

The above simple steps were successful in increasing the autopsy rate in our program and warrant consideration in attempting to improve the hospital autopsy rates.

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Manuscript submitted April 20, 1993 and
accepted April 27, 1993.

COGNITIVE BEHAVIOR THERAPY FOR CHRONIC FATIGUE SYNDROME

To the Editor:

The study of Lloyd et al¹ suggests that cognitive behavior therapy (CBT) is no more effective than clinic attendance in the management of chronic fatigue syndrome. These results contrast with our uncontrolled study reporting substantial benefits of CBT in a chronic and disabled group of CFS patients.² We have a number of observations concerning these different findings.

Our principal question concerns the nature of the treatment employed. One can assume that the immune therapy employed (dialyzable leucocyte extract) was indeed what the authors intended, but is this true of CBT? We have considerable doubts that the treatment used was comparable to CBT as we have described it for CFS.^{2,3}

At the heart of CBT is a behavioral approach to the impairment of activity that is part of the definition of CFS. Other benefits, such as those on morale, fatigue, mood,

sleep, and symptoms follow, but the primary aim of treatment is to restore activity and function. Lloyd et al give only a single measure of functional impairment—mean nonsedentary activity time. CBT had no more effect on this measure than did clinic attendance. One can question the use of an averaged single measure of what is usually both a complex and fluctuating level of disability.

CBT involves the achievement of mutually agreed activity targets. These are not prescribed, nor are they synonymous with graded exercise as indicated by Lloyd et al.¹ Targets are chosen on the basis of avoidance—they can involve minimal activity and convey no ergonomic or physiological benefits. They may not be physical activities at all—but may be designed to increase concentration, for example. They are chosen to be consistent, predictable, and achievable. In order to achieve these targets, rest must also be made planned and consistent. No mention is made of the role of rest in Lloyd et al's study.

Patients are warned that symptoms are to be expected, but instead of believing these are pathological and indicate damage, these symptoms may have physiological causes (the consequence of inactivity) and psychological causes (anxiety). This is the cognitive component. In practice most patients achieve these targets, but if they are unable to do so, or do not accept that rationale, then they will decline further participation and default from behavior therapy. If a patient completes the program, he or she must have increased their activity, even if everything else remains unchanged.

We therefore suggest that patients in the Lloyd et al¹ study may have attended the sessions, but did not comply with the program by gaining targets and carrying out homework. We agree with the treatment rationale that avoidance of activity perpetuates disability.

We also agree with the intentions of the authors to encourage "gradual re-exposure to physical activity without premature cessation due to fatigue," and that such activity was to be monitored by either the patient or spouse. However, it is unclear if such activity took place. If the patients were compliant with the program, then by definition the number of sedentary hours must have decreased. This did not happen. Alternatively, if the treatment rationale were misguided, and the advice erroneous, then the patients would have experienced a worsening of their clinical status, and would have refused to comply with the trial. This did not happen either—indeed, the absence of either refusals or dropouts for a trial of what appears on the surface to be either exercise therapy or psychological treatment in CFS is remarkable. We suspect that the patients were actually noncompliant with treatment. As avoidance of activity is at the heart of the perpetuation of disability, it is not surprising that treatment gains were limited.

Instead we feel that CBT may have failed for a number of reasons. First, the number of sessions was inadequate. The sample studied had a mean length of illness of 5 years (identical to our own experience). It is asking a lot of any psychological treatment to reverse 5 years of maladaptive behavior in 6 sessions. Second, no rating or indication is given of the experience and training of the therapists. Third, the treatment rationale may have been compromised by the presence of an immunological trial involving regular injections of active or placebo immunotherapy. The rationale that we use for CBT is based on the model that although immune and/or infective factors may have been responsible for illness onset, other factors are responsible for symptom perpetuation. We would find it hard to reconcile the two approaches being tested simultaneously and—given

the very strong correlation between the patients' symptomatic improvement and their belief (albeit erroneous) at the end of the trial that they had received active immunotherapy—we suggest that the patient group found it similarly hard. Indeed, we are tempted to suggest that this is a clear benefit for cognitive therapy!

We agree with several other conclusions reached by the authors. We have received extensive adverse criticism of our program under the misguided apprehension that graded activity would be harmful in CFS. We are delighted that Lloyd and colleagues have shown these fears to be groundless. Second, we agree that our study populations may well be different. Six of our patients in the pilot study needed inpatient treatment because they were partially or completely restricted to a wheelchair.⁴ Our impression, following helpful conversations with Drs. Lloyd and Hickie, is that we may see a more disabled group of patients with higher rates of psychiatric disorder than they do. We also believe that the differences in disability stem from the fact that Australian researchers, led by Lloyd and colleagues have convincingly demonstrated that the fatigue in CFS is not due to muscle dysfunction. The opposite view, which we consider both erroneous and dysfunctional, remains widespread in our country. Finally, we agree without reservation that the benefits of CBT in our open study may still have reflected nonspecific effects of treatment, likely to be important in a condition with such a high placebo response as CFS.

We are now addressing this issue in a trial comparing 12 sessions of CBT with an equal amount of a control treatment—namely, relaxation therapy.

In conclusion, the authors state that their findings do not support the hypothesis that CFS could be adequately treated by CBT alone.

We do not feel that this study is an adequate test of CBT in CFS. We also doubt that either a specific cause or a specific treatment will ever be found in a heterogeneous condition such as CFS.

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Manuscript submitted March 9, 1993, and accepted May 10, 1993.

To the Editor:

Lloyd et al¹ concluded that patients with chronic fatigue syndrome (CFS) did not respond to psychological therapy. Specifically they claim to have found that cognitive behavioral treatment (CBT) was no more effective than ordinary medical follow-up. An examination of the design of this study, however, indicates that only limited conclusions can be drawn.

Cognitive behavioral treatment is not a specific therapy but rather a category of treatments which can be administered in differing forms and doses. There are strong arguments to suggest that CBT may be effective in patients with CFS² and a preliminary study suggested it to

be effective in at least a proportion of patients.³

The form of CBT evaluated by Lloyd et al was based on the assumption that the principal factor perpetuating illness in CFS is a simple phobia of activity. In our experience, this model is inadequate. We have found that patients' belief that their symptoms are a result of physical disease and require medical treatment is also an important factor perpetuating illness² by preventing the patient working on psychological and social problems inhibiting recovery. Not only did the patients belief in physical disease appear to be unchallenged in this study, it may even have been unwittingly confirmed by the simultaneous administration of immunoglobulin injections. Although the majority of patients were depressed, the therapy did not specifically address this problem. Furthermore, the "dose" of CBT was far too small (6 sessions of less than 1 hour for patients who had been ill for up to 28 years) to realistically expect much effect.

The results obtained by the study are in keeping with these criticisms. The therapy failed even to achieve an increase in the patient's level of activity (suggesting noncompliance with the behavioral program) and improvement was correlated with the patient's belief that they had received active immunotherapy (which suggests patients believed this to be a more appropriate treatment for their physical illness). The investigators are to be congratulated for attempting a controlled evaluation of psychological therapy for CFS. Unfortunately the type and dose of therapy given was inadequate. The role of CBT in this condition remains to be evaluated.

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