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Psychiatric diagnosis and chronic fatigue syndrome: Controversies and conflicts

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Abstract
There is controversy about the making of psychiatric diagnoses in patients who have a diagnosis of chronic fatigue syndrome. The scientific controversies concern the purposes of diagnosis for the patient as well as for the doctor, the separation of diagnoses into medical and psychiatric and the intrinsically overlapping nature of symptom defined syndromes. The conflict arises from the practical and moral meaning of diagnoses, especially psychiatric diagnoses. At present the best clinical solution may to be make combined diagnoses such as CFS/depression. However, this apparently small issue should encourage us to ask the bigger question about the nature and purpose of diagnosis.
Conflict of interest. None

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Introduction

This article reviews the issue of psychiatric diagnoses in patients who meet diagnostic criteria for chronic fatigue syndrome (CFS). Most readers will be aware of the controversies surrounding the nature of CFS, even if they may not be quite as aware as the author of the intense passions that the subject arouses, especially in relation to psychiatric diagnosis. In this article we consider what we mean by a diagnosis, by a diagnosis of psychiatric disorder and by a diagnosis of CFS. What is the relationship between these different diagnoses, why does the issue generate so much heat, and what might be some useful ways forward in practice?

What is a diagnosis for?

First of all, it is worth considering what we mean by a diagnosis and why we make it. A diagnosis is a label for an illness. Whilst some may consider a diagnosis to be an objective ''entity'', other argue that diagnoses are in fact merely convenient ''constructions'' (Scadding, 1996). The case for diagnosis as construction is particularly compelling for those diagnoses that are based merely on the description of symptoms. Indeed the diagnoses

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at stake here – that of CFS and of psychiatric disorder – are literally the construction of committees. Hence rather than argue about the ultimate validity or otherwise of different diagnoses for a certain pattern of symptoms, we might profit by focusing on the relative utility of the various diagnoses (First et al., 2004). In order to consider utility we first need to consider the uses of the diagnosis that it can be evaluated on. Whilst this may seem obvious; namely to provide labels for illnesses that aid communication, provide prognostic information, and most importantly, guide treatment (Kendell, 1975) other purposes of diagnosis are often neglected. Patients are not the passive recipients of diagnoses; they have their own purposes for the diagnosis they are given. For them the diagnosis must be an acceptable label appropriately representing their experience of suffering, imply a plausible explanation of what is wrong with them, and preferably lead to effective treatment (Stone et al., 2002). Diagnoses also have important implications for their ability to negotiate their social responsibilities, health care and disability payments.

What does a diagnosis of chronic fatigue syndrome mean?

What is chronic fatigue syndrome?

The core symptoms described by a diagnosis of CFS are physical and mental fatigue exacerbated by physical and mental effort as well as subjective cognitive impairment, disrupted and unrefreshing sleep and some degree of widespread pain. Patients often report marked fluctuations in fatigue that occur from week to week and even from day to day. A number of operational diagnostic criteria to define more clearly what is meant by a case of CFS have been published. The first (Holmes et al., 1988) was in practice found to be excessively cumbersome and restrictive and simpler and less exclusive. Australian (Lloyd, Wakefield, Boughton, & Dwyer, 1988) and British (Oxford) (Sharpe et al., 1991) case definitions were subsequently published. The most recently published criteria were based on an international consensus and remain the most widely used (Fukuda et al., 1994; Reeves et al., 2003) (see also Table I).

Chronic fatigue syndrome is commonly considered to be a medical diagnosis in that the patients are managed in general medical settings. However, the medical label does not

Table I. Diagnostic criteria for chronic fatigue syndrome (CFS). Adapted from Fukuda et al. (1994).

Inclusion criteria:
(1) Clinically evaluated, medically unexplained fatigue of at least 6 months duration that is:
Of new onset (not life long)
Not result of ongoing exertion
Not substantially alleviated by rest
Associated with a substantial reduction in previous level of activities.
The occurrence of four or more of the following symptoms:
Subjective memory impairment, sore throat, tender lymph nodes, muscle pain, joint pain, headache, unrefreshing sleep, post-exertional malaise lasting more than 24 hours.
Exclusion criteria:
Active, unresolved or suspected medical disease; psychotic, melancholic or bipolar depression (but not uncomplicated major depression); psychotic disorders; dementia; anorexia or bulimia nervosa; alcohol or other substance misuse; severe obesity.

necessarily mean that a condition has an established pathology. Like many other medical diagnoses CFS is commonly regarded as a functional somatic syndrome. That is, a syndrome of somatic symptoms that is not associated with clearly identifiable structural disease pathology but assumed to reflect an abnormality in bodily functioning. There are a number of other functional somatic syndromes including irritable bowel syndrome and fibromyalgia. These are all defined by overlapping symptoms and indeed it remains controversial whether these should be considered separate conditions or variants of a general functional somatic syndrome (Wessely, Nimnuan, & Sharpe, 1999).

The symptoms of CFS have also on occasion been given the medical diagnosis of myalgic encephalomyelitis or ME (Anonymous, 1956). This term is used interchangeably with CFS by some and to denote a distinct medical diagnosis with a stronger presumption of bodily pathology by others. In recent official documents however the terms have been merged as CFS/ME (Sharpe, 2002).

What does a diagnosis of psychiatric disorder mean?

It is useful to begin by considering what we mean by ''psychiatric disorder'', how it differs from a ''medical'' diagnosis and the implications of this distinction.

Psychiatric diagnoses are descriptive and are defined almost entirely in terms of symptoms. Like functional syndromes they tend to overlap. The main reason that distinct diagnoses (for example of depression and anxiety) can be generated is that decision rules ban one diagnosis from being applied when another is present.

The defining feature that makes a diagnosis 'psychiatric' rather than 'medical' is simply that it is listed in the psychiatric diagnostic classifications of ICD-10 and DSM-IV. The placing of a diagnosis into psychiatric (as opposed to medical or surgical) categories arises because it had traditionally been regarded as lying within the scope of that sub-speciality of medicine. Disorders were thought appropriate for psychiatric management when they were considered to be ''mental'' in nature. The designation of a certain condition as ''mental'' as opposed to ''physical'' reflected the absence of known bodily pathology, a tendency for the illness to present with altered mental states and behaviour, or both.

The underlying assumption of this dichotomous classification, that disorders of the mind can be meaningfully separated from diseases of the body, and that mental illnesses are consequently fundamentally different entities from physical ones, has been called mind-body dualism. The idea of mind-body dualism is commonly attributed to the writings of the philosopher Descartes. Despite the fact that modern neuroscience casts serious doubt on the validity of this distinction (Kendell, 2001) so-called Cartesian dualism has and continues to exert a profound influence on western medical thinking, including that of patients and underpins the argument for separating diagnoses into medical and psychiatric.

The diagnoses of CFS and psychiatric disorder?

Despite having the medical diagnosis of CFS, many but not all such patients can also be given a psychiatric diagnosis as we shall see below. The commonly applicable diagnoses from DSM-IV and ICD-10 are shown in Table II.

Many patients with CFS will also meet criteria for depression and/or anxiety disorders, the precise prevalence depending on the nature of the patient population studied, the diagnostic criteria used, and how these criteria are applied. Clinical experience shows that the detection of symptoms of depression and anxiety during the patient's assessment is influenced by how searching the interview is and by the bias of the clinician and patient. Furthermore, once

Table II. Psychiatric diagnoses potentially applicable to patients with CFS.

DSM-IV category	ICD-10 category
Mood disorder	Mood disorder
Anxiety disorders	Anxiety disorders
Somatoform disorders	Somatoform disorders
Somatization disorder	Somatization disorder
Undifferentiated somatoform disorder	Undifferentiated somatoform disorder
Conversion disorder	Dissociative (conversion) disorders
Pain disorder	Persistent somatoform pain disorder
Hypochondriasis	Hypochondriacal disorder
Somatoform disorder NOS	Somatoform autonomic dysfunction
	Other somatoform disorders
	Somatoform disorder unspecified
	Neurasthenia (in other neurotic disorders category)

elicited the appropriateness of a psychiatric diagnosis will also depend on how the somatic symptoms are interpreted; that is if they are considered to be medical in origin they may not be counted toward a psychiatric diagnosis. Finally the diagnosis of depression and anxiety will depend on whether the definitions of atypical presentations of depression (Van Hoof, Cluydts, & De Meirleir, 2003) and anxiety (Kushner & Beitman, 1990) are accepted as an adequate basis for diagnosis.

Given these limitations of diagnosis it is not surprising that the estimates of prevalence vary. However a recent review suggested that more than 25% of medical clinical attendees with CFS have a current diagnosis of DSM major depression and 50–75% of a lifetime diagnosis (Afari & Buchwald, 2003). There has been less work seeking anxiety disorder diagnoses in patients with CFS. One study reported generalized anxiety disorder in half the clinic patients examined when the hierarchical rules that subsume it under major depression were suspended (Fischler, Cluydts, De Gucht, Kaufman, & De Meirleir, 1997). Panic disorder was diagnosed in 13% of a clinic sample (Manu, Matthews, & Lane, 1991). Posttraumatic stress syndrome (PTSD) has been reported to have higher than population prevalence in patients with CFS (Taylor & Jason, 2002).

Those patients with CFS who do not meet criteria for depressive or anxiety disorders, will almost certainly be eligible for a DSM somatoform disorder (or an ICD-10 neurasthenia) diagnosis (Sharpe, 1996). Somatoform disorders are descriptive diagnoses primarily defined by somatic symptoms that are not explained by disease and neurasthenia is an alternative psychiatric label for CFS. Like anxiety and depression the diagnosis depends on the clinicians' and patients' assumptions about their symptoms; if one regards CFS as a medical condition, the symptoms attributed to this will not be counted toward a diagnosis of a somatoform disorder; whereas if one regards them as medically unexplained they will be (Johnson, DeLuca, & Natelson, 1996). If a somatoform disorder is diagnosed the clinician has several to choose from: some patients will meet criteria for hypochondriasis because of persistent anxious concern about the nature of their illness, others meet criteria for somatization disorder because of a long history of multiple symptoms, whilst any remaining will fit the undemanding criteria for a diagnosis of undifferentiated somatoform disorder in DSM or neurasthenia in ICD-10. Whilst hypochondriasis and somatization may have some implication for management, undifferentiated somatoform disorder and neurasthenics do not, and merely replace one badly understood diagnosis with another.

Psychiatric comorbidity or alternative diagnosis?

Given the frequency with which psychiatric diagnoses can be made in patients who have a diagnosis of CFS, should these diagnoses be considered as coexisting conditions or as alternative diagnoses to CFS? For medical conditions that are defined by variables other than symptoms such as cancer symptoms consistent with a diagnosis of depression are regarded as evidence of an additional separate diagnosis and are referred to as *comorbid*. However if the patient's diagnosis is of a functional somatic syndrome the psychiatric diagnosis if potentially an *alternative* diagnosis.

Much of the literature on CFS adopts the assumption that it is a medical condition like cancer, consequently describing psychiatric diagnoses as comorbid. However the lack of a generally agreed pathology for CFS (Afari & Buchwald, 2003) (despite the voluminous biological research literature) makes such a distinction merely an assumption, rather than a proven fact. This leads us inevitably to the conclusion that, in the current state of knowledge, CFS and the appropriate psychiatric diagnosis (whether anxiety, depression or somatoform) have to be considered as competing alternative diagnoses, the choice depending on the clinician's and patient's preference at least as much as on science.

Does the diagnosis matter for clinicians?

Does the fact that CFS and psychiatric disorder are alternative diagnoses of the same symptoms really matter from a clinician's point of view? In practice it probably does, at least sometimes (Sharpe, Chalder, Palmer, & Wessely, 1997). Neglecting to make some psychiatric diagnoses may lead to the patient not receiving appropriate treatment, and having a worse outcome. This may occur because having not made the diagnosis, neither patient nor doctor then sees the psychiatric treatment as relevant. Anyone who has assessed large numbers of patients with CFS will be well aware of this shortcoming in care with many patients having untreated depressive and anxiety disorders. On the other hand if the patient does not accept the diagnosis of depression they cannot benefit from treatment for it. And if the psychiatric diagnosis is of undifferentiated somatoform disorder there is little benefit to be obtained by accepting it in any case!

Why is it such a hot issue for patients?

This is an interesting subject of inquiry in is own right. An obvious initial answer may be that people become upset because the suggestions that CFS is linked with or even better regarded as a psychiatric disorder is simply factually incorrect. However as we have seen the issue really is not clear cut and, on the basis of current evidence, it is really a matter of preference which diagnosis one chooses. It is notable that other conditions which straddle psychiatry and neurology such as dementia do not generate such controversy. It therefore seems that it is the psychological and social implications of being labelled as having a psychiatric illness about which there is particular sensitivity.

This issue brings us back to dualism. Dualism is not merely a neutral philosophical debate. There is an important moral aspect to dualism (Kirmayer, 1988). That is psychiatric and medical diagnoses have different moral implications in the eyes of both by the public and of many medical practitioners. Medical disorders are, by and large, regarded as unfortunate failures of the bodily machinery that are beyond the person's responsibility and control. Consequently, they attract the sympathy of others to the unfortunate victim. Psychiatric disorders on the other hand are often regarded as illnesses of mind, which

represent a failure of the faculties of reason and self-control. They carry an implication that the patient is not a victim but rather a person who has failed in the exercise of will and is consequently culpable, associations that encourage a response not of sympathy but of fear and contempt. This stigma associated with a psychiatric rather than a medical diagnosis may exert a strong influence on how a patient presents, to whom they are referred, and how they are subsequently managed.

So, for a person with an illness of ambiguous status such as CFS, the choice is between being given a diagnosis of a bona-fide medical condition which everyone regards as real, an adequate reason to be away from work, a reason to seek medical care and a blameless affliction *or* a psychiatric diagnosis which many people regard as imaginary brought on by yourself, evidence of laziness rather than illness and not really deserving of any particular sort of care. The rational person would arguably make the obvious choice. Furthermore if that person felt that the medical establishment had got it wrong, and indeed had got it wrong not by mistake but by virtue of a conspiracy to prevent his/her illness being regarded as legitimate, one might become politically active and make a big fuss. This seems to be what has happened (Walker, 2003).

From the perspective of the patient advocate, this issue is not a mere intellectual diversion but a serious battle. And, given the aforementioned considerations, perhaps an understandable battle. The territory being fought over is the very legitimacy of the illness. The battle lines were initially between CFS and psychiatric disorder, but have now been pushed back to between CFS and ME. The fact that there is no reliable way to distinguish between these conditions – both of which are defined by symptoms – is not the point. The point is that the *implications* of these diagnoses are very different and allow those who are concerned that chronic fatigue syndrome is becoming psychiatric to redraw a boundary between ''genuine neurological disease'' and ''stigmatized psychiatric illnesses''.

A useful way forward?

So should we use the diagnosis of CFS or the alternative psychiatric diagnosis? Arguably neither of these diagnoses alone is adequate; perhaps we should use both (Sharpe, 1998). Indeed proper use of the DSM-IV diagnostic scheme allows both diagnoses to be used by placing them on different axes. For example the assessor might record CFS on the medical Axis 3 and generalized anxiety disorder in the psychiatric Axis 1. The final diagnosis could then be CFS/generalized anxiety disorder. Ultimately, of course, we need to transcend this dualistic medical psychiatric dichotomy and derive a third way that avoids two diagnoses being given for the same symptoms (Mayou, Levenson, & Sharpe, 2003).

Conclusion

What can we learn? First, this issue forces us to ask uncomfortable questions about the nature of both psychiatric disorders and functional syndromes such as CFS, the extent to which we think of these as entities and the extent to which they are merely constructions which have no intrinsic existence, but which are merely different ways of looking at a pattern of a variety of symptoms (however genuine those symptoms are). Given the overlap within functional syndromes, within psychiatric diagnoses and between psychiatric diagnoses and functional syndromes, one might reasonably consider psychiatric and functional somatic syndrome diagnoses as a series of relatively arbitrary circles drawn on the map of symptoms. The size and overlap of these circles has been

drawn on the basis of limited evidence and they should be seen as arbitrary circles drawn on the map, rather than necessarily being features of the map itself.

Second, we need to ask whether our current practice of dividing illness into psychiatric and medical diagnoses is helpful at all (Kendell, 2001). Insofar as we have different hospitals, different specialist and different textbooks for each, it clearly is. However new scientific knowledge, such as the demonstration of a neural basis to many psychiatric disorders, is rendering crude dualistic thinking increasingly untenable, and replacing dualism by the alternative hypothesis that mind and brain are best regarded as simply two sides of the same coin – the mind/brain (Granville-Grossman, 1993), rather than separate entities. The implications of such a paradigm shift are potentially enormous and have not yet been fully realized (Sharpe & Carson, 2001). It implies that ''psychiatric disorders'' are no more distinct from ''medical conditions'' than the nervous system is from the rest of the body. Hence, not only is psychiatry rapidly becoming less ''brain-less'' but medicine will also have to become less ''mind-less'' (Eisenberg, 1986).

At present however if one has an ambiguous condition the rational choice may well be to vote ''medical'' rather than to vote ''psychiatric''. From this view point one may argue that it is not the views of those advocates who attempt to defend CFS from psychiatric territory which must change, but us who must change in the way we currently conceptualize illness. So whilst the issue of relationship between CFS and psychiatric disorder may seem to be merely a small issue, it does, in fact, raise issues which challenge the way we see the larger perspective of modern medical thought and practice.

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