue syndrome or systemic exercise intolerance disease: What's in a name?**

With interest I have taken notice of a contribution by Sen and colleagues (Sen et al., 2016). According to the Sen et al. (2016) replacing Chronic Fatigue Syndrome (CFS) (Fukuda et al., 1994), a “mental disorder” which is “characterized primarily by the symptom of severe, persistent and disabling fatigue” and “included in the DSM-IV-TR within the rubric of undifferentiated somatoform disorder”, by Systemic Exercise Intolerance Disease (SEID) (Institute of Medicine, 2015), a “more ‘biological’ disease”, implicates “a need to debate the failure of the bio-psycho-social model to ‘mainstream’ and destigmatize psychiatry”. We agree (Twisk, 2016) that the diagnostic criteria of SEID (Institute of Medicine, 2015) are inadequate to replace the diagnostic criteria of CFS (Fukuda et al., 1994). However to understand the reasons why “the bio-psycho-social formulation [...] has not found takers in the patient community” (Sen et al., 2016) some critical comments are appropriate.

Myalgic Encephalomyelitis (ME) has been described as a distinct neurological entity since 1938, often on account of outbreaks (Twisk, 2014). ME is characterized by typical muscular symptoms, e.g. prolonged muscle weakness after minor exertion, neurological symptoms, implicating cerebral dysfunction, and circulatory deficits (Ramsay and Dowsett, 1992). Much of the current confusion originates from the introduction of the diagnostic entity CFS. The only mandatory feature of CFS (Fukuda et al., 1994) is (unexplained) chronic fatigue. ME and CFS are two distinct, partially overlapping diagnostic entities (Twisk, 2014). Despite this the World Health Organisation (WHO) considers CFS to be a synonym of ME, a neurological disease (G93.3). The WHO has stated that “it is not permitted for the same condition to be classified to more than one rubric” (WHO, 2005). All in all, classifying CFS as “a undifferentiated somatoform disorder” (Sen et al., 2016) is incorrect.

The premise that ME/CFS (WHO G93.3) is a “mental disorder” (Sen et al., 2016) is the most important reason why “the bio-psycho-social formulation [...] has not found takers in the patient community” (Sen et al., 2016). As long as biopsychosocial models are extremely biased and could be qualified as (bio)psychosocial models (Maes and Twisk, 2010), the “the bio-psycho-social formulation” will be justly rejected. Moreover, the various (bio) psychosocial models for ME/CFS, with a strong emphasis on cognitions and behaviour have shown to be invalid and incomplete.

As the Institute of Medicine (2015) states “ME/CFS is a serious, chronic, complex, multisystem disease” and there is a “misconception that ME/CFS is a psychogenic illness or even a figment of the patient’s imagination”. “Strong evidence indicates that immunologic and inflammatory pathologic conditions, neurotransmitter signaling disruption, microbiome perturbation, and

metabolic or mitochondrial abnormalities are potentially important for the definition and treatment of ME/CFS.” (Green et al., 2015). “Both society and the medical profession have contributed to the disrespect and rejection experienced by patients with ME/CFS” (Green et al., 2015). As long as biopsychosocial models are primarily psychosocial models, in which cognitive and behavioral factors fully explain the abnormalities and symptoms, patients and researchers will rightfully reject the (bio)psychosocial models. Stigmatisation of psychiatry will end when the physical nature of ME/CFS and the secondary role of psychosocial factors are acknowledged by psychiatrists. At that moment psychiatrists can really help patients with psychosocial problems due to the severity of the illness and the (psychosocial) burden of being sick.

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