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**TO THE EDITOR:** The process of destigmatising chronic fatigue syndrome (CFS) is not advanced by either limiting enquiry to “acceptable” sciences or increasing the stigma already experienced by people with other neuropsychiatric disorders. Contrary to its intent, and in contrast to the recently published Royal Australasian College of Physicians (RACP) guidelines,<sup>1</sup> the recent statement by the immediate past president of the RACP and the Chairman of the ME/Chronic Fatigue Syndrome Association of Australia<sup>2</sup> is in danger of *increasing* the stigma for both people with CFS and people with other common mental disorders.

Unfortunately, key propositions in their letter (“There is no evidence that the illness is primarily psychological in origin”) are clearly at variance with the tone of the guidelines (see Box 1.5, p.S31; Box 1.7, p.S32; and, “Management” summary, p.S38). Their letter reinforces the classical “dualistic” and rather simplistic “biological” approach (eg, “There is significant evidence of a range of biological abnormalities occurring in people with CFS”). Unwittingly, it colludes with community-based beliefs that mental health problems are “not health”,<sup>3</sup> and often imaginary or under the voluntary control of the patient.<sup>4</sup>

There is no doubt that people with CFS share many experiences with people with other neuropsychiatric disorders. They both have daily experiences where their credibility is challenged, their disability is minimised and their needs for appropriate medical management are not met.

Australian research and best practice have been recognised internationally for emphasising the integration of psychological, psychiatric and biological factors and respect for the experiences of persons with these debilitating disorders.<sup>5</sup> Unfortunately, the major advances captured in the guidelines may now be undermined if the RACP is perceived to be backing away from supporting appropriate psychological assessment and provision of effective “psychological” treatments (such as cognitive-behavioural therapy and physical rehabilitation approaches). Similar equivocation has left clinical guideline processes in the United Kingdom in disarray.<sup>6</sup>

As demonstrated recently, prolonged fatigue syndromes are common in the Australian community, and the vast majority of those who seek healthcare services have concurrent depression or anxiety.<sup>7</sup> Real progress towards destigmatisation,

meaningful research progress and improved health services for people with CFS will only occur when the field is mature enough to deal with the clear relevance of psychological factors. Instead of rejecting “psychological factors” and associated treatments, relevant professional and consumer bodies should now join with the broader community movement towards increased community awareness of common neuropsychiatric disorders, genuine understanding of their (genetic, “biological”, psychosocial and personal) causes and provision of effective (pharmacological and psychological) treatments.<sup>8</sup>

1. Chronic fatigue syndrome. Clinical practice guidelines – 2002. *Med J Aust* 2002; 176 Suppl May 6: S17-S56.
2. Larkins RG, Molesworth SR. Chronic fatigue syndrome clinical practice guidelines [letter]. *Med J Aust* 2002; 177: 51-52.
3. Highet NJ, Hickie IB, Davenport TA. Monitoring awareness of and attitudes to depression in Australia. *Med J Aust* 2002; 176 Suppl May 20: S63-S68.
4. McNair BG, Highet NJ, Hickie IB, Davenport TA. Exploring the perspectives of people whose lives have been affected by depression. *Med J Aust* 2002; 176 Suppl May 20: S69-S76.
5. Lloyd AR, Hickie IB, Loblay RH. Illness or disease? The case of chronic fatigue syndrome. *Med J Aust* 2000; 172: 471-472.
6. Eaton L. Chronic fatigue report delayed as row breaks out over content. *BMJ* 2002; 324: 7.
7. Hickie I, Davenport T, Issakidis C, Andrews G. Neurasthenia revisited. *Br J Psychiatry* 2002; 181: 56-61.
8. Hickie IB. Responding to the Australian experience of depression. *Med J Aust* 2002; 176 Suppl May 20: S61-S62. □

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**TO THE EDITOR:** In the recent letter from Larkins and Molesworth<sup>1</sup> various statements are made on which I would like to comment.

From time to time everyone becomes physically or mentally exhausted, whether or not it is related to activity.

For some people this exhaustion becomes disabling. They deserve understanding and sympathy. We must do everything we possibly can to assist them to recover and to try to find possible causes.

Larkins and Molesworth acknowledge that chronic fatigue syndrome is a serious, disabling illness. When does ordinary exhaustion become disabling?

I would agree that at this stage there is no clinical evidence that the condition is primarily psychological. Nor is there evidence that it is primarily physical. There may be a mixture.

What is the “significant evidence” of a range of biological abnormalities occurring in people with CFS? What are these biological abnormalities and what physiological evidence is there for each one of these abnormalities to produce fatigue?

Larkins and Molesworth state that treatment plans should be “within the capabilities of the patient”: is there evidence to indicate that stimulating each patient to do just that little more each day will do harm?

It was stated that scientific evidence of the aetiology, pathology and treatment is grossly deficient. It is in fact absent. There is no evidence at all. Research is certainly required.

One of the problems is that, as soon as a medical advisor informs a patient that investigations have shown no serious abnormality, the patient often goes away and says to himself or herself or family that the “doctor said there is nothing the matter with me and that it is all in my head”. Nothing could be further from the truth. Something *is* the matter and it is up to us to find it out.

1. Larkins RG, Molesworth SR. Chronic fatigue syndrome clinical practice guidelines [letter]. *Med J Aust* 2002; 177: 51-52. □

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**IN REPLY:** We thank the writers for their comments on the CFS guidelines<sup>1</sup> and our joint letter about these guidelines.<sup>2</sup>

Hundertmark remarks on the interplay between physical and psychological factors in morbidity associated with CFS. We trust that our letter in no way contradicts this. Similarly, the inferences that Hickie drew from our letter are not supported by the text of the letter. Far from undermining the guidelines, our letter had the full support of the convenor of the working party responsible for the guidelines.

As clearly discussed in the guidelines, in the absence of specific diagnostic tests it is likely that a range of factors may contribute to the pathogenesis of CFS. Assumption of a primarily “psychological” pathogenesis is as unjustified as assumption of a primary “physical” basis. There are “abnormal” test results in many people with CFS, including abnormalities of the hypothalamic–pituitary–adrenal axis and some abnormalities of immune function. As stated, it is controversial whether such abnormalities are primary or secondary.

While cognitive-behavioural therapy with graded exercise is effective in some patients, the guidelines outline the deficiencies of the evidence which “significantly limit the generalisability of the findings”. As the guidelines indicate, and as is supported by our letter, treatment should be designed in