


Mapping the government of disability in myalgic encephalomyelitis/chronic fatigue syndrome

A critical feminist account

Joanne Hunt 

Research Affiliate, Department of Women's and Children's Health, Uppsala University, Uppsala, Sweden

Independent activist-scholar, UK

E-mail: joanne.hunt@uu.se

ORCID: 0000-0003-3868-5765

Submission date: 7 August 2024; Acceptance date: 22 September 2025; Publication date: 15 December 2025

Copyright

© 2025, Joanne Hunt. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial No Derivatives Licence (CC BY-NC-ND) 4.0 DEED <https://creativecommons.org/licenses/by-nc-nd/4.0/deed.en>, which permits the use, distribution and reproduction in any medium, provided the original author and source are credited, the material is not modified and is not being used for commercial purposes.

ABSTRACT

People with myalgic encephalomyelitis/chronic fatigue syndrome have historically been conceptualised in health and social policy as “undeserving” of societal support, largely via a variant of biopsychosocial model charged with promoting multifaceted harms. Whilst scientific literature has been preoccupied by paradigm conflicts pertaining to (bio)psychosocial and biomedical models of disability, the socio-cultural and biopolitical context driving (bio)psychosocial hegemony has received little mainstream scholarly attention. Nevertheless, this context is addressed within subjugated knowledges, notably through the epistemic labours of disabled activists and marginally situated scholars. This article espouses a feminist standpoint, feminist disability studies, and Foucauldian thought in re-examining and synthesising some of this work, locating psychosocial truth claims within an intersectionally oppressive and ever-expanding government of disability. I argue that greater respect for subjugated knowledges could lead not only to a more strongly objective and nuanced understanding of (bio)psychosocial hegemony but also to greater possibilities in terms of resistance.

KEYWORDS

biopolitics, biopsychosocial model, myalgic encephalomyelitis/chronic fatigue syndrome, feminist disability standpoint, Foucault, government of disability, history of the present, politics of knowledge production

I. Introduction: Subjugated Body/Minds, Subjugated Knowledges?

Myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), a diagnosis more prevalent among women, can be understood as occupying a site of paradigm conflict between a biomedical and particular variant of biopsychosocial model, where the latter model has become hegemonic (Hughes et al., 2023; Kennedy, 2012). The biopsychosocial model as conceptualised by Engel (1977) was said to seek a more holistic alternative to the biomedical model by acknowledging biological, psychological, and social influences in health and illness; however, it has been manipulated by professional and political interests in the disability arena, most notably in the UK but with international ramifications (Jolly, 2012; Stewart, 2016; Thorburn, 2012). This manipulated variant has elsewhere been recognised as the Waddell-Aylward biopsychosocial model (Shakespeare et al., 2017), a version applied in the service of social policy reforms coalescing around neoliberal-capitalist welfare retrenchment. Informed by the US income protection insurance industry, the Waddell-Aylward model has influenced social policy within and beyond the UK (Stewart, 2016). More specifically, the model has contributed to an expansive biopolitical governance of disability and difference and an ongoing process of biopsychosocial hegemony. Whilst “biopolitical governance” can be understood as a politically strategic management of life, “hegemony” refers to how those who have manipulated biopsychosocial discourse and practices strive to maintain dominance through socio-cultural and ideological as well as political and economic means (Kreps, 2015). As will become clear, this hegemony is intersectionally oppressive, impacting disproportionately on multiply marginalised groups (Gillberg, 2022; Hunt, 2024a; Hsu, 2024; Cieurria, 2024). In arguable complement with the Gramscian concept of hegemony and macro-analysis of power, Foucauldian thinking on biopolitics – the politically strategic deployment of power over life on an individual and population level – will be foregrounded as a framework through which to reveal the diffuse micro-politics implicated in governing people with ME/CFS (Foucault, 1980; Kreps, 2015; Tremain, 2001).

In the global disability arena, “the” biopsychosocial model often refers to the World Health Organization’s framework of disability, the International Classification of Functioning, Disability and Health (World Health Organization, 2001). However, as has been noted elsewhere (Shakespeare et al., 2017), the World Health Organization’s model of disability (a “person-in-context” model) and the Waddell-Aylward biopsychosocial model are by no means synonymous. Accordingly, my use of the term “(bio)psychosocial” highlights the Waddell-Aylward model’s minimisation

of biological factors and undue emphasis on individualistic psychosocial factors (such as purported maladaptive illness-related behaviours) within a misleadingly termed “holistic” approach (Kennedy, 2012; Maes and Twisk, 2010). This, combined with the model’s overlooking of socio-political context and associated power relations (Hunt, 2024a) effectively frames ME/CFS and other conditions subjected to parallel political agendas as individualistic, psychosomatic (understood as psychogenic) entities (Kennedy, 2012; Twisk and Maes, 2009). In this regard, as I will demonstrate, ME/CFS can be understood as the archetype of, and prototype for, an expanding category of impairment and disability positioned as “undeserving” for socio-cultural, economic, and biopolitical purposes. This socio-cultural, economic, and biopolitical context has been largely overlooked in peer-reviewed academic literature until recently (for a notable exception, see Rutherford, 2007). Before moving to an examination of sidelined knowledges that illuminate this context, the dominant account of (bio)psychosocial hegemony is briefly revisited.

From a dominant academic perspective, which in the case of ME/CFS is wedded to an epistemology tied to mainstream (hegemonic) psychology and biomedicine, (bio)psychosocial hegemony is largely considered a consequence of “bad science” (see Geraghty, 2022; Hughes et al., 2023; Putrino, 2024). Here, science refers to “the” (Western) scientific method: hypothetico-deductive, experimental endeavours that endorse and strive for value-neutrality and objectivity (Hughes et al., 2023). Ongoing paradigmatic debates around ME/CFS and other politically contested conditions are conceptualised as an artefact of presumed hegemonic scientific progress, of ME/CFS being caught amid a Kuhnian paradigm shift, with the (bio)psychosocial paradigm giving way to a favoured biomedical approach (see Hughes et al., 2023). Accordingly, common criticisms of this (bio)psychosocial approach in the ME/CFS space include a large body of biomedical literature having been overlooked, whilst the framing of psychological-social factors lacks empirical support and results in patient harm (e.g., Geraghty and Esmail, 2016; Geraghty, 2020). More specifically, (bio)psychosocial discourse (further entwined with cognitive-behavioural theories) has historically positioned people with ME/CFS as perpetuating their ill-health via unhelpful (“catastrophising”) cognitions and avoidant behaviours, predisposed by “maladaptive” personality traits and reinforced through “gains” such as attention from others and social security benefits (Sharpe, 2002; Wessely et al., 1989). Cognitive-behaviourally inspired psychosocial interventions, chiefly cognitive behavioural and graded exercise therapy, were developed by psychosocial proponents with a view to “correcting” such thoughts and behaviours and effectuating “recovery” (Wessely et al., 1989; Sharpe et al., 2022). However, and largely as result of the activism and resistance practices of people with ME/CFS, health authorities in the US and UK have determined that such therapies as treatments lack empirical support and risk harm, and pre-existing clinical recommendations have been withdrawn (Hughes et al., 2023; O’Leary, 2018). Nevertheless, proponents of a (bio)psychosocial approach continue to defend their position and have extended this approach to long Covid (Sharpe et al., 2022; White et al., 2023)

Whilst this dominant account and related practices of resistance have played a central role in countering (bio)psychosocial ascendancy, near-exclusive focus upon knowledge production tied to hegemonic science has eclipsed another part of the story. Mainstream scientific striving toward value neutrality and objectivity, combined with endorsement of an individual, reductionist model of disability and oppressive hierarchy of evidence within biomedicine and mainstream psychology, has masked the power-laden socio-cultural context that has favoured the (bio)psychosocial paradigm over alternatives (Hunt, 2025). Importantly for what follows, the privileging of mainstream scientific epistemology in contesting psychosocial hegemony has also subjugated other in-roads to knowledge such as minority academic disciplines and minority standpoints: feminist disability studies, and the work of multiply-marginalised knowers (perhaps most notably, disabled women) are of particular pertinence here (e.g., Bassett, 2009; Clifford, 2020; Jolly, 2012; Jones, 2016; Kennedy, 2012; Morris, 2018; Stewart, 2019; 2016; Thorburn, 2012). Such subjugation is particularly noteworthy given that the positioning of ME/CFS as an “undeserving” chronic illness, and its subsequent neglect, has been promoted by gendered, disabled, and otherwise intersectional power/knowledge hierarchies (Gillberg, 2022; Kennedy, 2012).

Following the above line of thought, the main objective of this article is to foreground the contributions of marginalised activist-scholars, further theorised through a feminist disability studies and Foucauldian lens, in offering a less “partial” (more socio-culturally and politically engaged) account of (bio)psychosocial hegemony than that gained exclusively through striving for dominant notions of objectivity and value neutrality. Correspondingly, I adopt standpoint theory and the concept of strong objectivity (Harding, 1992; Hills Collins, 1990). Nevertheless, I offer this account in complementarity with dominant epistemologies, with a general commitment to epistemological pluralism. Indeed, a central assumption underpinning my approach is that embracing diverse epistemologies can assist in achieving a less partial understanding of any given injustice, thus offering greater possibilities for resistance. I recognise that the knowledges embraced herein offer one in-road among many.

1.1 Theoretical grounding

Since I write as UK activist-scholar, and the UK can be considered a stronghold of psychosocial theorising (Kennedy, 2012; Stewart, 2016), I focus upon the UK historical and current climate. However, as will become clear, the government of ME/CFS is sited in a globalising climate of “neoliberal-ableist” welfare retrenchment and austerity politics (Goodley, 2017) implemented across Organisation for Economic Co-operation and Development (OECD) countries and carrying relevance beyond the UK and beyond ME/CFS (Berger, 2014; Bassett, 2009; Stewart, 2016, 2019, 2023). Throughout, I use the term “disabled people”, invoking the British social model of disability and the assertion from within the UK disabled people’s movement that disability can be understood as a form of social oppression imposed upon

people with “impairments”, or body/minds deemed to deviate from dominant social norms (Oliver and Barnes, 2012). From this perspective, ME/CFS (a chronic illness) may be understood as a form of impairment (Hale et al., 2020; Thomas, 2007). The British social model also lends itself to a historical-materialist understanding of ME/CFS, where disability is conceptualised as arising out of the capitalist mode of production, marginalising those who struggle to sell their labour power through positioning them as socio-economic problems (Ciurria, 2024; Clifford, 2020; Morris, 2018). However, as will next be unpacked, I consider (bio)psychosocial hegemony and the oppressive governing of people with ME/CFS to be biopolitically and culturally driven, as well as representing a socio-economic phenomenon. Additionally, I subscribe to a critical feminist problematisation of the disability–impairment distinction, recognising that impairment is shaped through social relations of power and that disability can be internalised and thus embodied (Goodley, 2017; Tremain, 2001; 2015). Therefore, I embrace the social model as a radical departure from historically dominant, individualistic models, such as the biomedical model, and as a springboard inspiring more recent critical feminist work within disability studies.

Highlighting the value of the feminist standpoint entreaty to “start thought from marginal lives” (Harding, 1992, 581), feminist disability studies arose from what might be termed a feminist disability standpoint: the recognition that disabled women’s experiences and knowledges had been sidelined within the feminist and disabled people’s movements (Bê, 2020). This field of scholarship can be located within critical disability studies (Goodley et al., 2021), a field that integrates “psychological, cultural, discursive and carnal” analytical planes into the social model’s vital insistence upon the “social, economic and political” (Meekosha and Shuttleworth, 2009, 50). Feminist disability scholarship may be understood as a bridge between early disability studies work foregrounding the social model, and more recent critical extensions (see Goodley et al., 2021). Such scholarship is thus well placed to illuminate a socio-economic, cultural, and biopolitical context that perpetuates (bio) psychosocial hegemony. Additionally, I assume a relationship between power and knowledge (power/knowledge) and its discursive-material shaping of impairment and disability, where “discursive-material” refers to the co-constitution of discourse (systems of representation of meaning arising from language and power) and materiality (physical realities such as bodies, objects, and space). Therefore, Foucauldian thinking is employed at its intersection with feminist disability studies, notably as per the framework of the “government of disability” (Tremain, 2001; 2015; see also Foucault, 1980; Jolly, 2003). Here, “government” is understood as actions that attempt to influence the actions of others, and more specifically as the management of individuals or groups considered to pose a problem to (neoliberal) governmental practice (Tremain, 2001; 2015). This framework positions disability as a biopolitical phenomenon, as a network of power relations that shapes conduct and subjectivities, changing the way disabled people understand themselves and rendering them governable, albeit I would suggest with capacity for resistance (see Beckett and Campbell, 2015). In what follows, I seek to map the emergence of the government of disability within the ME/CFS arena.

The form of power at play in the government of disability is biopower, a power over life that employs “numerous and diverse techniques for achieving the subjugation of bodies and the control of populations” (Foucault, 1978, 140). The network of power relations facilitating the government of individual body/minds and populations can be understood as arising from a disciplinary apparatus: “a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements” (Foucault, 1980, 194) that “responds to an urgent need in a given historical moment” (Tremain, 2020, 4). It has elsewhere been suggested that persons with ME/CFS have been positioned as problematic to governmental practice by a “psy-corporate-state complex” (Hunt, 2023): a network of actors and structures implicating academia (largely, psy), the disability insurance and rehabilitation industries, and the state, further reinforced through media complicity. What follows will demonstrate how this complex seeks to constitute and govern disability and impairment for socio-economic, ideological, and political purposes, encouraging or coercing marginalised groups to work on themselves in pursuit of the idealised, multiply privileged subject. At its most fundamental, the underpinning political impetus is one of creating and reinforcing intersectionally oppressive societal norms with a view to control and conformity, otherwise known as normalisation (Goodley, 2017; Tremain, 2020). This impetus or need may become more “urgent” in the shadow of the pandemic and global financial crisis.

In employing critical feminist disability studies in intersection with Foucauldian thinking, I hope to contribute to a “radical de-familiarisation of modern institutions and practices as caring and benevolent” (Meekosha and Shuttleworth, 2009, 57). The government of disability in the ME/CFS arena and beyond is underpinned by a governmentality (rationality of government) that is designed to “*rationalize* some form of that activity to those who practice it and those upon whom it is practiced” (Tremain, 2015, 18, original italics). Accordingly, I hope to illustrate that dominant social constructions of ME/CFS can be understood as a reflection and reinforcement of neoliberal-capitalist-ableist governmentality that applies a work cure (“work is good for health”) rationality in prioritising the market and private interests over compassionate citizenship and human rights. ME/CFS will be demonstrated to have been used as a template for reconstructing an ever-expanding group of disabled people in the service of neoliberal capitalism, reconstituting difference and diversity as “maladaptive” psychology, social deviance, and morally deficient character that can be corrected through multifarious technologies (means of deploying biopower). These technologies – including benefits assessments, work-focused interviews, training and recovery-oriented psychotherapies – might be best conceptualised as technologies of disciplinary power, which “determine the conduct of individuals and submit them to certain ends or domination” (Foucault, 1988 quoted in Becket and Campbell, 2015, 275). Such means of deploying biopower are increasingly outsourced to the private sector, transforming socio-economic “problems” into regulators of capital and sources of private profit (see Clifford, 2020; Stewart, 2016; Morris, 2018).

1.2 Methods

Consonant with Foucault's notion of critical scholarship, I approach this retracing of (bio)psychosocial governance in the spirit of a genealogy, or "history of the present" (Foucault, 1977, 31). A genealogical approach offers a different understanding of a problematic present-day phenomenon (here, biopsychosocial hegemony) through exploring the apparatus of power relations that has discursively-materially brought that phenomenon into existence. In short, it "allows for description of that which needs to be resisted" (Beckett and Campbell, 2015, 272). Foucault understood a genealogy as emerging from the union of disparate "subjugated knowledges" (Foucault, 1980): epistemic contributions positioned as naïve, unscientific, and toward the bottom of a socially constructed power/knowledge hierarchy, alongside erudite knowledges sidelined by dominant epistemologies. I seek to represent this union through employing thinking from an erudite yet minority discipline (feminist disability studies) to illuminate epistemic labours sidelined by dominant accounts of ME/CFS (e.g., Bassett, 2009; Clifford, 2020; Jolly, 2012; Jones, 2016; Kennedy, 2012; Morris, 2018; Stewart, 2016; Thorburn, 2012; Wendell, 1996). In striving to identify how particular truth claims are entwined with power, a genealogical account unearths a socio-historically contingent "regime of truth" (Foucault, 1980): the ways in which any given society determines what counts as truth, what methods are privileged in pursuit of truth, and the ensuing "effects of power" (ways in which power relations shape individual and collective practices). Accordingly, I seek to demonstrate that the ME/CFS and wider disability space has been infiltrated by a regime of truth that positions disabled knowledges as the lowest form of evidence, privileging purported "scientific" yet value-laden and poorly substantiated truth claims that serve neoliberal psy-corporate-state interests. The power effects of this regime can be understood through the lens of disablism (discriminatory practices against disabled people) and ableism: a power system, social order, and cultural imaginary "tied to the capitalist project of self-sufficiency" (Goodley, 2017, xv).

Since disability is shaped along the lines of gendered, classed, sexualised, and racialised discrimination, and ableism is co-constituted by other power systems and oppressive logics (Ciurria, 2024; Goodley et al., 2021), the government of disability impacts and is experienced differentially. Adopting a view through an intersectional lens, as per the work of Black feminist scholars (e.g., Crenshaw, 1989; Hills Collins, 1990), is helpful in situating myself vis-à-vis the subject matter. My positionality as a white, disabled, working-class woman variously enables and constrains my ability to engage with the "matrix of domination" (Hills Collins, 1990) as reinforced through (bio)psychosocial governance (see Gillberg, 2022; Hsu, 2024). Whilst the following genealogy is arguably less partial than dominant accounts privileging hegemonic science, it is nevertheless still partial. In the spirit of feminist praxis and the disability rights movements, my intention is to mobilise research for social change, in particular by promoting greater awareness of the subversive potential of subjugated knowledges. Consonant with feminist standpoint, I suggest that greater respect for marginalised knowledges could lead to a more strongly objective and nuanced

understanding of (bio)psychosocial hegemony within the ME/CFS arena and wider disability sphere, and thus to greater possibilities in terms of resistance. Predominantly, I draw on the work of disabled activist-scholars who are not employed within the academy; however, I also acknowledge the contributions of more dominantly situated knowers and collaborations between academics and disabled activist-scholars (e.g., Daguerre, 2004; Garthwaite, 2014; Mills and Pring, 2024; Rutherford, 2007; Shakespeare et al., 2017). Moreover, I recognise that the apparent binary between dominantly and marginally situated knowers is troubled by intersecting axes of oppression and that categorising people inevitably leads to exclusions. My account is thus necessarily selective and interpretative.

Before proceeding with this account, it is important to note that a biopolitical imagining of ME/CFS challenges both biomedical and (bio)psychosocial paradigms as described above. Indeed, I have elsewhere argued that biomedical and (bio)psychosocial approaches carry the same reductionist residue of hegemonic science, risking complicity with neoliberal-ableist cure/recovery agendas whilst overlooking socio-political influences in health, disability, and wider social inequity (see Hunt, 2025). In contrast, a biopolitical account recognises the interplay of body/minds, culture, society, and politics, supporting the feminist conviction that the personal is political. From a Foucauldian perspective, both medicalisation and psychologisation (as promoted by biomedical and (bio)psychosocial approaches to ME/CFS respectively) represent forms of biopower, surveilling and disciplining body/minds that fail or refuse to conform to imperialist (white, abled, cis-het-masculinist, Global North) logics (Foucault, 1977; 1978; 1980; Erevelles, 2011; Goodley, 2017). This is not to say that I do not support biomedical research in this field; rather, I find it to be insufficient: lacking socio-political engagement, downplaying the importance of intersectionality, and failing to account for subjective experience, especially among more marginalised people with ME/CFS (see Ciurria, 2020; 2024).

2. A subjugated account of ME/CFS

In the field of ME/CFS and other politically exploited conditions, the work of marginally situated scholar-activists demonstrates that (bio)psychosocial dominance cannot be fully explained through a mainstream lens of “bad science” and Kuhnian revolutions. These scholars contend that psychosocial ascendancy can additionally be understood through the interests of a network of alliances concerning the state, psy, and corporate realms (most notably the disability insurance industry), culturally invalidating intersectional representations, and an overarching climate of neoliberal welfare retrenchment (Jolly, 2012; Jones, 2016; Kennedy, 2012; Stewart, 2019; 2016; Thorburn, 2012; Wendell, 1996). A notable scholar in this regard is the late Angela Kennedy.

Kennedy was a sociologist and mother to a daughter who lives with ME/CFS; although having lectured within the academy, Kennedy’s work has been heavily sidelined within dominant academic accounts of ME/CFS. In 2012, Kennedy published a detailed critique of the biopsychosocial approach to ME/CFS (Kennedy, 2012),

which arguably represents one of the most comprehensive and epistemologically diverse accounts of (bio)psychosocial hegemony in the field of ME/CFS. This account focuses on what might be termed “bad science”: ethical and methodological flaws within research, logical fallacies and lack of evidential support vis-à-vis cognitive-behavioural and (bio)psychosocial theories, alongside medical harms sustained by people with ME/CFS. In this respect, Kennedy’s work precedes and parallels many of the now dominant academic accounts (e.g., see Geraghty, 2020; Geraghty and Esmail, 2016). However, recognising the value of feminist knowledges, Kennedy additionally explores the wider socio-cultural and political picture, including a detailed exploration of gendered narratives pertaining to hysteria and a brief account of welfare reform politics. Kennedy’s work on hysteria has been expanded by feminist scholars in the related and wider arena of “medically unexplained symptoms” (O’Leary, 2018), whilst her politically-informed critique has been developed by disabled activist-scholars, on which more later.

2.1 Intersectional “hystories”

Kennedy’s work offers a brief history of ME/CFS, complemented through the work of Canadian feminist disability studies scholar and person with ME/CFS, Susan Wendell (1996), and independent researcher Patrica de Wolfe (2009). Although viral outbreaks understood as ME can be traced back to at least the 1930s, the term ME came to prominence after a suspected viral outbreak at the Royal Free Hospital in London in 1955, which occasioned the term “Royal Free Disease” alongside “benign ME” (Kennedy, 2012; de Wolfe, 2009; Wendell, 1996). ME was recognised as a biomedical (neurological) condition by the World Health Organization in 1969; however, the Royal Free outbreak was later subjected to a psychiatric reconstruction as “mass hysteria”, with the reasoning that most of the patients affected were women (see also McEvedy and Beard, 1970). All three scholars situate this reconstruction within a historical and ongoing medico-social climate that is permeated with gendered, dis/abled power/knowledge relations (Kennedy, 2012; de Wolfe, 2009; Wendell, 1996). For example, Kennedy (2012) suggests that some psychosocial proponents used the observed female preponderance to justify the construction of ME/CFS as a form of maladaptive psychology, social deviance, and culturally sanctioned neurosis, drawing on narratives of neurasthenia and hysteria (also see O’Leary, 2018; Wessely, 1990). Kennedy’s (2012, 135) detailed analysis of clinical and social stereotyping of people with ME/CFS as “mad, bad and heartsink” points toward entanglements of disability and femininity constructed as “Other” (Goodley, 2017), thus highlighting intersectionality.

Intersectionality, with its roots in feminist-of-colour political activism and scholarship, delineates how systems of oppression (such as white supremacy) intersect with, structure and co-constitute other systems of oppression (e.g., neoliberal-capitalism), producing patterns of privilege/domination that cannot be fully captured in isolation or addition (e.g., see Crenshaw, 1989; Hill Collins, 1990). Since intersectionality emphasises how multiple axes of oppression or empowerment

contribute to an individual's unique positioning and experience, this approach can illuminate largely overlooked forms of oppression within the ME/CFS community. For example, the historical tendency to position ME/CFS as an affliction of white middle-class women, combined with under-representation of minoritised groups in ME/CFS research, may have restricted diagnosis and healthcare among racially, ethnically, and socio-economically marginalised people (see Ciurria, 2024; Gillberg, 2022; Hsu, 2024). Moreover, some research has observed greater prevalence and levels of physical impairment/disability among racially and economically oppressed persons with ME/CFS, with feminist scholarship positing such findings as an artefact of intersecting power systems such as racial-patriarchal-capitalism (Ciurria, 2020; 2024; see also Hunt, 2025). Finally, the historical conflation of ME/CFS with primary diagnoses of distress ("mental illness") has probably disproportionately impacted marginalised subgroups of this population, for example, racially oppressed, sexually marginalised and gender-non-conforming persons who are at greater risk of poor treatment within psychiatric services (see Gillberg, 2022; Hsu, 2024). Intersectionality thus reveals a government of disability that impacts differentially along the lines of interlocking socio-structural inequities. Certainly, whilst some patient organisations have claimed that ME/CFS does not discriminate on grounds of race, class, gender, and so forth (e.g., Action for ME, 2019; ME Association, 2022), research led by disabled scholars espousing an intersectional lens is not fully consistent with those claims (Ciurria, 2024; Hsu, 2024; Evans et al., 2023; Hunt et al., 2024).

Subjugated knowledges also demonstrate how power struggles over the nomenclature of ME/CFS play out within intersectional knowledge hierarchies. Kennedy (2012) notes how the term CFS was popularised by (intersectionally privileged) health bodies in the US during the late 1980s, and that this term was preferred among UK psychosocial proponents, chiefly multiply privileged psychiatrists. Kennedy (2012) also recounts how the term ME, and recognition of accompanying biomedical research, has been discouraged and downplayed by UK psychiatrists (see also Bassett, 2009). For example, psychiatrist Simon Wessely has suggested that ME – like the gendered, disabled, racialised, sexualised, and classed construct of neurasthenia – may be a way of seeking medical and cultural legitimacy for an inability to cope with modern life (Wessely, 1990). Relatedly, and consonant with Foucauldian thought (Foucault, 1980), Kennedy's work points toward how power and knowledge can become entwined through largely unevidenced truth claims and how individual and collective bodies become sites of power struggles and social control. A particularly striking example of this can be found in activist research examining the influence of UK academics on UK state officials vis-à-vis the long-term clinical and social representation of ME/CFS, to which I now turn.

Marginally situated researchers have drawn attention to the academic petitioning of UK Department of Work and Pensions officials on the clinical status of ME/CFS, most evidently during the early 1990s (Faulkner, 2016; Jones, 2016). These academic–state exchanges can be evidenced through UK National Archive data, which were redacted by the UK government, before being released under the

Freedom of Information Act by UK barrister and woman with ME/CFS Valerie Eliot Smith (Eliot Smith, 2015). The principal government interlocutor in these exchanges was the late Mansel Aylward, a civil service medical doctor whose role in (bio) psychosocial hegemony will later become clear. My own critique of these data (Hunt, 2024b) suggest that academic–state exchanges represent how “truth” is entwined with power relations: that power determines what can be legitimately known and by whom, whilst knowledge (especially knowledge that begets the status of truth) induces effects of power through constituting norms, conduct, and subjectivities. More specifically, data demonstrate that dominantly situated knowledge producers, including UK neurologist P. K. Thomas and psychiatrists Simon Wessely and Peter White (see McGrath, 1993; Wessely, 1993; White, 1993), appealed to scientific “evidence” and implicit or explicit tropes of hysteria and neurasthenia in persuading the UK government that ME/CFS (under the nomenclature “CFS”) should be positioned within health and social policy as perpetuated by maladaptive psychology. Positioning ME/CFS in this manner would facilitate its exemption from both state benefits and private income protection claims.

Whilst the “problem” of ME/CFS – like hysteria and neurasthenia – is gendered, dis/abled, sexualised, classed, and racialised, so too is the proposed “solution”: cognitive-behavioural therapies, which celebrate imperialist ideals such as rationality, activity-productivity, independence, and self-control, are advocated as routes to “recovery” (intersectionally privileged notions of productivity and normalcy). Additionally, and echoing Kennedy’s arguments, detailed analysis of academic petitioning suggests that truth claims proffered by psychosocial proponents were not well supported by contemporaneous scientific literature, despite frequent appeals to “evidence” and “expertise” (Hunt, 2024b). Finally, and again consonant with the thrust of Kennedy’s work, UK National Archive data reveal that psychosocial truth claims were privileged over knowledges positioned further down the power/knowledge hierarchy: the UK government decided to follow academic advice in positioning “CFS” as primarily psychosomatic and thus “recoverable” in official social policy documentation, contrary to the testimonies of many people with ME/CFS (see Hunt, 2024b).

The discussion thus far suggests that biopsychosocial hegemony is grounded in culturally oppressive intersecting power relations; however, analyses of National Archive data demonstrate other influences within the government of disability in the ME/CFS arena. These influences, described elsewhere as the psy-corporate-state complex (Hunt, 2023), implicate actors and structures associated with disability-related income protection schemes, state social security systems, the clinical rehabilitation arena (notably psychiatry), media, and scientific publishing. This complex has been illuminated through research produced by disabled activist-scholars, whose work uncovers the wider socio-economic climate driving (bio)psychosocial hegemony. It is to these epistemic labours that I now turn.

2.2 Socio-economic antecedents

Disabled activist-scholar and former National Health Service health professional Mo Stewart, and disabled activist-scholar and disability consultant Ellen Clifford, have

each produced a considerable body of research that greatly assists in tracing the genealogy of (bio)psychosocial hegemony in its socio-economic and political context, with direct relevance to ME/CFS (Clifford, 2020; Stewart, 2019; 2016). This work can be complemented through the research of disabled activists and independent scholars such as Kitty Jones, Gill Thorburn, George Berger, George Faulkner, and Rosa Morris alongside the late Debbie Jolly, co-founder of UK-based organisation Disabled People Against Cuts (Berger, 2014; Faulkner, 2016; Jolly, 2012; Jones, 2016; Morris, 2018; Thorburn, 2012).

Stewart locates the antecedents of biopsychosocial governing in UK politician and former prime minister Margaret Thatcher's neoliberal-capitalist administration and her close relationship with then US president Reagan, more specifically Thatcher's desire to privatise public services and remove social protections, with a view to replacing the UK's healthcare and welfare systems with a US-style system of private health and income protection insurance (Stewart, 2016; 2019). Relatedly, Stewart recounts how the UK government sought to curb increasing claims for sickness benefits (Invalidity Benefit and its successor, Incapacity Benefit) from the late 1970s onwards. In this regard, both Stewart and Clifford detail numerous technologies of disciplinary power: increasingly strict and arduous assessments, training and work programmes, alongside increased conditionality, sanctions and surveillance that seek to attach disabled people to the labour market regardless of their capacity to work and the quality of available work (Stewart, 2016; Clifford, 2020). Of particular relevance to ME/CFS, and drawing on Rutherford (2007), Stewart also notes concerns from within the income protection insurance industry from the 1980s onwards, where rising interest rates combined with increasing claims from people with "subjective" health conditions (conditions lacking diagnostic biomarkers such as ME/CFS) threatened profits. These coinciding trends created an opportunity for state-corporate alliances to form.

Charting the evolution of these state-corporate alliances, Stewart (2016) recounts how the UK government drew support internally from the UK medical civil service, where the late Mansel Aylward would play a central role, and externally from the US disability insurance (income protection insurance) industry, recruiting Unum (then, UnumProvident) executive John LoCascio to advise John Major's Conservative administration in the early 1990s (see also Morris, 2018; Rutherford, 2007). The ethically problematic activities of Unum are beyond the scope of this article but have been widely captured in activist-scholar literature (e.g., Stewart, 2019; Cross, 2013). Nevertheless, this union of corporate, state and clinical realms – with input from the psy disciplines – would result in an individualistic, psychologising approach to "disability assessment medicine", described by Aylward as "the speciality concerned with the assessment of people with disabilities that provides impartial medical advice and reports for decision makers in the United Kingdom" (Aylward, 2003, 287). Marking a step toward this variant of disability assessment medicine, Aylward and LoCascio (1995) created the All Work Test assessment (to determine eligibility for Incapacity Benefit) under Major's administration in 1995.

The assessment curtailed the authority of family doctors and patient expertise-by-experience in favour of UK government-appointed assessors (“disability analysts”), whilst emphasising the alleged role of psychology in long-term “sickness”. Importantly, and subsequent to the above-mentioned psy-mediated petitioning of Aylward and other UK government officials, CFS was cited by Aylward and LoCascio (1995) as an example of individual psychology posing a barrier to “recovery”. Despite the more stringent provisions of the All Work Test, Incapacity Benefit claims – notably from people living with psycho-emotional distress (“mental health problems”) – continued to rise, and more active and conditional technologies of disciplinary power ensued.

In 1998, the New Labour government implemented their “New Deal” (Welfare-to-Work) scheme, a set of social policy reforms inspired by US workfare policies, galvanising a shift toward a highly conditional UK welfare system (Stewart, 2016; Daguerre, 2004; Jolly, 2003). Benefits receipt became increasingly conditional on participation in various work-related activities: encouragement of direct employment sought to reduce the welfare bill whilst a disciplinary apparatus of government-appointed assessors, employment advisors, work-focused interviews and compulsory training would help regulate the flow of human capital and turn the welfare state into a source of profit (Rutherford, 2007; Clifford, 2020; Morris, 2018). Applying a historical-materialist analysis of disability, Morris (2018) and Clifford (2020) argue that such reforms are underpinned by a neoliberal-capitalist mode of production that positions people who experience difficulty selling their labour power as a socio-economic problem whilst exploiting this “problem” in the service of “disciplining both unemployed labour and the existing workforce” (Clifford, 2020, 224). More specifically, both Morris and Clifford apply the Marxist concept of the reserve army of labour to explain how disabled people have become central to controlling the labour supply and wage inflation in capitalist societies. This reserve pool of labour allows disabled people to be enlisted and disposed from waged labour as per the interests of the market whilst exerting downward pressure on wages and permitting exploitative work conditions (see also Ciurria, 2024). In bringing an intersectional lens to bear on this analysis, and recalling Ciurria’s (2020) invocation of racial-patriarchal-capitalism, other feminist scholarship has highlighted the heavily gendered, classed, and racialised nature of the reserve army (Erevelles, 2011).

A historical-materialist perspective points toward a political need for a fluid administrative category of disability or a splitting of the category of disability that maps approximately onto deserving/undeserving (disabled/not really disabled) rhetoric (Morris, 2018; see also Soldatic, 2020; Ciurria, 2024). To some degree, this need has been achieved through “an intensification of the rhetoric about who ‘deserves’ to receive such benefits” (Morris, 2018, 3) as clearly evidenced in media and government discourse (Stewart, 2016; Mills and Pring, 2024). Additionally, and remembering the function of the reserve army, it has been suggested that a “partially disabled subject” represents “a highly valued commodity of exchange” (Soldatic, 2020, 238) in ambiguiting the category of disability and allowing disabled people to be enlisted

and discarded, as per labour market fluctuations. However, whilst the government of disability in the ME/CFS space can be partially understood through this lens, it does not account for the role of the psy disciplines and their intersectionally oppressive power/knowledge regimes in cementing ME/CFS within the social imagination as “undeserving”. In this regard, a 2001 gathering near Oxford in the UK points toward a bigger picture.

Funded by the UK Department of Work and Pensions, the Woodstock meeting has been described as catalysing the “transformation of the welfare system” (Rutherford, 2007, 38), arguably employing ME/CFS as its template. The meeting was attended by psychiatrists and ME/CFS researchers Simon Wessely, Michael Sharpe, and Peter White, together with Mansel Aylward, John LoCascio, and other psy-corporate-state actors. By this timepoint, Aylward was Chief Medical Advisor, Medical Director, and Chief Scientist at the UK Department of Work and Pensions. The proceedings of this gathering are reflected in a publication co-authored and inspired by its attendees (Halligan et al., 2003). As captured by Stewart (2016), Aylward set the parameters for a new approach to disability assessment medicine during the meeting, by emphasising the need to better consider the (unevidenced yet repeatedly asserted) “subject’s choice and intent” in allegedly perpetuating impairment or, as Aylward termed it, “inappropriate illness behaviours” (Aylward, 2003, 297).

Of pertinence to this genealogical account, Aylward and his Woodstock affiliates focused upon what would later be described as “common health problems”: alleged subjective health complaints, including mental health and musculoskeletal conditions, and with particular emphasis upon so-called medically unexplained symptoms which represent a long-standing interest of Wessely, White, and Sharpe (see Faulkner, 2016; Thorburn, 2012). Whilst the biomedical model was considered inadequate for understanding the rise in benefits claims among people with these conditions, dominant applications of the biopsychosocial model were also problematised for insufficiently capturing “freewill” (alleged conscious choice and intent) in perpetuating impairment (Aylward, 2003; see also Stewart, 2016; Morris, 2018). In this regard, a biopsychosocial approach to back pain, as put forward by Woodstock attendee and surgeon the late Gordon Waddell, was positioned as a promising candidate (Waddell, 1998; see also Halligan et al., 2003). Additionally, to bolster the motif of impairment/disability as a self-imposed or self-serving phenomenon, the constructs of hysteria and neurasthenia were repeatedly invoked, with Aylward following psy’s lead in comparing “chronic fatigue” to neurasthenia (Aylward, 1998; see also Halligan et al., 2003). This nascent discourse foreshadows the emergence of the Waddell-Aylward biopsychosocial model as now governs ME/CFS and the wider disability space: not only a primarily psychological or psychosocial model of impairment, but also a neoliberal-ableist, individualistic, responsabilising, and intersectionally oppressive account of maladaptive psychology and social deviance (Hunt, 2025). This emergent psy-corporate-state mediated regime of truth gained material expression through the 2006 Reform bill and 2007 UK Reform Act.

As detailed by Stewart (2016), the 2007 reform introduced sickness benefit Employment and Support Allowance (replacing Incapacity Benefit) and the eligibility-policing Work Capability Assessment (replacing the Personal Capability Assessment in 2008). By this point, French company Atos, with various connections to Unum and psychosocial proponents, was conducting benefits assessments (Berger 2014; Stewart 2016; Clifford 2020). Stewart (2016) explains that the Work Capability Assessment was informed by a model applied by Unum to counter disability-related income protection claims, explicitly identified by Unum as “biopsychosocial”. Additionally, Stewart details how the Work Capability Assessment is a “functional” assessment, which disregards the claimant’s clinical history, diagnosis, and prognosis, further scales back the opinion of family doctors and disabled people’s testimony, and has as its sole focus what the claimant “can do” as per the opinion of government-appointed assessors (Stewart, 2016). Clifford (2020) suggests this downgrading of particular knowledges (including disabled expertise-by-experience) might explain the high rates of rejections overturned at appeal, when disabled people and those directly involved in their support are heeded. Nevertheless, not all rejected claims reach appeal, with many disabled activists and allied academics detailing how increasingly active, conditional, and compulsory technologies of disciplinary power have been associated with enormous psychological distress, destitution, and suicides amongst disabled people (e.g., Clifford, 2020; Mills and Pring, 2024; Stewart, 2016). The changes heralded by the 2007 Act thus served to further increase the suffering of disabled people whilst also increasing the power and reach of what disabled activist-scholar Gill Thorburn (2012) calls the “biopsychosocial lobby”. The alliances and interests comprising this lobby are further evidenced in the work of the UnumProvident Centre for Psychosocial and Disability Research at Cardiff University.

2.3 The Cardiff connection

The Cardiff research centre, established in 2004 and for some time sponsored by UnumProvident, was directed by Aylward, with fellow Woodstock attendees Gordon Waddell and Peter Halligan as honorary professor and associate director respectively (see Stewart, 2016; Rutherford, 2007). Accordingly, the centre’s work reinforced and extended truth claims produced at Woodstock, drawing heavily on Waddell’s biopsychosocial approach to chronic back pain and extending this to all impairment positioned as “subjective”, including ME/CFS (Berger 2014; Rutherford, 2007; Thorburn, 2012). Waddell promoted truth claims that long-term impairment associated with back pain was perpetuated by (individualistic) psycho-socio-cultural factors: avoidance of activity creating anxiety and physiological deconditioning, unhelpful cognitions about prognosis, the “gains” of the sick role (including disability benefits), and overindulgent, collusive healthcare professionals (Waddell, 1998). Waddell also believed that recovery (measured largely by return to work) could be effectuated by cognitive-behavioural approaches and “active rehabilitation”, thus strongly aligning with the psychiatric position on ME/CFS. Waddell’s work, further

integrated into output from further psy-corporate state gatherings (e.g., Halligan and Aylward, 2006; White, 2005) became the template for various government-commissioned monographs issuing from the Cardiff centre (see Thorburn, 2012). Among these monographs, “The Scientific and Conceptual Basis of Incapacity Benefits” (Waddell and Aylward, 2005) specifically acknowledges the contributions of Wessely and White. This publication has been said to provide the intellectual foundation for the 2006 Reform bill and 2007 Reform Act, thus radically changing the socio-political landscape for people with ME/CFS and wider disabled communities (Rutherford, 2007). As Jolly (2012) suggests, the Cardiff centre lent “academic credibility” to a psy-corporate-state produced psychosocial regime of truth, ostensibly justifying increasingly draconian reforms with appeals to the (purported but lacking) scientific evidence that work is unequivocally good for health. Central to this regime of truth, and building on Woodstock truth claims, was the construct of common health problems.

Thorburn (2012) and Morris (2018) detail how the construct of common health problems was discursively constituted by Cardiff associates to cement what had become a victim-blaming narrative of disability. Echoing the Woodstock proceedings, common health problems are said to include mental health, musculoskeletal, and cardiorespiratory conditions that are largely subjective phenomena and are heavily entwined with individualistic psychosocial factors such as poor attitude, maladaptive illness behaviours, and collusion with others to remain in the sick role. Once again, “conscious choice, motivation and effort” (Waddell and Aylward, 2010, 21) are held to be central in perpetuating disability, where disability is conceptualised as per the medical model. Common health problems are said to be responsible for the increasing rates of sickness benefit claims and disproportionate use of biomedical healthcare resources, thus positioning this group of disabled people as an economic problem (see also Shakespeare et al., 2017). Moreover, people with common health problems, within which group women are said to be disproportionately represented, are ascribed a similar level and form of impairment as that “experienced at times by most adults of working age” (Waddell and Aylward, 2010, 6). This promotes an “inability to cope with the stresses of everyday life” narrative which, reinforced through inferences to social deviance and moral deficiency, is evocative of neurasthenia (see Wessely, 1990). Accordingly, and echoing psychiatric discourse on ME/CFS, cognitive-behavioural technologies are promoted within the Cardiff centre’s output as a route to recovery, with CFS explicitly mentioned among common health problems, notably as a “mental health problem” (see Waddell and Burton, 2004). It could be argued that the construct of common health problems and associated discourse offered a means to designate a group of “not really disabled” people, thus creating a deserving/undeserving hierarchy and an ostensible justification for removing social protections from the undeserving (Morris, 2018; also see Thorburn, 2012; Shakespeare et al., 2017; Soldatic, 2020). ME/CFS was thus cemented as undeserving within social policy landscapes.

The striking convergence between the Cardiff centre’s discourse on common health problems and psychiatry’s psychosocial discourse on ME/CFS has been

detailed elsewhere and noted as an inevitable artefact of the psy-corporate-state complex of alliances (Hunt, 2024a). The concept of a psy-corporate-state complex, drawing from a wealth of work on the psy-complex (Miller and Rose, 1994; Rose, 1998), recognises how psy-mediated power/knowledge relations constitute particular “problems” positioned as manageable through their own “expert” regimes, notably by transforming at the level of subjectivity. Acting on others to transform their personhoods has been argued to be the most potent and profound means of governing life (Miller and Rose, 1994). I therefore now turn to a more detailed examination of psy’s role in producing a psychosocial regime of truth and facilitating the biopolitical governance of ME/CFS.

2.4 The Psy(-Corporate-State) Complex

Both Kennedy (2012) and Faulkner (2016) trace antecedents of the psychosocial government of ME/CFS to academic papers written by psy actors in the late 1980s (e.g., Wessely et al., 1989). These papers contain embryonic constructions of ME/CFS as both a biopolitical problem and the proposed solution: CFS (as is the preferred psychiatric term) is positioned as a potential economic drain, a possible cultural phenomenon (with implicit narratives of neurasthenia), and a fertile ground for psychosocial rehabilitative interventions (see Faulkner, 2016; Kennedy, 2012). Relatedly, and again as noted by activist-scholars, some psychiatrists in the ME/CFS arena have supported conditionality, with Wessely et al. (1989) arguing that patients should be expected to comply with treatment before being classified as disabled (Faulkner, 2016). The above account of Woodstock and the Cardiff centre’s activities demonstrates how this emergent neoliberal-ableist governmentality – the constitution of a socio-economic “problem” to be managed through psy knowledge regimes – has infiltrated state and corporate realms. Additionally, such governmentality has been crudely imported into these realms through UK psychiatrists providing consultancy for the UK government and for (re)insurance companies with a view to determining the occupational health dimensions of ME/CFS and the implications for benefits and income protection claims (Bassett, 2009; Jones, 2016).

The truth and power effects of these alliances have become woven into the fabric of clinical research and practice, gradually transforming subjectivities. For example, UK national clinical guidelines on ME/CFS, for almost 15 years promoting cognitive-behavioural interventions as route to recovery, were partially informed by the Cardiff centre’s research on the importance of work and health (see Hunt, 2022). Clinical communities thus unwittingly internalised psychosocial truth claims, reproducing them through practice and research. Moreover, the UK PACE trial (White et al., 2011), critiqued in detail by Kennedy and others (e.g., Kennedy, 2012; Marks, 2017), can be considered a product of psy-corporate-state alliances and a microcosm of macro-economic policies. The trial, part-funded by the UK Department of Work and Pensions, with Aylward’s assistance, and with aforementioned UK psychiatrists among the principal investigators and wider management, claimed to demonstrate that cognitive-behavioural and graded exercise therapy were moderately effective in

“treating” ME/CFS. However, ethical and methodological flaws in the trial design were identified (Kennedy, 2012; Marks, 2017), whilst reanalyses of trial data suggested that improvement and recovery rates had been overinflated (Wilshire et al., 2018). Nevertheless, the trial was heralded a success by much of the UK press (Faulkner, 2016), signalling complicity in mainstream knowledge-producing spheres.

Subjugated knowledges reveal numerous examples of complicity in reinforcing (bio)psychosocial hegemony, most notably from within the media and scientific publishing arena. In this regard, such complicity could be understood as an extension of the “corporate” component of the psy-corporate-state complex, although psy involvement has been evidenced. As Kennedy details, newspapers have contributed to the narrative that people with ME/CFS lack insight into the purported psychological perpetrators of their suffering, and respond to any suggestion of psychological aetiology or maintenance in a “militant”, “fundamentalist”, and even “violent” manner, thus invoking the trope of hysteria through implication of irrational, unpredictable and unruly body/minds (Kennedy, 2012; see also de Wolfe, 2009). A similar, albeit more subtle, dynamic can be observed within scientific publishing, where hysteria narratives have been invoked (de Wolfe, 2009), whilst some scientific journals have declined to retract or correct studies problematised by people with ME/CFS and allies (Faulkner, 2016). Some psy actors and psychosocial proponents have occupied influential positions in high-ranking journals, whilst Simon Wessely has served as scientific advisor for the UK Science Media Centre, which provides the UK media with science-related briefings (see Faulkner, 2016).

The psy complex, strengthened by corporate-state complicity, has thus constituted ME/CFS as socio-economic, biopolitical “problem”, constituted the (deviant, undeserving) subjectivities of those allegedly posing the problem, and constructed a solution in the guise of normalising technologies, all of which reinforces a psycho-centric, neoliberal-capitalist-ableist regime of truth. Here, Foucault’s understanding of discourse as “practices that systematically form the objects of which they speak” (Foucault, 1972, p.49) is evident. Disability as per the social model is reconstituted as a myth, whilst impairment (and disability understood as an individualistic phenomenon) is reconstituted as self-imposed social deviance and dysfunctional individual psychology. Equally evident is the feminist disability concept of the government of disability (Tremain, 2001; 2015), produced through a vast apparatus (coalescing around a psy-corporate-state complex), which constitutes impairment and shapes disabled subjectivities for its own ends. The government of disability in the ME/CFS arena highlights how discourse produces very “real” (material) power/knowledge effects in terms of discriminatory policy, practice, and its impact upon disabled bodies (disablism), and in terms of normalising rationalities that feed such discrimination (ableism). Before bringing this history of the present to a close, it is important to acknowledge that the power effects of the government of ME/CFS not only persist at time of writing but also infiltrate the wider disabled community.

3. Ongoing Government of Subjectivities

The government of disability as inflicted upon people with ME/CFS has continued to gain traction with the global financial crisis of 2008, subsequent austerity measures as introduced by the UK coalition cabinet, and increasingly draconian workfare schemes implemented by successive administrations (see Clifford, 2020). The Waddell-Aylward biopsychosocial model persists, directly or indirectly, in driving increasingly conditional and punitive social policies, for example, informing stringent assessments for the disability benefit Personal Independence Payment, which replaced Disability Living Allowance as per the provisions of the 2012 Welfare Reform Act (Cross, 2013). Moreover, the construct of common health problems can still be discerned in contemporary UK government policy, arguably associated with attempts to subsume long Covid into a (bio)psychosocial regime of truth (Hunt, 2024c). This extension of biopolitical governance to long Covid is perhaps unsurprising given the condition's defiance of neoliberal-ableist, imperialist norms and "values", its inheritance of oppressive truth claims vis-à-vis ME/CFS as a post-infection condition, and long Covid's disproportionate impact upon women – and upon other historically oppressed groups (Cohen and van der Meulen Rodgers, 2023; see also Gillberg, 2022; Hsu, 2024). Relatedly, recent work by disabled researchers suggests that similar forms of government apply to a wider disability sphere pertaining to "energy-limiting conditions" (Evans et al., 2023; Hale et al., 2020). The concept of energy-limiting conditions delineate chronic illnesses, including but not limited to ME/CFS and long Covid, that share energy limitations (conceptualised as energy impairment) as a central experience and foundation for disablism and ableism (dis/ableism), most evidently in the form of social and clinical disbelief and dismissal. Such dis/ableism, entwining with other forms of discrimination and oppressive social orders, can be traced back to power relations, structures, and complexes as mapped out within this article.

Finally, it is noteworthy that the government of disability – in ostensible contrast to psy-corporate-state appeals to scientific objectivity – is a profoundly affective endeavour. As Stewart (2016) recognises, disabled people are increasingly governed by fear: threat of ever-increasing surveillance, hostile media, and dismissive government rhetoric, including an over-exaggeration of the "problem" of benefit fraud (also see Clifford, 2020; Garthwaite, 2014). Such rhetoric, which has been theorised as inducing disgust among non-disabled publics and shame among disabled communities (Soldatic, 2020), persists despite the United Nations finding the UK culpable of grave and systematic violations of disabled people's rights through its austerity policies (see Pring, 2024). As already discussed, government of subjectivities also proceeds through injecting the administrative category of disability and the concept of impairment with uncertainty and exploiting that uncertainty in the interests of capital (Jolly, 2003; Morris, 2018; Soldatic, 2020). Technologies of disciplinary power implicated in the government of disability thus act as both "validating devices" (Stone quoted in Morris, 2018, 5) – determining who is positioned as disabled and deemed deserving of social protections – and dividing practices – categorising and

othering on grounds of purported difference (see Foucault, 1977; 1978; 1982). The impact of this affective governance is clearly evidenced in the subjectivities of the ME/CFS and wider disabled communities: anxiety, self-doubt, decreased self-esteem, and identity disruption are widely reported among those subjected to these regimes of truth (e.g., see Gillberg, 2022; Hale et al., 2020; Evans et al., 2023). The Foucauldian assertion that government and subjectivity are tightly tied and that history imprints onto body/minds (Foucault, 1984; Galvin, 2006), is evidenced here.

4. Conclusion

This article has sought to offer a “history of the present” of the government of ME/CFS, drawing on epistemic contributions of disabled activists and other marginally situated knowers, further theorised through the lens of feminist disability studies and Foucauldian thought. Dominant social constructions of ME/CFS reflect and reinforce historically contingent socio-cultural and biopolitical trends: neoliberal-ableist governmentality prioritising the market and private interests, entwined with intersectionally oppressive cultural constructions of the idealised citizen-subject in the Global North, resulting in systematic invalidation and marginalisation of the Other. More specifically, subjugated knowledges suggest that ME/CFS was used as a template for reconstructing disabled people into “undeserving” (psychologically maladaptive, socially and morally deviant) would-be citizens, to be normalised via individualistic psychosocial, cognitive-behavioural technologies of disciplinary power, thus transforming socio-economic “problems” into regulators of capital. Consistent with a feminist standpoint, I hope to have offered a more holistic understanding of the government of ME/CFS than that gleaned from “the” scientific method alone. In particular, by starting my account from marginalised lives rather than mainstream academic accounts of ME/CFS, some light has been shed on “the social mechanisms through which power relations are made to appear obviously natural and necessary” (Harding, 1992, 584).

This article has sought to reveal “the effects of the power of a discourse that is considered to be scientific” (Foucault, 1980, 84) where this discourse is tied to the Waddell-Aylward (bio)psychosocial model and UK government work and health directives. This discourse is in fact heavily value-laden, constituting impairment as lifestyle choice, a form of moral failure and social deviance for which disabled people allegedly refuse to take responsibility, and constructing disability (understood as social oppression) as a myth. Nevertheless, the process of deconstruction undertaken in this article gives rise to the possibility of alternative (re)constructions and “counter-rationalities” (Beckett and Campbell, 2015, 273; Foucault, 1980). Similarly, whilst the government of disability shapes subjectivities (Tremain, 2015), there is also a role for agency, whilst resistance represents an effect of power (Meekosha and Shuttleworth, 2009; Foucault, 1978; 1980; Beckett and Campbell, 2015). Therefore, I hope that this article will inspire discussion among researchers, policymakers, and healthcare practitioners, importantly in co-production with disabled communities, as to how a post-(bio)psychosocial policy landscape might be envisaged. In Foucauldian terms, “as

soon as one can no longer think things as one formerly thought them, transformation becomes both very urgent, very difficult, and quite possible” (Foucault, quoted in Galvin, 2006, 509). I believe that subjugated knowledges, as platformed within this article, can play an important role in this transformation.

REFERENCES

- Action for ME. (2019). “Misconception: M.E./CFS only effects adults. Truth: #MECFS does not discriminate. It can affect anyone - of any age, of any gender, of any race. It’s hard to put an accurate number on just how many young people have M.E.; prevalence rates vary widely, up to as high as 3%.” Twitter (now X) 14 August. <https://x.com/actionforme/status/1161602298092695553>
- Aylward, M. (1998). Chronic fatigue and its syndromes: Historical perspectives. Proceedings of the 12th International Congress London 5-6 June. <https://www.eumass.eu/wp-content/uploads/2016/09/1998-Londonabstractbook.pdf>
- Aylward, M. (2003). Origins, practice, and limitations of disability assessment medicine. In P. Halligan, C. Bass, and D. A. Oakley (Eds.), *Malingering and illness deception* (pp. 287–300). Oxford: Oxford University Press.
- Aylward, M. and Locascio, J. J. (1995). Problems in the assessment of psychosomatic conditions in social security benefits and related commercial schemes. *Journal of Psychosomatic Research*, 39(6), 755–765. [https://doi.org/10.1016/0022-3999\(95\)00037J](https://doi.org/10.1016/0022-3999(95)00037J)
- Bassett, J. (2009). Who benefits from “CFS” and “ME/CFS”? *The Hummingbirds’ Foundation for ME*. <https://web.archive.org/web/20170703175349/http://www.hfme.org/whobenefitsfromcfs.htm>
- Bê, A. (2020). Feminism and disability: A cartography of multiplicity. In N. Watson and S. Vehmas (Eds.), *Routledge handbook of disability studies* (2nd edition, pp. 421–435). New York: Routledge.
- Beckett, A. E. and Campbell, T. (2015). The social model of disability as an oppositional device. *Disability & Society*, 30(2), 270–283. <https://doi.org/10.1080/09687599.2014.999912>
- Berger, G. (2014). Gordon Waddell’s biopsychosocial attack on disabled people. *Disabled People Against Cuts (DPAC)*, 24 September. <https://dpac.uk.net/2014/09/gordon-waddells-biopsychosocial-attack-on-disabled-people/#:~:text=Gordon%20Waddell%E2%80%99s%20biopsychosocial%20attack%20on%20>
- Ciurria, M. (2020). Capitalism and chronic fatigue. *Biopolitical philosophy* (blog). 18 December. <https://biopoliticalphilosophy.com/2020/12/18/capitalism-and-chronic-fatigue-guest-post-by-michelle-ciurria/>
- Ciurria, M. (2024). Disability, ableism, class, and chronic fatigue. In S. Tremain (Ed.), *The Bloomsbury guide to philosophy of disability* (pp. 293–331). London: Bloomsbury Academic.
- Clifford, E. (2020). *The war on disabled people: Capitalism, welfare and the making of a human catastrophe*. London: Ze Books.
- Cohen, J. and van der Meulen Rodgers, Y. (2023). An intersectional analysis of long COVID prevalence. *International Journal for Equity in Health*, 22(1), Article 261. <https://doi.org/10.1186/s12939-023-02072-5>
- Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: a Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1989(8), 139–167
- Cross, M. (2013). Demonised, impoverished and now forced into isolation: The fate of disabled people under austerity. *Disability & Society*, 28(5), 719–723. <https://doi.org/10.1080/09687599.2013.808087>
- Daguerrre, A. (2004). Importing workfare: Policy transfer of social and labour market policies from the USA to Britain under New Labour. *Social Policy & Administration*, 38(1), 41–56. <https://doi.org/10.1111/j.1467-9515.2004.00375.x>

- De Wolfe, P. (2009). ME: The rise and fall of a media sensation. *Medical Sociology Online*, 4(1), 2–13
- Eliot Smith, V. (2015). The Secret Files Unwrapped: Part I – The importance of fair and accurate records. *Law and Health: Due process and civil society*, 20 January. <https://valerieeliotsmith.com/2015/01/20/the-secret-files-unwrapped-part-i-the-importance-of-fair-and-accurate-records/>
- Engel, G. L. 1977. The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286), 129–136. <https://doi.org/10.1126/science.847460>
- Erevelles, N. (2011). *Disability and difference in global contexts: Enabling a transformative body politic*. New York: Palgrave Macmillan.
- Evans, B., Allam, A., Hale, C., Bê Pereira, A., Rose, M. and Ruddock, A. (2023). *Gendered experiences of healthcare for people with energy limiting conditions*. Retrieved from <https://disbeliefdisregard.uk/wp-content/uploads/2023/09/ELC-Report.pdf>
- Faulkner, G. (2016). *“In the expectation of recovery”: Misleading medical research and welfare reform*. Sheffield: The Centre for Welfare Reform. Retrieved from <https://citizen-network.org/uploads/attachment/492/in-the-expectation-of-recovery.pdf>
- Foucault, M. (1972). *The archaeology of knowledge and the discourse on language*. New York: Pantheon Books.
- Foucault, M. (1977). *Discipline and punish: The birth of the prison* (Trans. A. Sheridan). New York: Random House.
- Foucault, M. (1978). *The history of sexuality volume I: An introduction*. New York: Random House.
- Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings 1972–1977*. New York: Vintage Books.
- Foucault, M. (1982). The Subject and Power. *Critical Inquiry*, 8(4), 777–795.
- Foucault, M. (1984). Nietzsche, genealogy, history. In: P. Rabinow (Ed.), *The Foucault reader* (pp. 76–100). New York: Pantheon.
- Galvin, R. (2006). A genealogy of the disabled identity in relation to work and sexuality. *Disability & Society*, 21(5), 499–512. <https://doi.org/10.1080/09687590600785969>
- Garthwaite, K. (2014). Fear of the brown envelope: Exploring welfare reform with long-term sickness benefits recipients. *Social Policy & Administration*, 48(7), 782–798. <https://doi.org/10.1111/spol.12049>
- Geraghty, K. (2020). The negative impact of the psychiatric model of chronic fatigue syndrome on doctors’ understanding and management of the illness. *Fatigue: Biomedicine, Health & Behavior*, 8(3), 167–180. <https://doi.org/10.1080/21641846.2020.1834295>
- Geraghty, K. (2022). A gentle reminder to @bengoldacre, who inspired me to with his work on trials, to challenge bad science, ME/CFS hasn’t gone away, the PACE trial stands in the Lancet and Ben said in 2013 talk to RCGPs, withholding trial evidence is “research misconduct” - why did PACE get a pass. Twitter (now X), 26 April. <https://x.com/keithgeraghty/status/1518835984510734337>
- Geraghty, K. J. and Esmail, A. (2016). Chronic fatigue syndrome: Is the biopsychosocial model responsible for patient dissatisfaction and harm? *British Journal of General Practice*, 66(649), 437–438. <https://doi.org/10.3399/bjgp16X686473>
- Gillberg, C. (2022). Jane Addams’s pragmatist feminist thoughts and actions for and with ill and disabled women. In P. M. Shields, M. Hamington and J. Soeters (Eds.), *The Oxford Handbook of Jane Addams* (pp. 603–624). Oxford: Oxford University Press.
- Goodley, D. (2017). *Disability studies: An interdisciplinary introduction* (2nd edition). Thousand Oaks, CA: Sage.
- Goodley, D., Lawthom, R., Liddiard, K., and Runswick-Cole, K. (2021). Key concerns for critical disability studies. *The International Journal of Disability and Social Justice*, 1(1), 27–49.
- Hale, C., Benstead, S., Lyus, J., Odell, E., and Ruddock, A. (2020). *Energy impairment and disability inclusion: Towards an advocacy movement for energy limiting chronic illness*. The Centre for Welfare Reform. <https://chronicillnessinclusion.org.uk/wp-content/uploads/2021/04/energy-impairment-and-disability-inclusion.pdf>

- Halligan, P. and Aylward, M. (Eds.). (2006). *The power of belief: Psychological influence on illness, disability, and medicine*. Oxford: Oxford University Press.
- Halligan, P., Bass, C., and Oakley, D. A. (Eds.). (2003). *Malingering and illness deception*. Oxford: Oxford University Press.
- Harding, S. (1992). After the neutrality ideal: Science, politics, and “strong objectivity”. *Social Research*, 59(3), 567–587.
- Hills Collins, P. (1990). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. New York: Routledge.
- Hsu, V. J. (2024). Framing the activists: gender, race, and rhetorical disability in contested illnesses. *Quarterly Journal of Speech*, 110(2), 198–220.
- Hughes, B., Lubet, S., and Tuller, D. (2023). Despite resistance, policy makers push the paradigm on ME/CFS and long COVID. *Health Affairs Forefront*. 14 September. <https://www.healthaffairs.org/content/forefront/despite-resistance-policy-makers-push-paradigm-me-cfs-and-long-covid>
- Hunt, J. (2022). *Biopsychosocial model or bio-political Ideology? Medically unexplained symptoms, welfare reform and the implications for Long-Covid*. Citizen Network Research. <https://citizen-network.org/library/biopsychosocial-model.html>
- Hunt, J. (2023). Biopolitics, disavowed disability and the psy (corporate-state) complex: Common health problems and cognate labels. *The Journal of Critical Psychology, Counselling and Psychotherapy*, 23(2), 6–16.
- Hunt, J. (2024a). Holistic or harmful? Examining socio-structural factors in the biopsychosocial model of chronic illness, ‘medically unexplained symptoms’ and disability. *Disability & Society*, 39(4), 1032–1061. <https://doi.org/10.1080/09687599.2022.2099250>
- Hunt, J. (2024b). On power and truth: The case of myalgic encephalomyelitis / chronic fatigue syndrome. *The Journal of Critical Psychology, Counselling and Psychotherapy*, 24(3), 7-18. https://egalitarianpublishing.com/JCPCP/2024/jcpcp2403_Hunt.html
- Hunt, J. (2024c). Inheriting discriminatory socio-political landscapes as ‘undeserving’ disabled people: The legacy of common health problems and the future for long COVID. *Critical Social Policy*, 44(3), 535-547. <https://doi.org/10.1177/02610183241229050>
- Hunt, J. (2025). Toward the emancipation of “medically unexplained” and energy-limiting conditions: Contesting and reimagining psy through the lens of feminist disability studies. *Feminism & Psychology*, 35(2), 187-205. <https://doi.org/10.1177/09593535241267091>
- Hunt, J., Runacres, J., Herron, D., & Sheffield, D. (2024). Exploring the experience of healthcare-related epistemic injustice among people with myalgic encephalomyelitis / chronic fatigue syndrome. *The Qualitative Report*, 29(4), 1125-1148. <https://doi.org/10.46743/2160-3715/2024.6519>
- Jolly, D. (2003). The government of disability: Economics and power in welfare and work. *Disability & Society*, 18(4), 509–522. <https://doi.org/10.1080/0968759032000081039>
- Jolly, D. (2012). A tale of two models: Disabled people vs Unum, Atos, government and disability charities. *Disabled People against Cuts*. 8 April. <http://dpac.uk.net/2012/04/a-tale-of-two-models-disabled-people-vs-unum-atos-government-and-disability-charities-debbie-jolly/>
- Jones, K. S. (2016). Rogue company Unum’s profiteering hand in the government’s work, health and disability green paper. *Politics and Insights*. 29 November. <https://politicsandinsights.org/2016/11/29/rogue-company-unum-had-a-profiteering-hand-in-the-governments-work-health-and-disability-green-paper/>
- Kennedy, A. (2012). *Authors of our own misfortune? The problems with psychogenic explanations for physical illnesses*. The Village Digital Press.
- Kreps, D. (Ed.). (2015). *Gramsci and Foucault: A reassessment*. London: Routledge.
- Maes, M. and Twisk, F. N. (2010). Chronic fatigue syndrome: Harvey and Wessely’s (bio)psychosocial model versus a bio(psychosocial) model based on inflammatory and oxidative and nitrosative stress pathways. *BMC Medicine*, 8(1), 35. <https://doi.org/10.1186/1741-7015-8-35>

- Marks, D. F. (2017). Special issue on the PACE trial. *Journal of Health Psychology*, 22(9), 1103–1105. <https://doi.org/10.1177/1359105317722370>
- McEvedy, C. P. and Beard, A. W. (1970). Royal Free epidemic of 1955: A reconsideration. *BMJ*, 1(5687), 7–11. <https://doi.org/10.1136/bmj.1.5687.7>
- McGrath, M. (1993). Chronic fatigue syndrome: Summary of the talk given by Professor P. K. Thomas CBE DSc MD FRCP and Dr S. Wessely BM BCh MRCP MRCPsych on 2.11.93. *The National Archives*. Ref BN 141/1 508554. Retrieved from <https://valerieeliotsmith.files.wordpress.com/2015/01/natarchbn141dss.pdf>
- ME Association. (2022). “ME/CFS is indiscriminate; affecting children, young people, and adults – irrespective of socio-economic background or ethnicity.” Facebook 18 October. <https://www.facebook.com/meassociation/posts/pfbid03PgErGPYLxdnyeTLbnzxERMhR3UddRRcDkQ7Qk1UoWWFF77H63ip6majyzxQMekFl>
- Meekosha, H. and Shuttleworth, R. (2009). What’s so “critical” about critical disability studies? *Australian Journal of Human Rights*, 15(1), 47–75. <https://doi.org/10.1080/1323238X.2009.11910861>
- Miller, P. and Rose, N. (1994). On therapeutic authority: Psychoanalytical expertise under advanced liberalism. *History of the Human Sciences*, 7(3), 29–64. <https://doi.org/10.1177/095269519400700302>
- Mills, C. and Pring, J. (2024). Weaponising time in the war on welfare: Slow violence and deaths of disabled people within the UK’s social security system. *Critical Social Policy*, 44(1), 129–149. <https://doi.org/10.1177/02610183231187588>
- Morris, R. K. S. (2018). *In/validating disability: changing labour markets and out of work disability benefits*. PhD thesis, University of Leeds.
- O’Leary, D. (2018). Why bioethics should be concerned with medically unexplained symptoms. *The American Journal of Bioethics*, 18(5), 6–15. <https://doi.org/10.1080/15265161.2018.1445312>
- Oliver, M. and Barnes, C. (2012). *The new politics of disablement*. Basingstoke: MacMillan.
- Putrino, D. (2024). The folks out there pushing Graded Exercise Therapy (GET) and Cognitive Behavioral Therapy (CBT) for infection-associated disease states like #LongCOVID, #MECFS and chronic #Lyme produce bad science and peddle harmful/dangerous rhetoric are truly deplorable, but what’s more, 1/. X, 5 April. <https://x.com/PutrinoLab/status/1776220311660159437>
- Pring, J. (2024). Seven years on and no progress on disability rights by UK government, says UN. *Disability News Service*, 25 April. <https://www.disabilitynewsservice.com/seven-years-on-and-no-progress-on-disability-rights-by-uk-government-says-un/>
- Rose, N. S. (1998). *Inventing our selves: Psychology, power, and personhood* (Revised). Cambridge: Cambridge University Press.
- Rutherford, J. (2007). New Labour, the market state, and the end of welfare. *Soundings*, 2007(36), 40–54.
- Shakespeare, T., Watson, N., and Alghaib, O. A. (2017). Blaming the victim, all over again: Waddell and Aylward’s biopsychosocial (BPS) model of disability. *Critical Social Policy*, 37(1), 22–41. <https://doi.org/10.1177/0261018316649120>
- Sharpe, M. (2002). Functional symptoms and syndromes: Recent developments. In: *UnumProvident: Trends in health and disability*, (pp. 14–21). Retrieved from <https://citizen-network.org/uploads/attachment/829/appendix-biopsychosocial-model.pdf>
- Sharpe, M., Chalder, T., and White, P. (2022). Evidence-based care for people with chronic fatigue syndrome and myalgic encephalomyelitis. *Journal of General Internal Medicine* 37(2), 449–452. <https://doi.org/10.1007/s11606-021-07188-4>
- Soldatic, K. (2020). Social suffering in the neoliberal age: Surplusity and the partially disabled subject. In N. Watson and S. Vehmas (Eds.), *Routledge handbook of disability studies* (pp. 237–249). Oxon: Routledge.
- Stewart, M. (2016). *Cash not care: The planned demolition of the UK welfare state*. London: New Generation Publishing.

- Stewart, M. (2019). The impact of neoliberal politics on the welfare and survival of chronically ill and disabled people. In M. Berghs, T. Chataika, Y. El-Lahib and K. Dube (Eds.), *The Routledge handbook of disability activism* (pp. 41–56). London: Routledge.
- Stewart, M. (2023). The public health crisis created by UK social policy reforms. *Justice, Power and Resistance*, 6(2), 217–228. <https://doi.org/10.1332/GQDH4178>
- Thomas, C. (2007). *Sociologies of disability and illness: contested ideas in disability studies and medical sociology*. New York: Palgrave Macmillan.
- Thorburn, G. (2012). Illness as “deviance”, work as glittering salvation and the “psyching-up” of the medical model: Strategies for getting the sick “back to work”. *International Green Socialist*. <https://internationalgreensocialist.wordpress.com/illness-as-deviance-work-as-glittering-salvation-and-the-psyching-up-of-the-medical-model-strategies-for-getting-the-sick-back-to-work/>
- Tremain, S. (2001). On the government of disability, *Social Theory and Practice*, 27(4), 617–636.
- Tremain, S. (Ed.). (2015). *Foucault and the government of disability*. Ann Arbor: University of Michigan Press.
- Tremain, S. (2020). Field notes on the naturalization and denaturalization of disability in (feminist) philosophy: What they do and how they do it. *Feminist Philosophy Quarterly*, 6(3), 1–4.
- Twisk, F. N. M. and Maes, M. (2009). A review on cognitive behavioral therapy (CBT) and graded exercise therapy (GET) in myalgic encephalomyelitis (ME)/chronic fatigue syndrome (CFS): CBT/GET is not only ineffective and not evidence-based, but also potentially harmful for many patients with ME/CFS. *Neuro Endocrinology Letters*, 30(3), 284–299.
- Waddell, G. (1998). *The back pain revolution*. London: Churchill Livingstone.
- Waddell, G. and Aylward, M. (2005). *The scientific and conceptual basis of incapacity benefits*. London: The Stationery Office.
- Waddell, G. and Aylward, M. (2010). *Models of sickness and disability: Applied to common health problems*. London: Royal Society of Medicine.
- Waddell, G. and Burton, A. K. (2004). *Concepts of Rehabilitation of the Management of Common Health Problems*. London: The Stationery Office.
- Wendell, S. (1996). *The rejected body*. New York: Routledge. <https://doi.org/10.4324/9780203724149>
- Wessely, S. (1990). Old wine in new bottles: Neurasthenia and “ME”. *Psychological Medicine*, 20(1), 35–53. <https://doi.org/10.1017/S0033291700013210>
- Wessely, S. (1993). Letter to Mansel Aylward, 1 October. *The National Archives*. Ref BN 141/1 508554. Retrieved from <https://valerieeliotsmith.files.wordpress.com/2015/01/natarchbn141dss.pdf>
- Wessely, S., David, A., Butler, S. and Chalder, T. (1989). Management of chronic (post-viral) fatigue syndrome. *The Journal of the Royal College of General Practitioners*, 39(318), 26–29.
- White, P. (1993). Letter to Mansel Aylward and Rodney Grahame, 10 November. *The National Archives*. Ref BN 141/1 508554. <https://valerieeliotsmith.files.wordpress.com/2015/01/natarchbn141dss.pdf>
- White, P. (Ed.). (2005). *Biopsychosocial medicine: An integrated approach to understanding illness*. Oxford: Oxford University Press.
- White, P., Goldsmith, K. A., Johnson, A. L. et al. (2011). Comparison of adaptive pacing therapy, cognitive behaviour therapy, graded exercise therapy, and specialist medical care for chronic fatigue syndrome (PACE): a randomised trial. *The Lancet*, 377(9768), 823–836. [https://doi.org/10.1016/S0140-6736\(11\)60096-2](https://doi.org/10.1016/S0140-6736(11)60096-2)
- Wilshire, C. E., Kindlon, T., Courtney, R. et al. (2018). Rethinking the treatment of chronic fatigue syndrome—A reanalysis and evaluation of findings from a recent major trial of graded exercise and CBT. *BMC Psychology*, 6(1), 6. <https://doi.org/10.1186/s40359-018-0218-3>
- World Health Organization. (2001). *International Classification of Functioning, Disability and Health*. Retrieved from <https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health>