Differentiating ME/CFS from Psychiatric Disorders

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ME/CFS is not a psychiatric disorder I

- **Rates of psychiatric disorder in ME/CFS are similar to rates in other chronic medical conditions.** (Thieme *et al*, 2004;Hickie *et al*, 1990).
- **How one defines ME/CFS has a major impact on the psychiatric comorbidity rates measured.** (Jason *et al*, 2004).

ME/CFS is not a psychiatric disorder II

- **Rates of personality disorder in ME/CFS are not elevated.** (Pepper *et al*, 1993; Saltzstein *et al*, 1998;Chubb *et al*, 1999)
- **Physiology is different in ME/CFS than depression. Anxiety has not been compared.** (Pazderka-Robinson *et al*, 2004; Flor-Henry *et al*, 2003; Scott & Dinan, 1998)

ME/CFS is not a psychiatric disorder III

- **The genetics of depression and ME/CFS are independent.** **(Hickie *et al*, 1999)**
  - **ME/CFS is also genetically different from FM (Garcia-Fructuoso *et al*, 2008**
- **In prospective studies, illness severity predicts outcome in ME/CFS.** **(Darbishire *et al*, 2005)** **but**
- **Psychological symptoms and cognitive beliefs do not.** **(Deale *et al*, 1998;Jones *et al*, 2004a)**

Research Design is Critical

- **How one defines ME/CFS has a major impact on the psychiatric comorbidity rates measured. (Jason *et al*, 2004).**
- **Somatization is the most glaring example (Johnson et al 1996).**
- **The CDC empirical definition does not differentiate well (Jason 2007).**

Co-Morbid Psychiatric Symptoms

- **Patients with ME/CFS get all psychiatric symptoms just like anyone else.**
- **Don’t assume the symptoms are due to the ME/CFS.**
- **As in the general population, Depression and Anxiety are the most common.**
- **Depression and Anxiety are the most difficult to differentiate from the symptoms of ME/CFS.**

DSM IV Major Depression

5 or more of following symptoms:

1. depressed mood (sad or empty) most of the day nearly every day
2. decreased interest or pleasure in most activities nearly all the time
3. significant (>5% change) weight loss or weight gain not due to dieting and/or change in appetite (up or down)
4. insomnia or hypersomnia nearly every day
5. objective (notable by others) psychomotor agitation/retardation nearly all the time
6. fatigue or loss of energy nearly every day
7. feelings of worthlessness or excessive guilt nearly every day
8. decreased ability to think or concentrate or indecisiveness nearly every day

- Duration of > 2 weeks
- Level of functioning decreased from before
- Must have either 1 depressed mood or 2 loss of interest or pleasure

DSM IV Generalized Anxiety

Does the subject have:

1. **Excessive worry on most days (about many things, not just illness)**
2. **Duration > 6 months**
3. **Difficulty controlling worry**
4. **Must have 3 or more of the following symptoms:**
   - ✴ **feeling restless or keyed up**
   - ✴ **easily fatigued**
   - ✴ **difficulty concentrating/mind going blank**
   - ✴ **irritability**
   - ✴ **muscle tension**
   - ✴ **sleep disturbance (difficulty falling asleep or unrefreshing sleep)**
5. **Symptoms cause clinically significant distress/impairment**
6. **Symptoms are NOT due to direct physiological effects of a medical condition (eg. ME/CFS)**

Clinical Differences between ME/CFS and Psychiatric Disorder I

- **ME/CFS commonly has an acute infectious onset. Depression and anxiety do not.**
- **ME/CFS has post exertional malaise. In depression and anxiety, most feel better after exercise.**
- **Depression has decreased mood, and increased negative affect: anhedonia, apathy, hopelessness, suicidal ideation, self reproach). ME/CFS does not.**

Clinical Differences between ME/CFS and Psychiatric Disorder II

- **ME/CFS has diurnal variation with pm the worst time of day. Depression is opposite.**
- **Orthostatic intolerance, tachycardia and other autonomic dysfunctions are common in ME/CFS. Not found in Depression. Anxiety has autonomic hyperarousal.**
- **Immune manifestations including tender lymph nodes, sore throat, chemical and food sensitivities common in ME/CFS. Not found in Depression or Anxiety.**

Clinical Differences between ME/CFS and Psychiatric Disorder III

- **Loss of body thermostatic stability, intolerance to extremes of temperature common in ME/CFS. Not reported in Depression or Anxiety.**
- **ME/CFS - Children have a better prognosis than adults. Depression and Anxiety - Children have a worse prognosis than adults.**

Common Types of "Depression" in ME/CFS

1. **Reactive grief due to loss of health, social connections, family support, financial capability, career and uncertainty regarding all of these.**
2. **Biological change in mood/cognition as part of the disorder of ME/CFS (similar to mood change in MS or Parkinson's disease and as reported in epidemic ME).**
3. **Comorbid depressive disorder.**
4. **Mood change due to medication or food or withdrawal from either.**

Common Types of "Anxiety" in ME/CFS

1. **Anxiety about health e.g. prognosis, cause of symptoms or unpredictability of symptoms.**
2. **Anxiety as a result of the impact of having ME/CFS. Anxiety about being denied disability payments is common.**
3. **Biological anxiety as part of the physical disorder of ME/CFS.**
4. **Co-morbid anxiety disorder; GAD and social anxiety being the most common.**
5. **Anxiety in reaction to drug or volatile organic exposure or fear of such exposures in people with co-morbid MCS.**

Consider a Co-morbid Psychiatric Diagnosis when

- **The psychiatric symptoms precede the onset of physical symptoms.**
- **Pessimism, anxiety, etc. is generalized beyond health and illness related issues.**
- **The psychiatric symptoms are intransigent and having a negative effect on treatment.**

Clinical Tips

Ask which activities the patient enjoys when s/he has a good day. If s/he can't think of anything, consider depression. If s/he has a long wish list consider ME/CFS.

Ask if the patient worries about things that are not health related.

Evaluate whether patient's thinking is understandable in the circumstances or dysfunctional and resistant to change.

Clinical Approach I

The best psychiatric antidote for patients with ME/CFS is improved physical health & quality of life.

Clinical Approach II

Spend time listening to patient's worries and explaining why certain diagnoses may or may not be relevant.

Undertake appropriate investigation and referral to rule out feared diagnoses such as cancer, MS or heart disease. (People with ME/CFS can be reassured, people with anxiety may not be).

Validation by physician of diagnosis is therapeutic and does NOT reinforce "illness behavior" any more than in any other disease.

Clinical Approach III

Active support of patient obtaining sustainable school/work conditions or leave of absence from school or work, disability insurance, etc.

Offer to meet with family members to explain the illness and help patient negotiate support.

Clinical Approach IV

- **Ask about suicidal ideation. Suicide is among the top three causes of death in ME/CFS.** **(Smith *et al*, 2006;Jason *et al*, 2006)**
- **In some cases, quality of life is so low that suicide is seen as a reasonable alternative. Assist with finding hope.** **(Jevne & Miller 1999)**
- **Assist patient with grief process as you would in any other serious, chronic medical condition.**

When to use Psychotropic Drugs

Treat psychiatric symptoms in ME/CFS similarly to similar symptoms in the absence of ME/CFS.

No antidepressant has been shown to improve the core symptoms of ME/CFS
(White & Cleary, 1997; Vercoulen *et al*, 1996)

Psychotropic medication should be tried if psychiatric symptoms are interfering with sleep and rehabilitation.

Start Low and Go Slow

- **Patients with ME/CFS can be more sensitive to medications.**
- **Be willing to titrate and give patient permission to experiment with drug doses within a safe range.**
- **Consider compounded drug doses.**

Response to Treatment

- **Notice whether psychotropic treatment leads to improvement in either psychiatric symptoms, symptoms of ME/CFS or both.**
- **This will help validate diagnostic hypothesis.**

Conclusions

- **ME/CFS is not a psychiatric disorder but many patients have co-morbid symptoms.**
- **Offer validation and practical support as in any other medical condition.**
- **Psychiatric symptoms should be diagnosed and treated.**