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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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- 1 Sharpe M, Hawton K, Simkin S, Surawy C, Hackmann A, Klimes I, et al. Cognitive behaviour therapy for the chronic fatigue syndrome: a randomised controlled trial. *BMJ* 1996;312:22-6. (6 January.)
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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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- 1 Sharpe M, Hawton K, Simkin S, Surawy C, Hackmann A, Klimes I, et al. Cognitive behaviour therapy for the chronic fatigue syndrome: a randomised controlled trial. *BMJ* 1996;312:22-6. (6 January.)
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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?

Both my approach and that of Sharpe and colleagues recognise that negative mood states and social problems must be dealt with. Another common aspect of management is that emphasis is on a "collaborative rather than an adversarial approach." A turning point is often when a patient develops confidence and starts to feel able to exert some control over the illness.³ At this stage energy levels are higher and activity also increases, but I do not recommend an emphasis on greater activity until a patient feels 80% normal.³

I believe that the patients' beliefs about the chronic fatigue syndrome—that it was mainly physical, was caused by a virus, or was myalgic encephalomyelitis—were not a major factor in the improvement of Sharpe and colleagues' patients. It was probably far more important that there was collaboration to deal with the patients' problems with a definite regimen, regular appointments, and clear objectives.

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Authors' reply

EDITOR,—We addressed a clinical question of practical importance to ourselves and our colleagues—namely, could we improve the disability and fatigue of patients referred to a hospital clinic with severe medically unexplained fatigue (the chronic fatigue syndrome)? The available evidence indicated that the prognosis for these patients was poor¹ and (contrary to S A Chilton's suggestion) that there were no treatments of proved and accepted effectiveness.^{2,3} We chose cognitive behaviour therapy because it is effective in related conditions⁴ and because (for reasons given in the paper) we did not agree with Charles Shepherd's suggestion that its application to the chronic fatigue syndrome has been adequately evaluated. We chose to compare this therapy with sympathetic medical care from physicians experienced in assessing the syndrome as this is the best care available to most patients referred to hospital. Our results clearly show that patients who received cognitive behaviour therapy improved substantially more than those who were given only medical care.

Many of the methodological points raised by the correspondents were addressed in our original paper. Several correspondents ask, however, whether a simpler or alternative intervention might not have produced a similar benefit when compared with simple medical care. We agree that both replication of our result and the evaluation of alternative approaches are needed. Some data are already available. Colleagues at King's College Hospital, London, recently compared a similar form of cognitive behaviour therapy with a relaxation treatment matched for time (A Deale *et al*, world congress of cognitive and behavioural therapies, Copenhagen, Denmark, Jul 1995). They found that the cognitive behaviour therapy was substantially more effective, which suggests that neither simple attention

nor relaxation treatment is adequate for this condition. We agree with the correspondents who suggest that the next steps for research should include identification of the effective ingredients of cognitive behaviour therapy and the delineation of factors relating to the patient that predict a good response.

Shepherd, Ray Gibbons and colleagues, and K K Eaton all suggest that we neglected the biological component of our patients' illness. In fact (and contrary to Stephen M Lawrie's selective quotation), we take an explicitly biopsychosocial view of the chronic fatigue syndrome. We have been at pains to point out that the relative effectiveness of cognitive behaviour therapy does not mean that the illness is "all in the mind." While biological factors are likely to be important, however, their precise nature remains uncertain.

Many more questions still need answers: Gibbons and colleagues ask whether cognitive behaviour therapy is effective for extremely disabled patients, Shepherd suggests that homeopathy can work as well, and D O Ho-Yen speculates that his treatment has a similar effectiveness. We hope that these questions will be addressed in randomised controlled trials as only in this way will it be possible to adopt an evidence based approach to treatment. For the time being, intensive and individually tailored cognitive behaviour therapy is one of the few approaches that has been found to help most patients attending hospital outpatient clinics with this chronic and disabling illness.

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Tobacco funding for academics

A public relations disaster

EDITOR,—We write to express our profound dismay and concern at the news that Cambridge will accept £1.5m from the British American Tobacco Company to establish a chair of international relations.¹

From our perspective this is a public relations disaster and a blow to public health advocacy for tobacco control. You are presumably aware that the transnational tobacco companies, such as BAT, are targeting children and young women in the Asia Pacific region. Purpose designed advertising and other promotional activities are successfully recruiting large numbers of young people to smoking in this region, with disastrous consequences for their health. We regard tobacco related disease as the principal threat to the health of Asia Pacific communities now and in the future. The revenue from which the Cambridge chair will partly be funded has been generated from sales which are leading to the commonest registered causes of death, the commonest causes of morbidity, and the greatest

health care demand and health care costs in this Territory, the People's Republic of China, and other Pacific rim countries.

We are astonished that the prestige and status accorded by a named chair in Cambridge can be bought so cheaply by an organisation whose product injures or kills at least half of those who use it as intended.

Finally, what are the implications of this sponsorship for academic freedom in Cambridge? For example, in 1993 the Thai government's efforts to control the importation of American tobacco and protect the health of its population was dealt with very effectively by the industry. They brought in Senator Robert Dole to threaten the Thais with trade sanctions. The nefarious activities of the tobacco industry in this region and other parts of the world are ruthless and disgraceful. Yet we note that the industry is to be given a say in the selection of staff and students in Cambridge university. In the circumstances, would the impact of transnational tobacco companies on governments' policies, trade, and international relations be a subject eligible for academic research and discourse in Cambridge's new unit?

We respectfully urge Cambridge to reject this proposal and to dissociate itself from this form of patronage by the tobacco industry.

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Buying respectability

EDITOR,—Cambridge University's proposed acceptance of funding for a chair from the tobacco conglomerate BAT (British American Tobacco)¹ invites questions about whether there are any benefactors from whom the university would not consider accepting such funding.

It is not inconceivable that a pornographic consortium might seek to fund a chair in erotic literature, the Libyan or Iraqi governments to fund chairs in counterinsurgency, or Zaire's disgustingly wealthy President Mobutu to fund a chair in community development. Money is no object to such groups, but respectability and decency are qualities they crave on the international stage. As the chief executive of Brown and Williamson (BAT's subsidiary in the United States) said to Congress in 1994, "Congressman, it's hard for me to envision becoming more of an outcast than I am."

Plainly, there are standards beneath which an esteemed university would not venture. Yet by colluding with a tobacco company's desire to buy respectability, Cambridge will send a message to the world that tobacco companies deserve such respect. Dr Richard Hurt recently wrote about the push by companies such as BAT into Russia: "Stalin was a ruthless dictator who caused the death of millions of Russians. Although his reign of power lasted for more than 25 years, it had a finite duration and was confined to the 20th century. The death and disability that will be caused by the use of Western tobacco products are just beginning and will continue for many decades. Stalin may have intentionally ordered many of his victims to be killed, but most died as a result of his policies, which were intended to accomplish strategic and political goals. For Western tobacco companies, death is simply the most pronounced by-product of the use of their