Cerebral ventricular size and dyskinesia

SIR: Following publication of Cooper *et al*'s letter (*Journal*, October 1991, **159,** 583–584), we have looked again at the unpublished data in our study. Cortical atrophy had been evaluated 'blind', at the time of the computerised tomography (CT) scans by a consultant neuroradiologist. Scores were given for the frontal, temporal, parietal, and occipital regions, and the scores summed. The total atrophy score was not found to be related to dyskinesia development and was not reported in our paper. We have now reanalysed the frontal scores separately. Frontal atrophy was less correlated with age ($r=0.34$) than VBRs or total atrophy scores. When age was allowed for, there was a significant correlation between frontal atrophy and dyskinesia development ($r=0.40$; $P=0.03$). There was no evidence of an association between neuroleptics and frontal atrophy.

We thank Dr Cooper and his colleagues for their suggestion that we should reanalyse our data. The results given above are preliminary and more appropriate analyses remain to be done. Nevertheless, these results support their hypothesis that frontal cortical atrophy is associated with dyskinesia development and so add to the increasing evidence of frontal lobe deficits in schizophrenia.

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Chronic fatigue syndrome

SIR: We were interested to read Lynch *et al*'s comments on the problems associated with the term chronic fatigue syndrome (*Journal*, September 1991, **159,** 439). While we are aware of the shortcomings of the name 'myalgic encephalomyelitis' (ME), we do not regard 'chronic fatigue syndrome' (CFS) as a suitable replacement, for the reasons outlined below.

Firstly, it is difficult to see the advantages of using the same name for such different conditions as ME, tiredness and effort syndrome. It is a little like combining appendicitis, Crohn's Disease and irritable bowel syndrome and referring to all three as abdominal pain syndrome.

Secondly, since the vast majority of individuals suffering from chronic fatigue do not have CFS, the new term is misleading. For instance, a recent study by Manu *et al* (1991) revealed that only 9 of the 200 patients presenting with chronic fatigue fulfilled the American diagnostic criteria for CFS. Similarly, David *et al* (1990) reported that out of 70 patients suffering from unexplained chronic fatigue, only one was thought to have CFS. Yet despite the obvious differences in severity and aetiology, a number of writers have generalised research findings from the former to the latter (e.g. Stewart, 1990).

The confusion between the two has also encouraged the trivialisation of ME, with 'tiredness' replacing references to exhaustion (Welsby, 1990) and writers claiming that it is not a disease but merely 'a human predicament' (Hodgkinson, 1991). As for the comment that patients are people who 'expect to feel 100%, 100% of the time' (Welsby, 1990), this is not only rather unkind but also unjustified in most cases of ME.

Unfortunately, the new UK consensus criteria will make matters worse. Apart from their 'poor predictive validity', they are broader than those used in other countries where CFS generally corresponds to what is known as ME. Indeed, there are no references to any symptoms which would differentiate CFS from chronic fatigue. Consequently, patients diagnosed with CFS in Britain form a much more heterogeneous population than CFS patients from America and Australia and it is therefore difficult to compare research.

The failure to distinguish ME from unexplained chronic fatigue has also complicated the evaluation of treatment. For example, while graded exercise and cognitive therapy appear to be helpful in patients diagnosed according to British criteria (Butler *et al*, 1991), this regime was no better than another ineffective treatment when recently tested in a sample of patients selected according to the much more stringent Australian definition (Hickie, unpublished).

We hope that this letter provides a basis for further discussion and that it will not be too long before ME is once more accepted as a clinical entity in its own right.

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DASH scale

SIR: Expansion or clarification of the DSM–III–R categories, which illuminates and improves the quality of life of persons with learning disability, is to be welcomed. Despite the rigorous data collection carried out by Matson *et al* (*Journal*, September 1991, **159**, 404–409) the DASH scale deserves critical attention.

The authors have restricted their attention to DSM–III–R's Axes I and II. They have ignored Axis III (medical conditions), Axis IV (environmental conditions likely to trigger Axis I and II conditions), and Axis V (the person's functional strengths). DSM–III–R's strength is that it includes categories essential in a useful description of the person and the context in which Axis I and II conditions are manifest. These focus on the likely interventions and, therefore, resources needed to improve the individuals' performance and quality of life. Failure to record Axes IV and V creates serious problems in applying the categories to an individual, since it appears to suggest that a person's behaviour is independent of environmental factors, and fails to take account of the possible functions of the behaviour. Many people with and without learning disabilities show a clear escalation cycle of behaviour which is related to the response style of the people with whom they are interacting.

The following examples are taken from people with learning disabilities.

(a) A person asks appropriately for a cup of tea, and receives the answer 'no' or is ignored. After repeating the request appropriately several times she attempts to take cups of tea being held by others. Appropriate requests for more food are refused or ignored in the same way, and are followed by attempts to take others' food. As this is effectively blocked, the person starts vomiting on a table top or floor, and eating it up before staff can wipe or vacuum it away. Given ordinary food when she requests it appropriately, the person prefers this and stops the self-induced vomiting. As long as her appropriate requests are ignored (a clear Axis IV problem) this person will score items 1, 3, 4 of eating disorders, and items 1, 11, and 13 of impulse control and miscellaneous behaviour problems. If she hits out or expresses displeasure verbally at staff or other people, she is also likely to score on items 2 and 5 of this category.

(b) A person who sits rocking in a chair is called to come and eat. She shouts 'no' clearly and gesticulates annoyance to the adult approaching her. The adult continues forward to the person, puts out her hand to the person and repeats her request several times, each time meeting a louder shout of 'no' and clearer gestures confirming the verbal communication. The adult takes the person by the hand and prompts her to stand up and come to the dinner table. The person lifts up her arm and punches the adult on the face and chases her out of the room. Four adults move towards the person to restrain her, and the adult nearest the person's head is bitten on the hand. When adults invite the person to join in activities while standing still, from a distance of four feet or more, and when they respond early to the person's 'no' to invitations to dinner, and repeat the invitation some time later, the escalations in assault behaviour almost cease, and the person participates in a wider range of interesting activities. Under the above Axis IV conditions this person scores item 5 of rating disorders, and items 1, 2, 3, 4, and 5 of impulse control and miscellaneous behaviour problems.

(c) A person can express sexuality appropriately and discretely in a long-term relationship where this is supported by adults in authority. With policy changes, a veto is placed both on meetings between the friends, and particularly on their expressions of mutual sexuality. They then meet secretly but indiscretely around the campus where their masturbation is more observable by passers by. One of the partners also approaches other people and makes indiscrete sexual propositions to them, and the people approached complain. Under these Axis IV conditions these people score items 1, 2, and possibly 3 of sexual disorders.

Attention to all axes of DSM–III–R may, if done accurately, illuminate these complex situations, and create opportunities for caring adults of all disciplines to collaborate in finding creative ways of overcoming what appear to be impossible problems through simple but important improvements in the environment of the people for whom they have responsibility.

Descriptions restricted to Axes I and II may both prolong the practice of blaming or labelling victims, and get in the way of effective and humane