

Chronic Fatigue Syndrome: The psychiatrist's approach

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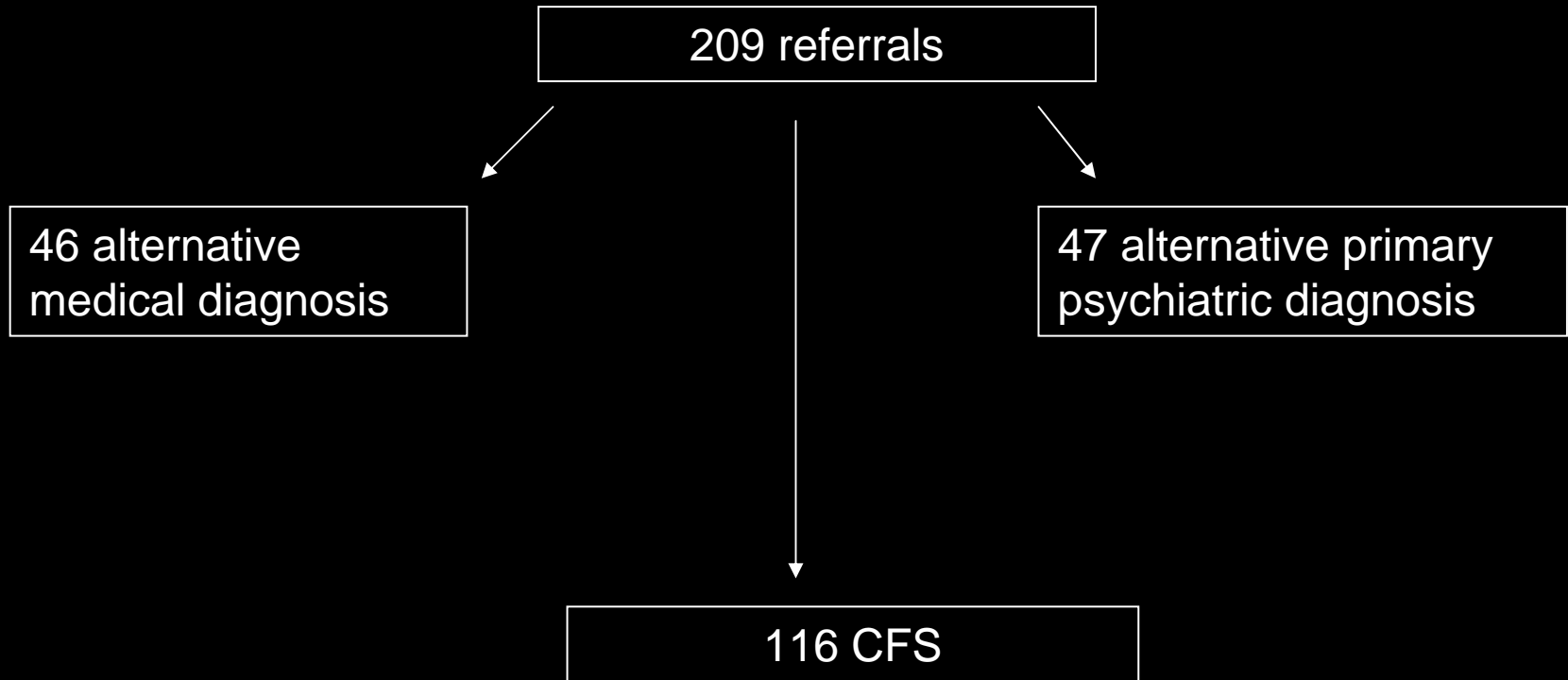
Why have a “psych” in CFS

- Misdiagnosis
- Suicide
- Comorbidity
 - Predisposing
 - Precipitating
 - Perpetuating
- Impact of psychological processes

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Barts CFS service: Professor Peter White, personal communication



Reasons for misdiagnosis

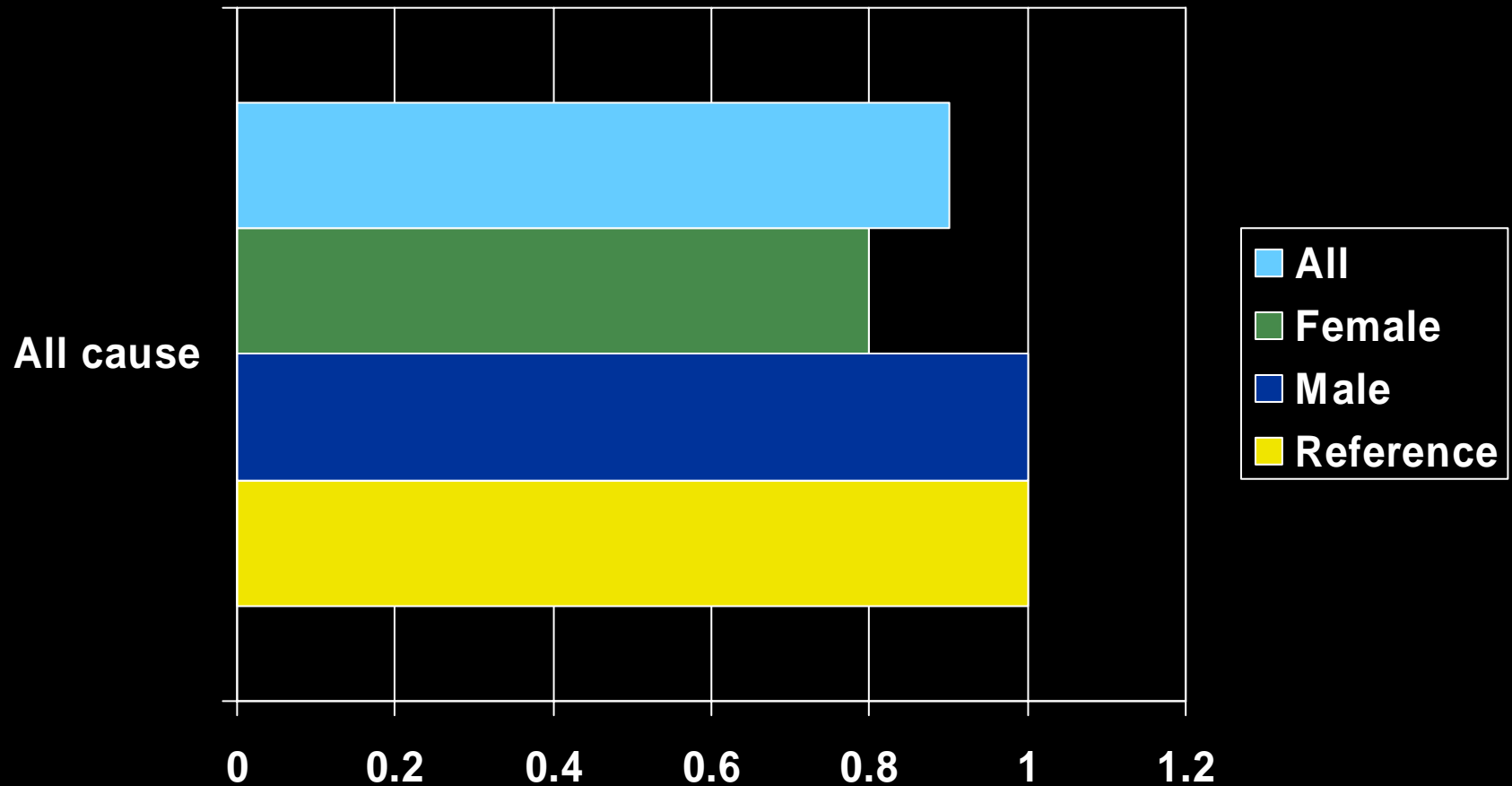
- Symptomatic overlap (fatigue in depression; isolation in psychosis; physical symptoms in panic disorder...)
- Demographic overlap (disorders typically start in early adult life)
- Stigma of psychiatric disorder

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Standardised mortality ratios for chronic fatigue syndrome

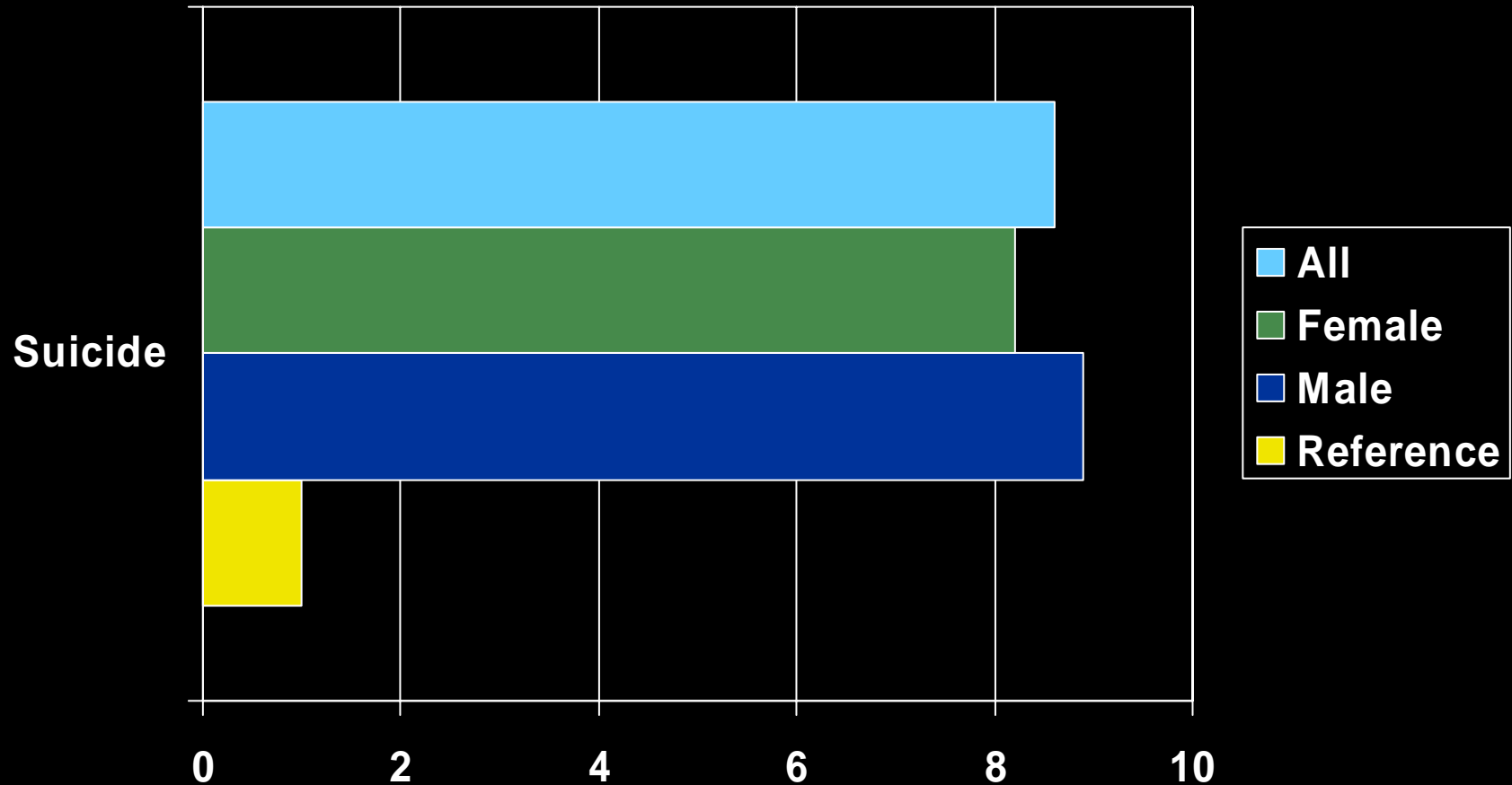
Smith et al, Psychological Medicine, 2006 36 1301-6



1201 patients with chronic fatigue or CFS followed for mean of 9 years

Standardised mortality ratios for chronic fatigue syndrome

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Why have a “psych” in CFS

- Misdiagnosis
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- Mechanisms
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Current psychiatric disorder in CFS compared with medical controls

<i>Reference</i>	<i>Psych disorder in CFS</i>
Wessely & Powell	72%
Katon et al	45%
Wood et al	41%
Pepper et al	23%
Fischler et al	77%
Johnson et al	45%

Current psychiatric disorder in CFS compared with medical controls

<i>Reference</i>	<i>Control group</i>	<i>Psych disorder in CFS</i>	<i>Psych disorder in controls</i>	<i>Relative risk</i>
Wessely & Powell	Neuromuscular	72%	36%	2.0
Katon et al	Rheumatoid	45%	6%	7.5
Wood et al	Myopathy	41%	12.5%	3.3
Pepper et al	Multiple sclerosis	23%	8%	2.9
Fischler et al	ENT/ dermatology	77%	50%	3.4
Johnson et al	Multiple sclerosis	45%	16%	2.8

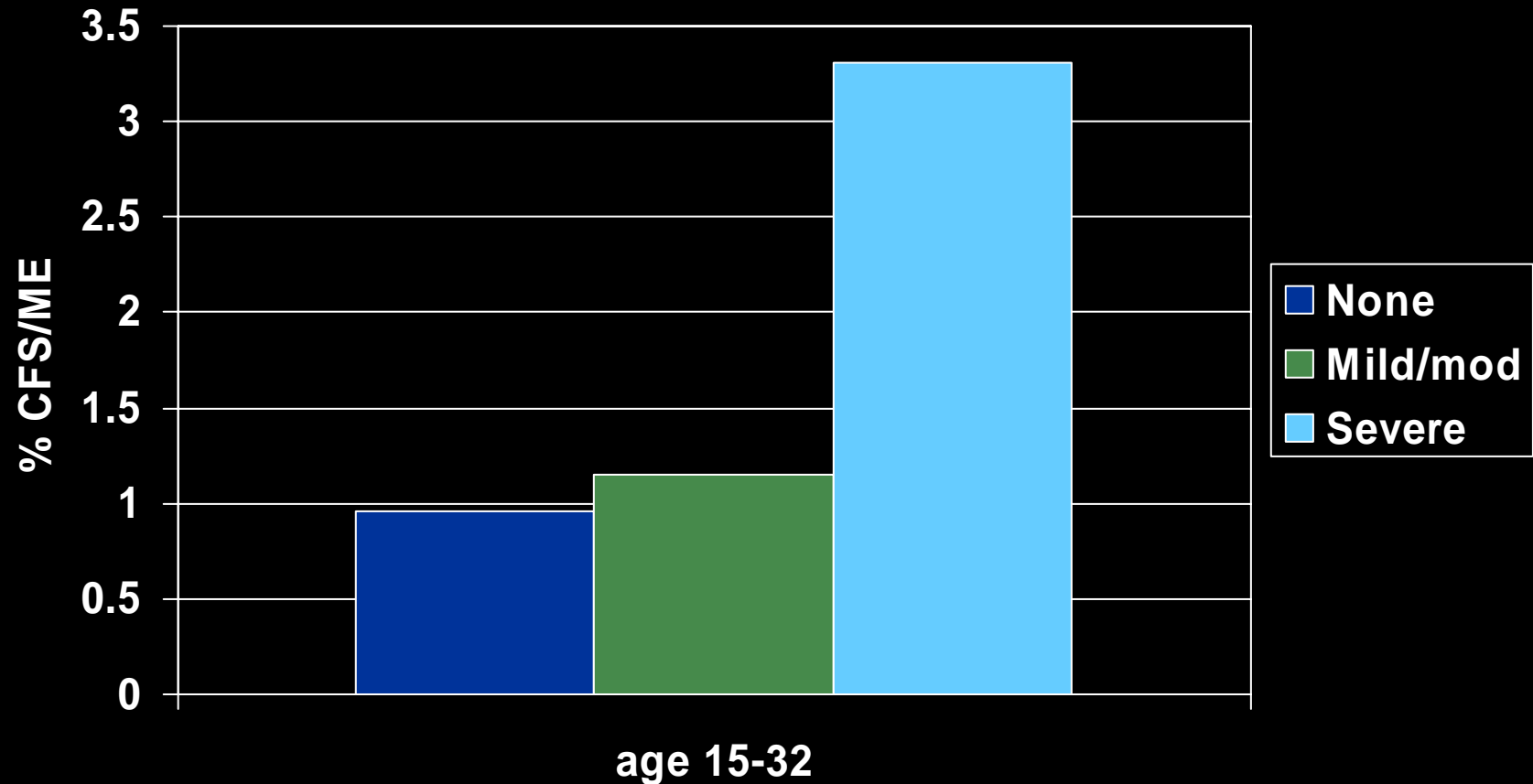
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Impact of psychological processes

Risk of CFS/ME by age 53 according to psychiatric disorder aged 15-32

Harvey et al, Psychological Medicine 2007



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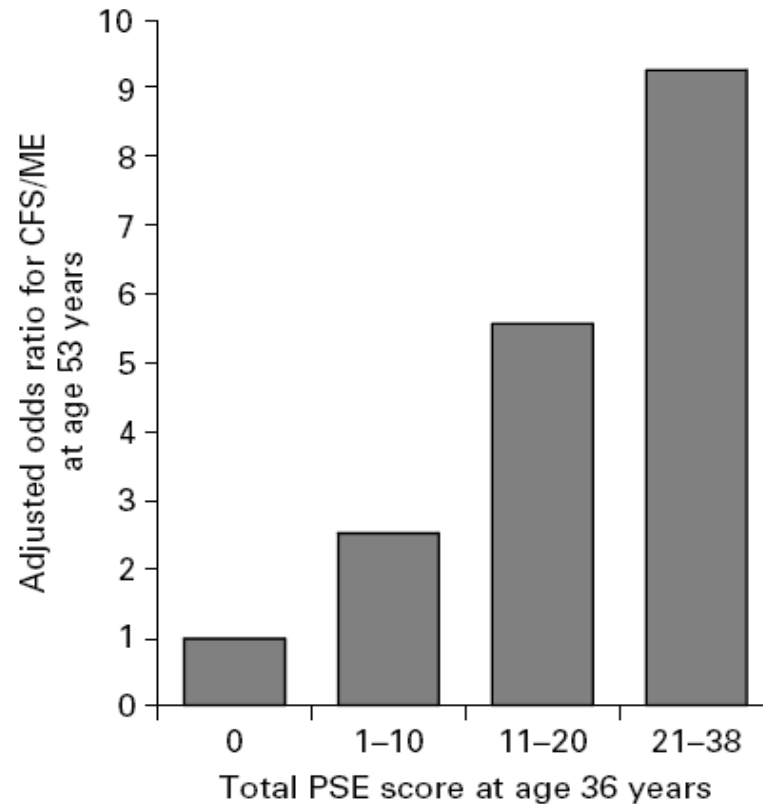


Fig. 1. Total Present State Examination (PSE) score at age 36 and odds ratios (adjusted for gender) for a later diagnosis of chronic fatigue syndrome/myalgic encephalomyelitis (CFS/ME). p value for trend = 0.001.

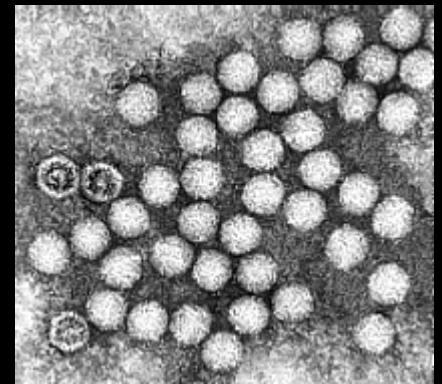
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Outcome of serious viral infections

Hotopf et al, 1996

Outcome	Viral meningitis n=83	Other infections n=76	OR (95% CI)
Chronic fatigue	21 (25%)	15 (20%)	1.1 (0.5-2.6)
Oxford CFS	12 (14%)	8 (10%)	1.0 (0.3-2.8)
CFS CDC 1988	8 (10%)	3 (4%)	1.8 (0.4-8.0)
GHQ case	39 (48%)	37 (51%)	0.6 (0.3-1.3)



Risk factors for development of fatigue following serious viral infections *Hotopf et al, 1996*

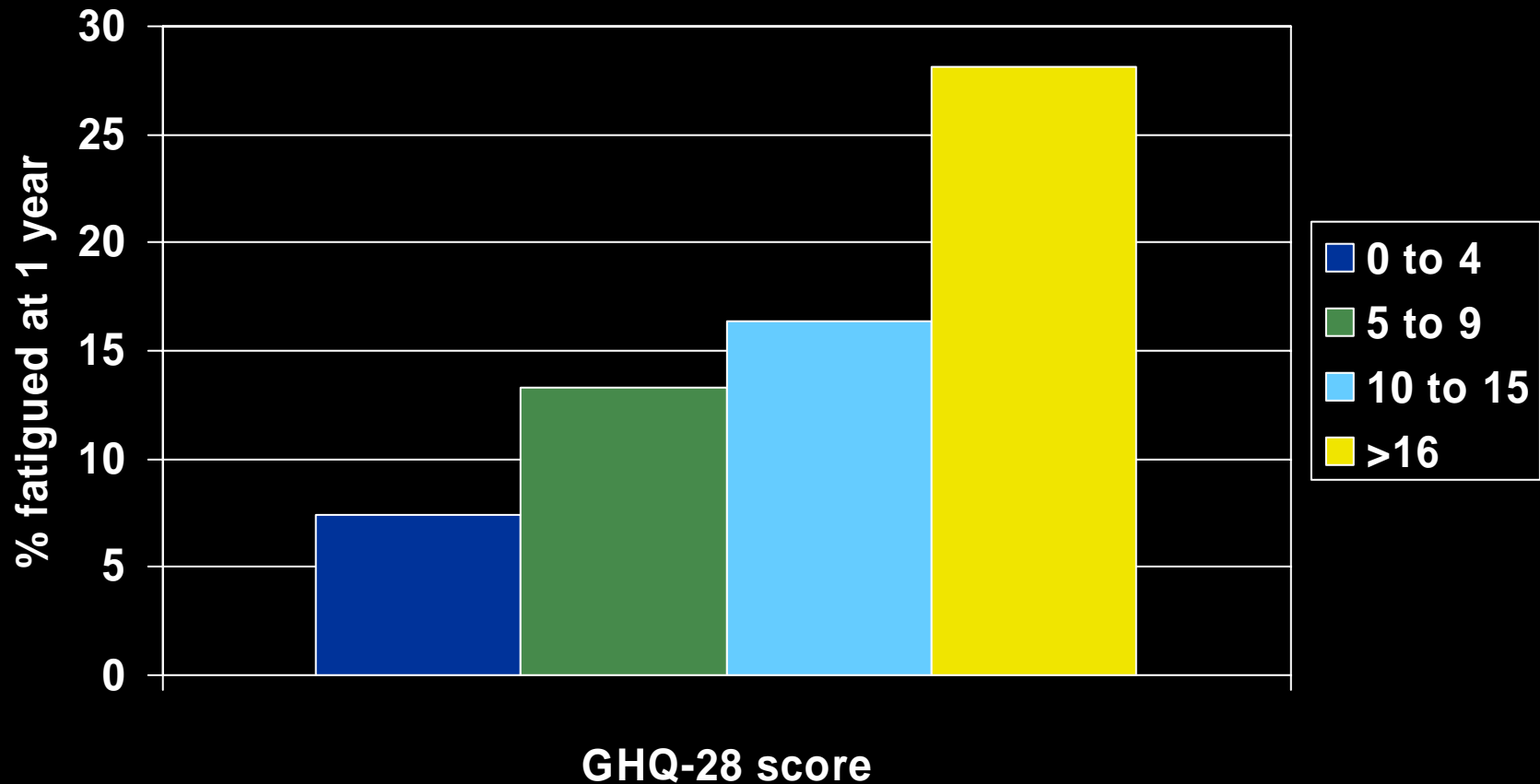
Criterion	Past psychiatric history	Prolonged convalescence
	<i>odds ratios (95% confidence intervals)</i>	
Chronic fatigue	1.3 (0.5-3.4)	4.9 (1.8-11.7)
Oxford CFS	3.6 (1.2-10.6)	4.9 (1.3-18.8)
CFS CDC 1988	7.8 (1.8-34.3)	3.8 (0.7-20.9)

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Impact of psychiatric disorder on recovery from substantial unexplained fatigue

Skapinakis et al, Psych Med, 2003 33 857-866



N=487

Systematic review of prognosis

Cairns & Hotopf, Occ Med 2005, 55 20-31

- 28 articles, mainly from specialist settings
- 14 used operational criteria for CFS in adults. Median full recovery rate 5% (range 0-31%).
- Median improvement 39.5% (8-63%).
- Very variable range of follow up durations!
- Return to work in 8-30% in the 3 studies which reported it.

CFS risk factors for poor prognosis

Cairns and Hotopf, 2005

18 studies:

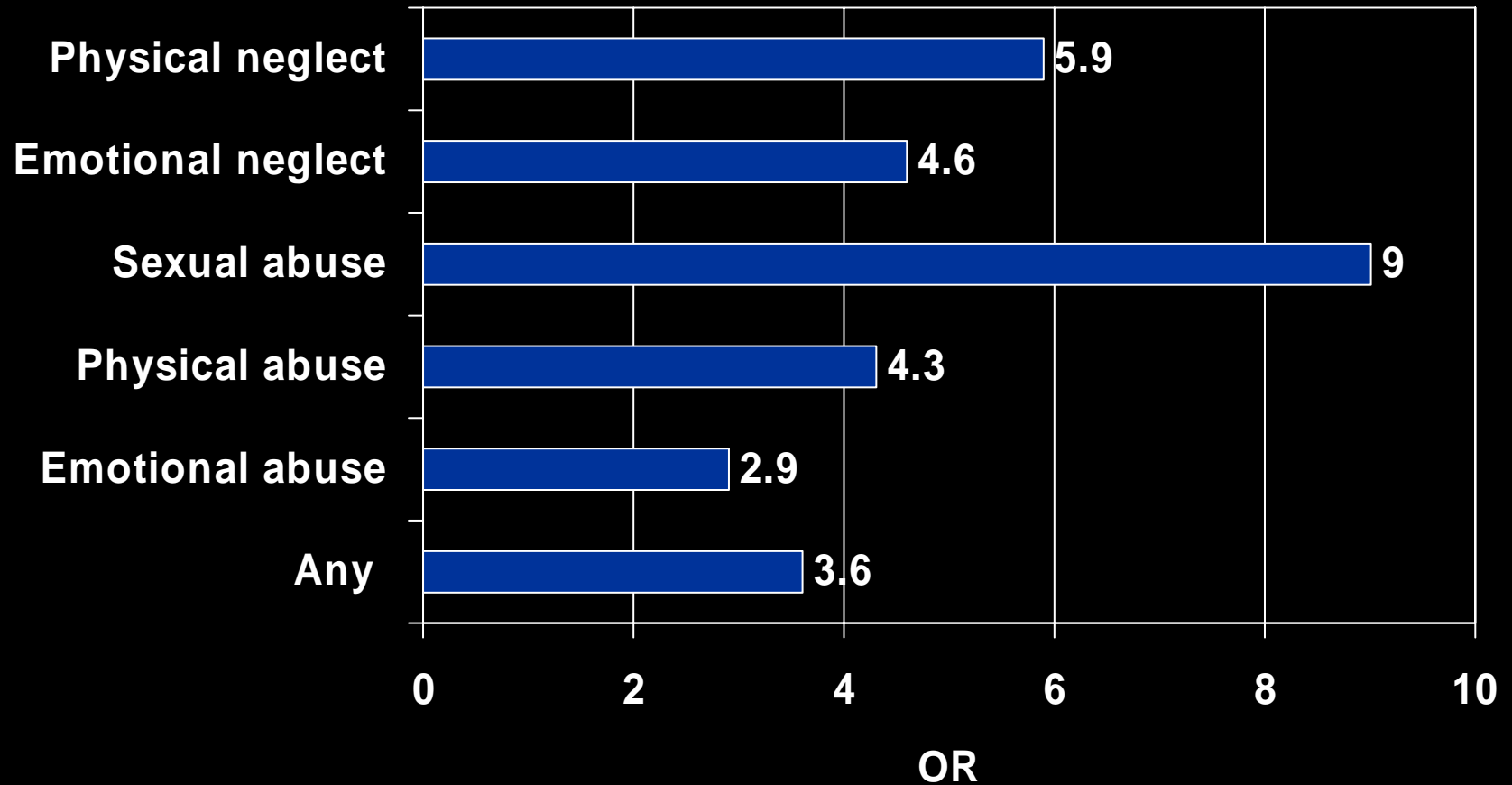
- Older age (4+ 2-)
- Duration of fatigue (4+ 2-)
- Multiple symptoms (2+)
- Psychiatric disorder (7+ 2-)
- Physical attribution (4+ 0-)
- Physical risk factors (1+ 4-)

“Upstream” causes of overlap

- Genetic pleiotropy
- Similar biological mechanisms
- Similar environmental risk factors

Adverse childhood experiences and CFS

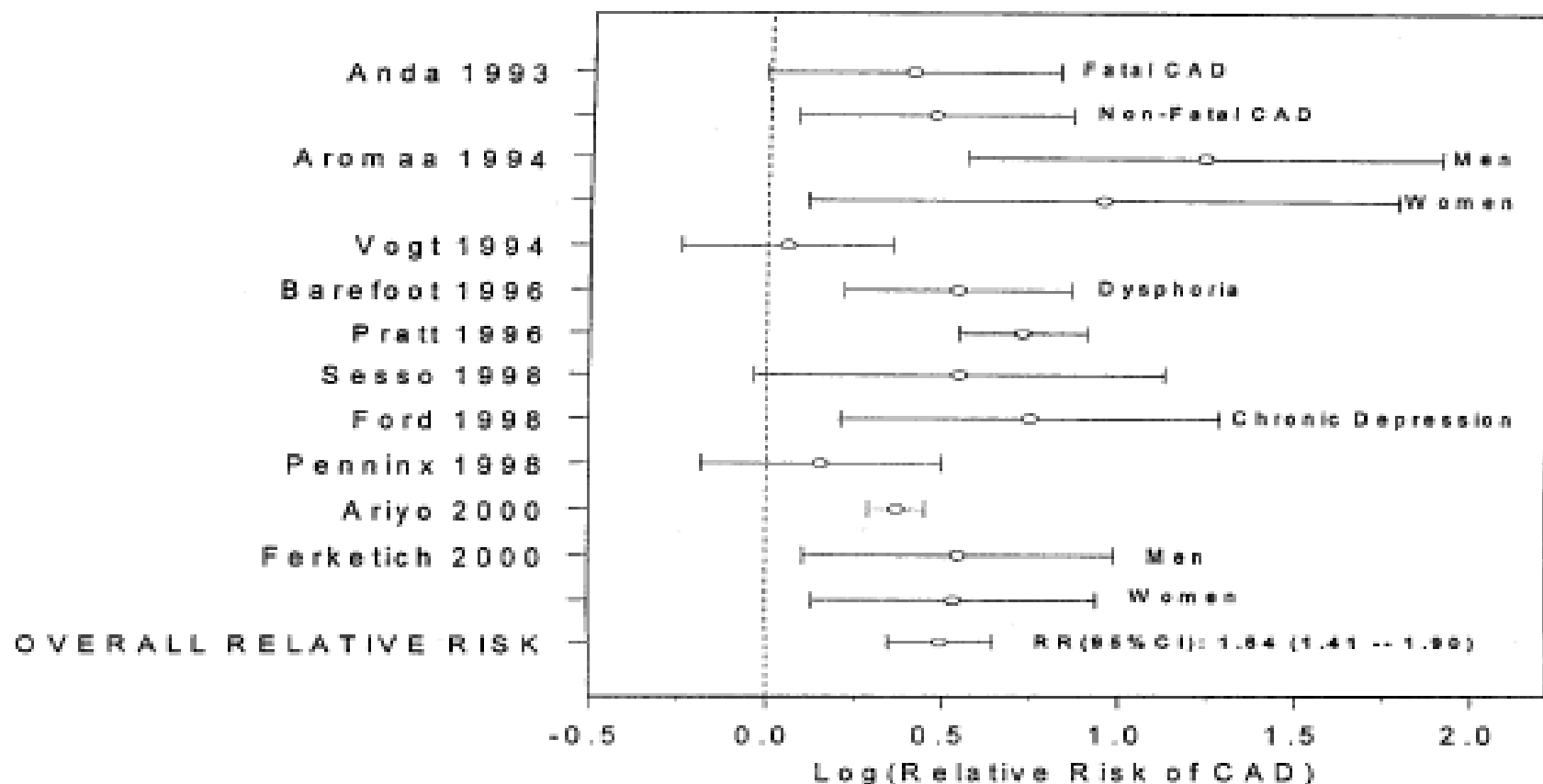
Heim et al 2006 Arch Gen Psych 63 1258-66



Psychiatric disorders matter,
not just in CFS

Do Depressive Symptoms Increase the Risk for the Onset of Coronary Disease? A Systematic Quantitative Review

LAWSON R. WULFIN, MD, AND BONITA M. SINGAL, MD



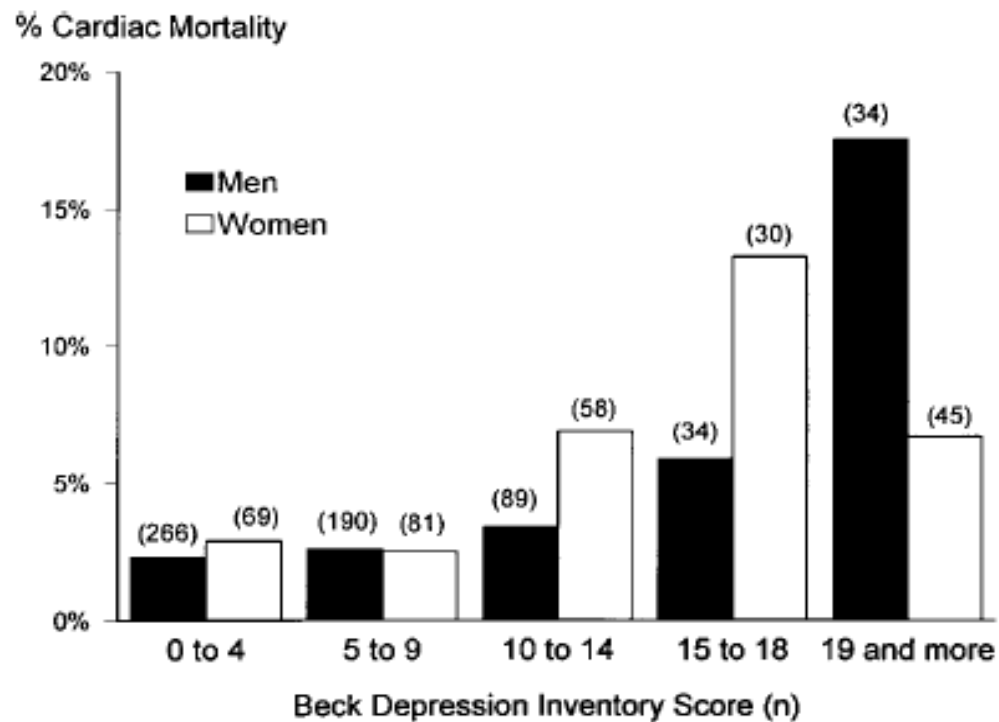


Fig. 1. One-year cardiac mortality in relation to the Beck Depression Inventory score and gender.

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Cognitions and CFS

- Strong attributions of exclusively physical cause is a risk factor for poor prognosis
- Hurt=harm cognition seems most powerful predictor
- Changing hurt=harm is associated with better result in CBT

The Vicious Circle of Fatigue

PREDISPOSING FACTORS

personality: perfectionist, driven, high standards, previous anxiety/depression

PRECIPITATING FACTORS

Life events, stress, busy lifestyle,
illness/infection

SYMPTOMS

rest/reduced activity

worsening of symptoms

over-activity alternating with inactivity
depending upon symptoms

Frustration, helplessness,
anxiety, depression

sleep problems &
reduced fitness

Increased symptoms
upon activity

Fear and further
reduction of activity

Beliefs impact on functioning in other physical diseases

Furze et al, J Psychosomatic Research 2005 59 323-9

- 133 angina sufferers followed from baseline to one year.
- Cognitions measured on York Angina Beliefs Scale
- “Low misconceivers” had less anxiety, depression and better functioning at baseline
- Strongest predictor of improved functioning after 1 year was change in angina related cognitions

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	I DON'T HAVE ANY IDEA ABOUT THIS
1. It is not always necessary for people with angina to stop what they are doing when they get angina pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Angina is a kind of small heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. People develop angina because they have too much stress in their lives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. There's no need for people with angina to take life easy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. People with angina should always avoid things that bring it on	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. People with angina should exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Any sort of excitement is bad for people with angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Angina is caused by a worn out heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. If people with angina don't rest when they get angina pain it could be fatal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Return to work after a heart attack

Petrie et al, *BMJ* 1996, 312 1191-4

	Early return N=40	Late return N=36	P
Identity	7.5	8.4	0.25
Timeline	8.3	9.8	0.001
Cure/control	23.9	23.6	0.78
Consequences	25.7	29.4	0.0005
Mental health index	53.1	50.6	0.09
Days in hospital	7.2	7.5	0.7
Peak CPK	1672.9	2400.2	0.09

Psychiatric assessment

- Taking a good history
- Identify psychiatric AND physical illness exclusions
- Identifying suicide risk
- Identifying cognitive, behavioural and affective responses to symptoms.

Establishing a working relationship

- Take physical complaints seriously.
- Respect illness beliefs
- Note and empathise experience of not being believed by others.
- Note effect and impact of illness
- Allow time, allow rest periods.

Medical differential diagnosis

- General conditions: occult malignancy, autoimmune disease, endocrine disease, organ failure.
- Neurological: MS, MG, Parkinson's disease, Myositis.
- Infectious: Chronic active hepatitis, HIV
- Respiratory: Asthma
- Chronic toxicity: Alcohol, solvents, heavy metals
- Sleep disorders: Narcolepsy, Obstructive sleep apnoea

Psychiatric differential diagnosis

- Depressive disorder
- Anxiety disorder
- Somatoform disorder
- Other – eating disorder, substance dependence, psychotic disorder

Past

- What was going on in your life when you got ill?
- What were your first symptoms?
- What did you think was happening to you?
- What did doctors say to you?
- What did your family think?

Present

- When was CFS or ME first diagnosed?
- What did you think about CFS/ME?
- What is your understanding now about why you're ill, and what keeps you ill?
- What is your typical day like?
- What can / can't you do?
- What support / assistance do you get?

Future

- How do you think things will be in 1 year?... And 5 years?
- What do you think is the most realistic plan of action for now?
- Is there anything you'd really like to be able to do now, which you can't?
- Do you think anything really holds you back from getting better?

Formulation

	Predisposing	Precipitating	Perpetuating
Bio	?exercise	Viral illness	Deconditioning Sleep disorder
Psycho		Life events Mood disorder	Hurt=harm cognitions Mood disorder
Social	Occupational issues		Iatrogenesis