Cognitive behaviour therapy for the chronic fatigue syndrome

Evening primrose oil and magnesium have been shown to be effective

EDITOR,—In their paper on cognitive behaviour therapy for the chronic fatigue syndrome Michael Sharpe and colleagues state that many pharmacological treatments have been suggested but none are of proved value.¹ Last year Lewith stated that the only two treatments that had been properly evaluated were evening primrose oil and magnesium by injection.² Intramuscular magnesium supplements have been given to patients with low red cell magnesium in a double blind placebo controlled trial; myalgia and fatigue improved in about 70% of subjects.³ Evening primrose oil has been used to treat myalgic encephalomyelitis and is the only other treatment that has been adequately tested in a controlled trial. High doses in randomised controlled trials have been shown to have a significant effect in 70-80% of patients with myalgic encephalomyelitis or the chronic fatigue syndrome.⁴ I would be interested to hear Sharpe and colleagues' comments about these papers.

S A CHILTON
General practitioner

Martonside Medical Centre,
Middlesbrough,
Cleveland TS4 3BU

- 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.)
- 2 Lewith G. Chronic fatigue syndrome. *Update* 1995;50:765.
- 3 Cox IM, Campbell MJ, Dowson DI. Red blood cell magnesium levels and the chronic fatigue syndrome (ME): a case control study and a randomised controlled trial. *Lancet* 1990;337:757-60.
- 4 Behan PO, Behan WMH, Horrobin D. The effect of high doses of essential fatty acids in the post-viral fatigue syndrome. *Acta Neurol Scand* 1990;82:209-16.

Good general care may offer as much benefit as cognitive behaviour therapy

EDITOR,—Successful outcomes have been reported from controlled clinical trials of an eclectic range of treatments—from immunotherapy to magnesium supplementation—for the chronic fatigue syndrome.¹ Unpublished data suggest that equal success can be achieved with some forms of alternative therapy (for example, homoeopathy) when patients believe strongly in the approach. Most physicians, however, continue to view all such results with healthy scepticism. An equally cautious view needs to be taken when assessing Michael Sharpe and colleagues' study of cognitive behaviour therapy.² In a disorder that is almost certainly heterogeneous in nature, two important questions need to be answered before we can conclude that cognitive behaviour therapy is of value.

Firstly, does cognitive behaviour therapy offer any more benefit than good general care, support, and use of drugs for symptomatic relief (particularly for alleviating insomnia, myalgia, and any coexistent depression), which is increasingly being provided by general practitioners and the primary health care team? The protocol used in a controlled study of cognitive behaviour therapy in Australia may help with the answer to this.³ Control patients in Sharpe and colleagues'

study, who failed to show any significant improvement after one year, received "no further specific explanation or advice" apart from being advised to increase their level of activity gradually. By comparison, the control group in the Australian study—whose improvement was similar to that of those receiving cognitive behaviour therapy—were given medical care by a unit with recognised skill in all aspects of managing the chronic fatigue syndrome.

Secondly, are patients who benefit from cognitive behaviour therapy a subgroup with appreciable coexistent psychiatric morbidity? Although Sharpe and colleagues' study contained a high proportion (67%) of patients with depression, anxiety, or somatisation disorder, no useful information is provided on whether these factors may have influenced outcome. Findings from an American controlled study of cognitive behaviour therapy suggest, however, that a subset of patients with the chronic fatigue syndrome, who have high levels of depressive symptoms and maladaptive thinking regarding their fatigue, are the ones who can really benefit from this type of behavioural intervention.⁴

The apparent success rates for pharmacological, psychological, and alternative treatments in the chronic fatigue syndrome indicate that assessment of each patient remains the most important determinant when approaches to management are being considered. Until more is known about the precise pathoetiology of the syndrome this is likely to remain the case.

CHARLES SHEPHERD
Honorary medical adviser

ME Association,
Stanford le Hope,
Essex SS17 0HA

- 1 Shepherd C. *Myalgic encephalomyelitis: post-viral fatigue syndrome. Guidelines for the care of patients.* 2nd ed. Stanford le Hope: ME Association, 1995.
- 2 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.)
- 3 Lloyd AR, Hickie I, Brockman A, Hickie C, Wilson A, Dwyer J, *et al.* Immunologic and psychologic therapy for patients with chronic fatigue syndrome: a double-blind, placebo-controlled trial. *Am J Med* 1993;94:197-203.
- 4 Friedberg F, Krupp LB. A comparison of cognitive behaviour treatment for chronic fatigue syndrome and primary depression. *Clin Infect Dis* 1994;18 (suppl):105-9.

Patients were not representative of all patients with the syndrome

EDITOR,—Michael Sharpe and colleagues conclude that cognitive behaviour therapy leads to a sustained reduction in functional impairment for patients with the chronic fatigue syndrome.¹ The levels of disability of the 60 patients who took part in the study suggest, however, that these patients do not represent a comprehensive cross section of patients with the syndrome. The 60 patients scored 60-78 on the Karnofsky scale assessing disability and so represent a different population from the 143 patients reported on by Case History Research on ME (myalgic encephalomyelitis), who would have scored 30-60 (R Gibbons *et al.*, first world congress on chronic fatigue syndrome and related disorders, Brussels, Nov 1995). Fifty nine of these 143 patients reported functional deterioration after sustained, incrementally increased physical exertion.

The authors did not assess other symptoms common in the chronic fatigue syndrome, such as

pain, nausea, muscle weakness, or balance problems—a measure of the reduction of which was taken as a standard for "success" in an earlier trial.² The lack of evidence of significant changes in other measures besides "the principal complaint of severe fatigue" in the authors' study tends to diminish the validity of their conclusions.

If functional capacity alone is to be assessed in a trial a validated instrument should be used. The Karnofsky scale is not sensitive enough to measure function since a value of 80 implies "normal activity with effort; some signs or symptoms of disease." But what does the phrase "normal activity" mean? Does it mean being able to get up, dress, and walk at a level sufficient to maintain (unemployed) independence or does it mean an ability to perform all these activities together with a return to full time employment and participation in sport?

Given the heterogenous nature of the chronic fatigue syndrome, we are concerned at the apparent enthusiasm for cognitive behaviour therapy, which may be helpful for patients who have factors such as depression or maladaptive behaviour (too much bed rest) but may in the long term be detrimental to a specific subgroup of patients. We note that in Sharpe and colleagues' trial the condition of four of the 30 patients given cognitive behaviour therapy had deteriorated after 12 months. Could these patients have a distinct type of the chronic fatigue syndrome, meeting the original clinical criteria for myalgic encephalomyelitis,³ and be at risk from cognitive behaviour therapy?

RAY GIBBONS
Researcher
ANNE MACINTYRE
Researcher
CHRIS RICHARDS
Researcher

Case History Research on ME (CHROME),
3 Britannia Road,
London SW6 2HJ

Advice to authors

We receive more letters than we can publish: we can currently accept only about one third. We prefer short letters that relate to articles published within the past four weeks. Letters received after this deadline stand less chance of acceptance. We also publish some "out of the blue" letters, which usually relate to matters of public policy.

When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Wit, passion, and personal experience also have their place.

Letters should have fewer than 400 words and no more than five references (including one to the BMJ article to which they relate); references should be in the Vancouver style. We welcome pictures.

Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

Please enclose a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

Letters will be edited and may be shortened.