with electroconvulsive therapy. The reader was left wondering why this lady with a delusion that her food was being poisoned was not diagnosed as chronic paranoid schizophrenia.

Surely it would be wiser to apply the terms atypical anorexia nervosa or anorexia nervosa-like to such cases (Arya, *Journal*, February 1991, **158**, 285–286) until more is known about their (psycho-) pathogenesis.

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Reference

BERNSTEIN, I. C. (1972) Anorexia nervosa: 94-year-old woman treated with electroshock. *Minnesota Medicine*, **55**, 552–553.

Chronic fatigue syndrome

SIR: I read with interest the article by Hickie *et al* (*Journal*, April 1990, **156**, 534–540) about the chronic fatigue syndrome (CFS). It inspires a few reflections concerning the criteria and the study, and concerning the existence of the CFS itself.

Their criteria are of two orders: psychological and immuno-infectious. It risks associating two different types of patients: some with post-infectious syndrome and some with psychological problems. Fatigue is one of the most common symptoms in medicine (Adams, 1980; Bugard, 1989). Patients with 'fatigue', 'concentration/memory impairment' and occasional 'lymphadenopathy' may have diagnosis of CFS. What is the frequency of lymphadenopathy in the general population? What do we know about relations between fatigue, depression and immunological deficit? Is not chronic fatigue usual in infectious diseases and after?

What is the interest of a control group "selected from the in-patient and out-patient psychiatric services"? Why not from medical units? Do the authors suppose that the difference between the group of patients with CFS and the control group is necessarily non-psychiatric?

The authors find 29 cases of depression among 48 patients with CFS but they say CFS is different from depression and near medical pathology. Is CFS a medical equivalent of depression (Rodin & Voshart, 1986)? We might test this hypothesis by using antidepressant drugs in CFS or looking for the presence of the same biological disorders both in CFS and depression. The GHQ and Zung scores are elevated as with medical patients. Severe depressive disorders are rare in CFS. However, this quantitative result does not exclude the association of depression and CFS.

The authors make the interesting hypothesis of clinical similarities between CFS and depression. They show it to be false, but CFS could be culturally differentiated depression with overmedicalisation. The patients with CFS had the "conviction that they are physically ill" and "they held this belief and rejected psychological interpretations". According to Balint (1972), a medical rather than a psychological diagnosis is favoured, which could increase diagnosis of CFS and reduce those of depression or hysteria and other equivalent diagnoses in DSM–III–R (American Psychiatric Association, 1987). As stated by the authors, the patients with CFS have a "reluctance to accept psychological interpretations of their somatic symptoms" and have a high score on the denial subscale. Criteria for CFS must be more stringent (e.g. previous history of documented infectious illness, no depression, presence or not of psychiatric symptoms, etc).

Further studies are required to remove the confusion between CFS and depression. They should analyse the psychological context at the beginning of CFS and its psychological evolution. They will define whether fatigue is a result of, or only increased by, infectious disease, whether depression is cause or consequence, and whether CFS is a morbid entity or the somatic expression of a psychological disorder.

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References

ADAMS, R. D. (1980) Lassitude et asthénie. In *Harrison's Principles of Internal Medicine* (eds K. J. Issdelbacher, R. D. Adams, E. Braunwald *et al*, 3rd French edn, 1982), pp. 77–80. Paris: Flammarion & McGraw-Hill.

AMERICAN PSYCHIATRIC ASSOCIATION (1987) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn, revised). Washington, DC: APA.

BALINT, M. (1972) *Le médecin, son malade et la maladie. The Doctor, His Patient and The Illness.* (French edn). Paris: Payot.

BUGARD, P. (1989) *La fatigue et les états asthéniques*. Paris: Doin.

RODIN, G. & VOSHART, K. (1986) Depression in the medically ill: an overview. *American Journal of Psychiatry*, **143**, 696–705.

Family intervention

SIR: There is a point raised by McCreadie *et al* (*Journal*, January 1991, **158**, 110-113) which merits special emphasis. The authors noted the disappointing results of family intervention when compared with previous accounts (see, for example, Smith & Birchwood, *Journal*, May 1990, **156**, 654–660). The authors, in their discussions of this discrepancy,

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