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Use an interdisciplinary approach

EDITOR,—From their randomised trial in the chronic fatigue syndrome Michael Sharpe and colleagues conclude that cognitive behaviour therapy is more effective than “medical care” in improving day to day function.¹ It is not clear that the data presented justify this conclusion.

Firstly, the authors do not compare like with like: the group given cognitive behaviour therapy received 16 hours of therapy while the “medical” group received no intervention. Secondly, the “medical” group of patients were “advised to increase their level of activity by as much as they felt able,” which may have had adverse effects if the activity was unsupervised and inappropriate.² This could have affected the results by making the group given cognitive behaviour therapy seem to improve by more than they did. Thirdly, all patients, and particularly those with the chronic fatigue syndrome, need detailed discussion of their problems. Many doctors will not have been aware that in providing such discussion—surely the duty of all doctors—they were in part providing cognitive behaviour therapy.

Perhaps it is inappropriate to complain that the authors did not address the physical problems of the chronic fatigue syndrome as this was not part of their remit. However, physical factors, including perfusion changes³ and erythrocyte rigidity, are present.⁴ Over 100 papers in the literature show that stress damages the immune system⁵: cognitive behaviour therapy is likely to be helpful.

Surely the best way of treating this complex disorder is by using an interdisciplinary approach rather than the limited potential of any single modality. This study might have been more productive if the medical group had undergone a comparable and appropriate programme of physical management.

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Essential elements of the treatment must be identified

EDITOR,—We have several practical and theoretical concerns about Michael Sharpe and colleagues' study of cognitive behaviour therapy in the chronic fatigue syndrome.¹ The authors managed to obtain almost 100% uptake of treatment and compliance among patients who were

attending an infectious diseases clinic and were strongly convinced that their chronic fatigue had a physical cause. We would struggle to engage our patients similarly, even with two hours for an initial appointment, and we could not offer them anything approaching an hour of treatment a week for four months. The difference between what was provided in the study and what clinicians can routinely offer their patients makes it important to identify the essential elements of the treatment.

The package given included cognitive techniques such as “question[ing] a simple disease explanation,” “strategies to reduce excessive perfectionism and self criticism,” and a problem solving approach of “gradual and consistent increases in activity.” The continuing improvement after the end of treatment is unusual for the cognitive psychotherapies and suggests that the behavioural component was most effective. We find it puzzling, therefore, that the authors attribute the beneficial effects of treatment to “a specific effect on illness perpetuating beliefs and coping behaviour,” particularly as these attitudes did not change substantially. The patients would inevitably report less avoidance of exercise if they were complying with the study. After treatment at least half of the patients still believed that the illness was physical (from tables 2 and 5), and the vast majority still applied the damaging label of “myalgic encephalomyelitis” to their condition.

Although the authors rightly state that their results tell us little about aetiology, they will inevitably be taken (at least by some people) to mean that the condition is primarily psychological—particularly as the authors have stated elsewhere that the chronic fatigue syndrome “does not reflect a particular biological process, but rather specific psychologic and behavioural mechanisms.”² Notwithstanding an artificial distinction between biology and behaviour, such “psychologisation” of the illness ignores increasing evidence of specific neurobiological abnormalities.^{4,5}

If, as we suspect, the behavioural component of the treatment proves to be the essential therapeutic element then this will provide more specific information for hypotheses on the causes of the chronic fatigue syndrome and allow the most efficient use of an effective but time consuming treatment.

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Cognitive behaviour therapy should be compared with placebo treatments

EDITOR,—Lest Michael Sharpe and colleagues' paper lends respectability to the notion that the chronic fatigue syndrome is a diagnostic entity or

suggests that cognitive behaviour therapy has any value specific to the condition,¹ I wish to make three points.

Firstly, the disorder that the authors treated is heterogeneous, the only defining criteria used being fatigue, impaired daily activities, and the absence of signs of physical disease or “severe depression.” Claims for a specific effect in any diffuse symptom complex are dangerous. Quinine is effective in many cases of cramp, but neither the symptom nor the benefit is specific.

Secondly, cognitive behaviour therapy and any comparable substitute were denied the control patients, who were therefore matched only on pretreatment criteria regarding their clinical state and not controlled in respect of a comparable treatment. Despite the authors' claim for a “specificity of treatment effect” the benefits shown are consistent with the provision of much attention, encouragement, and a positive attitude to the nature of the illness and the strategies to counter it.²

Thirdly, Sharpe and colleagues did not compare cognitive therapy with other treatments or placebo, and the improvements (including persistence after the treatment had ended) are compatible with a placebo effect.³ The “return to normal functioning (albeit with continuing fatigue) in most cases” is typical of the outcome for many such patients managed by other means. Before this expensive and time consuming remedy is generally applied, a formal comparison of cognitive therapy with placebo treatments is needed.

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Patients' beliefs about their illness were probably not a major factor

EDITOR,—Michael Sharpe and colleagues' study confirms that the best medical advice for patients with the chronic fatigue syndrome is not “nothing can be done” or that “the disease will burn itself out.”¹ The study produced improvement in 73% of the patients, which is comparable to the 80% improvement produced by my management techniques.^{2,3} Interestingly, my approach seems to be fundamentally different from that of Sharpe and colleagues.

Two previous studies of cognitive behaviour therapy in patients with the chronic fatigue syndrome showed no benefit over ordinary medical management.^{4,5} What is meant by cognitive behaviour therapy may go some way to explaining this apparent discrepancy between previous studies and that of Sharpe and colleagues. Most of us would agree that “inaccurate and unhelpful beliefs, ineffective coping behaviour, negative mood states, social problems, and pathophysiological processes all interact to perpetuate the illness.”¹ I would also agree with Sharpe and colleagues' next statement that “treatment aims at helping patients to re-evaluate their understanding of the illness and to adopt more effective coping behaviours.” Sharpe and colleagues conclude that patients gain benefit from cognitive behaviour therapy because it reduces their beliefs that illness is mainly physical, the cause is a virus, the illness is myalgic encephalomyelitis, and exercise should be avoided. My approach in the initial management aims to increase the patients' beliefs in these areas.³ So how could our results be similar?