

mental health is a question that is not scientifically testable, as women with unwanted pregnancies cannot be randomly assigned to abortion *v.* abortion denied groups. It seems inappropriate therefore for Casey to talk of potential litigation against abortion providers for failing to provide information on a possible causal link between abortion and subsequent mental health problems.<sup>7</sup>

Debates on this topic and others such as racism tend to be endless, so I suggest that if anyone wishes to continue further, they should do so by direct personal emails.

- 1 Fergusson DM, Horwood LJ, Boden IM. Abortion and mental health disorders: evidence from a 30-year longitudinal study. *Br J Psychiatry* 2008; **193**: 444–51.
- 2 Rowlands S, Guthrie K. Abortion and mental health. *Br J Psychiatry* 2009; **195**: 83.

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doi: 10.1192/bjp.195.4.368c

**Response to the Editor:** We were dismayed and deeply concerned to learn, from the Editor's note to Professor Cooper's letter,<sup>1</sup> that we had been characterised as holding a pro-choice position in our commentary on Fergusson *et al*'s paper.<sup>2</sup> This was not mentioned in the commissioning process and, if it had been, the invitation would have been declined. Our commentary acknowledged a range of opinions among ourselves. Our arguments were based on an analysis of Fergusson *et al*'s paper, explicitly eschewing any partisan approach, and stating quite clearly that the debate on the rights and wrongs of abortion is primarily moral, legal and ethical rather than psychiatric or indeed scientific. We hoped we had been very clear in this approach, and most strongly reject any suggestion that our commentary was based in beliefs from either 'side of the debate'.

- 1 Tyrer P. Editor's note. *Br J Psychiatry* 2009; **194**: 571.
- 2 Fergusson DM, Horwood LJ, Boden JM. Abortion and mental health disorders: evidence from a 30-year longitudinal study. *Br J Psychiatry* 2008; **193**: 444–51.

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doi: 10.1192/bjp.195.4.369

**Editor's note:** This correspondence is now closed.

### Diagnosing chronic fatigue syndrome

In their comparative epidemiological study of chronic fatigue syndrome in Brazil and London, Cho *et al*<sup>1</sup> conclude that cultural differences affect only the recognition, rather than occurrence, of this condition. Although a reasonable interpretation of the epidemiological data, without complementary consideration of the cultural context this assertion is likely to obscure some of the most salient features and clinical significance of the study. The authors note that 'both population and healthcare professionals seem unfamiliar with the construct of the syndrome.' Recognition of the community and professional inattention to and low priority of chronic fatigue syndrome, however, is not necessarily a failing; it may also be regarded as an updated example of Kleinman's<sup>2</sup> formulation of the category fallacy – the imposition of alien diagnostic concepts where they lack local

validity. The assertion of underrecognition is incomplete without consideration of alternative formulations of the problems that in some respects resemble the syndrome, but are not diagnosed. Do conditions such as neurasthenia in East Asia and dhat syndrome in South Asia have characteristic patterning of distress or meaning in Brazil?

If one accepts the authors' tacit premise that the constructs of chronic fatigue syndrome and related UK formulations (encephalomyelitis and fibromyalgia) are unquestionably valid diagnoses for use everywhere, then the conclusion that chronic fatigue syndrome is neglected by professionals but no less important in the Brazilian population is valid. Accepting that premise, however, requires that we ignore the fact that the syndrome is neither in the ICD or DSM, and neurasthenia was rejected after consideration in the draft version of DSM-IV.<sup>3</sup> Standard texts in the field of cultural psychiatry regard chronic fatigue syndrome as a North American culture-bound syndrome.<sup>4</sup> Earlier research by some of the same Brazilian authors also highlights the social determinants of essential features of chronic fatigue, rather than the categorical diagnosis of the syndrome.<sup>5</sup>

Culturally sensitive clinical care will benefit from a reconsideration of cultural interpretations of these study data and from additional cross-cultural research. Are other diagnoses or local clinical and cultural formulations used to manage and treat such patients locally? Are other non-medical sources of help and social interventions given higher priority by patients and communities in Brazil?

Findings of Karasz & McKinley<sup>6</sup> showing the tendency of North Americans to 'medicalise' and South Asians to 'socialise' similar clinical vignettes recommend consideration of that point. Among patients studied by Cho *et al*, one might also ask whether higher rates of associated common mental disorders suggest that these psychiatric conditions are more likely to be the focus of treatment. The emphasis on underrecognition of chronic fatigue syndrome is likely to prove less important for community mental health and culturally sensitive care than questions of how such clinical patterns are understood in the population and explained by professionals.

- 1 Cho HJ, Menezes PR, Hotopf M, Bhugra D, Wessely S. Comparative epidemiology of chronic fatigue syndrome in Brazilian and British primary care: prevalence and recognition. *Br J Psychiatry* 2009; **194**: 117–22.
- 2 Kleinman A. Depression, somatization, and the new cross-cultural psychiatry. *Soc Sci Med* 1977; **11**: 3–10.
- 3 Paralikar V, Sarmukaddam S, Agashe M, Weiss, MG. Diagnostic concordance of neurasthenia spectrum disorders in Pune, India. *Soc Psychiatry Psychiatr Epidemiol* 2007; **42**: 561–72.
- 4 Griffith EE, Gonzalez CA, Blue HC. Introduction to cultural psychiatry. In *Textbook of Clinical Psychiatry, Fourth Edition* (eds R Hales & S Yudofsky): 1551–83. American Psychiatric Publishing, 2003.
- 5 de Fatima Marinho de Souza M, Messing K, Menezes PR, Cho HJ. Chronic fatigue among bank workers in Brazil. *Occup Med (Lond)* 2002; **52**: 187–94.
- 6 Karasz A, McKinley PS. Cultural differences in conceptual models of everyday fatigue: a vignette study. *J Health Psychol* 2007; **12**: 613–26.

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doi: 10.1192/bjp.195.4.369a

**Authors' reply:** The assertion that chronic fatigue syndrome is a culture-bound syndrome of high-income Western countries may be largely based on the observation that 'clinical descriptions of chronic fatigue syndrome, also known in some countries as myalgic encephalomyelitis, have arisen from a limited number