CFIDS Association of America

working to make CFS widely understood, diagnosable, curable and preventable

Psychiatric and Psychosocial Aspects of Chronic Fatigue and Immune Dysfunction Syndrome (CFIDS) in Children and Adolescents

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A. Children and adolescents, as do adults, have a variety of psychiatric and psychological reactions caused by having CFIDS.

1. There is no good evidence that psychological factors are a major cause of CFIDS, in spite of earlier claims to the contrary. Indeed such spurious claims were a major cause of hobbling clinical and basic research efforts and still cast a pall of doubt. It may be that psychological factors are among the many other stressors that play a part in the onset of CFIDS but they are not the primary cause.
2. It is important to recognize that there are psychiatric symptoms which are primarily biologically caused manifestations of CFIDS and other, often overlapping, symptoms which are secondary reactions to having CFIDS. The latter are the kind of psychological reactions commonly seen in most people, including children, who have any chronic disabling illness, as well as reactions more specific to CFIDS.

    a. Among the major primary biologically caused symptoms are acute and chronic anxiety episodes and panic attacks, emotional lability, sleep problems, and depression. There are in addition a variety of cognitive effects, such as memory deficits, attentional difficulties, language comprehension problems etc. which will be discussed by Dr. Robert Sedgewick. SPECT scans, MRI's, EEG's, and neuropsychological tests have been used to pinpoint affected areas of the brain, showing organic involvement of portions of the cerebral cortex as well the limbic system. The limbic system, linking several brain areas is complex, contains areas that are the sites of emotions, and has connections with both the endocrine and immune systems such that there are probable inter-reactive feedback mechanisms. Many of these biologically-based problems may fluctuate in severity often in conjunction with other physical symptoms.

    b. Each of the psychological symptoms can be compounded by secondary psychological effects. For example, a teenager who is subject to the myriad of physical symptoms (described by David Bell), told by her physician that its all in her head (wrong), or that there is nothing that can be done (wrong), who struggles with a mysterious illness which can't yet be cured and about which little is known including prognosis, who at times is confused, unable to remember names, words, directions usually

familiar and well known, who can't do what she used to be able to do, who wants to do what her peers are doing academically and socially but is hampered by fatigue and unpredictable cognitive resources, is likely to become anxious and depressed. And so would anyone!

B. There are a variety of diagnostic categories that have been confused with the psychological symptoms of CFIDS.

1. These include:

   - Major depressive disorder and dysthymia
   - School avoidance or school phobia
   - Somatoform disorders (somatization, hypochondriasis)
   - Malingering

Each of these can be distinguished from the manifestations of CFIDS. See Tables 1, 2, 3, & 4.

Table 1:

Characteristics which differentiate CFIDS from mood disorders:

CFIDS	Mood Disorders
	Depressive episode (DSM III-R 296.2)
Frustrating and severe fatigue but often with continued motivation	Fatigue accompanied by lacks of interest or motivation
Frequent flu like onset	Onset not usually associated with physical illness
Somatic symptoms include sore throats, fevers, myalgias, visual symptoms, etc.	May involve somatic symptoms but rarely myalgias, sore throat, fever, or visual symptoms
Sleep disorder in Non-REM phases	Sleep disorder in REM phases
Depressed mood: Grief, fear and despair are understandable, given the patient's symptoms and circumstances	Depressed mood: Dysphoria, anxiety, and hopelessness are inappropriate or excessive
Suicidality appears to be a response to desperation	Suicidality may be desperate, but also may be experienced as thoughts of death or self-harm which are persistent, recurrent or intrusive
Self-doubt	Self-blame
Responsive to positive stimuli	Unable to respond with pleasure to praise, rewards or good news
Fluctuating multi-system complaints, some vague	

	Presentation may include persistence and idiosyncratic, pervasiveness of symptoms; possible recognizable syndrome of melancholia (anhedonia, diurnal variation, early a.m. awakening, psychomotor retardation or agitation, and anorexia); may also have brooding or rumination, or psychotic symptoms (delusions or hallucinations)
Decreased concentration with specific cognitive impairments	
May benefit from low doses of antidepressants although some need standard doses and others can't tolerate any	Globally decreased concentration may be due to preoccupations, distractibility, slowed mentation
	Treatment requires full therapeutic dose of antidepressant medication
Cognitive difficulties, somatic symptoms, and energy level are not responsive to psychiatric treatment even if mood improves	
	Entire syndrome is alleviated by treatment

Table 2:

Characteristics which differentiate CFIDS from anxiety disorders:

CFIDS	ANXIETY DISORDERS
	Panic Disorder (DSM III-R 300.01)
Panic attacks accompanied by fatigue, sleep disorder, and multi-system complaints	Somatic symptoms limited to episodes of panic or fear of a recurrence of panic
	Panic seen as extreme and unrealistic
Panic or anxiety may be clearly related to understandable fears about illness and its effects	*Agoraphobia, School Phobia (DSM III-R 300.2, 309.21)*
Avoidance behaviors such as staying at home, may not eliminate symptoms	Avoidance behaviors constrict functioning but control symptoms
	Generalized anxiety (DSM III-R 300.02)
Anxiety symptoms are variable and may coincide with fluctuation or physical symptoms	Symptoms of anxiety (autonomic hyperactivity, motor tension, worries) are persistent and chronic
Anxiety symptoms may appear sporadically or independent from	Worries and concerns are about two or more life circumstances or events

worries, or in context of illness and its effects	

Table 3:

Characteristics which differentiate CFIDS from somatoform disorders:

CFIDS	SOMATOFORM DISORDERS
	Hypochondriasis (DSM III-R 300.7)
CFIDS is clinically recognizable and real	Enduring and unrealistic fear or belief of having a serous disease; no detectable pathology or actual loss of body function
	Conversion Disorder (DSM III-R 300.11)
Multiple symptoms	May be single symptom
Possibly explained by infectious or immune response mechanisms	Symptom cannot be explained by any known pathophysiological mechanism or physical disorder
	Somatization Disorder (Briquet's Syndrome) (DSM III-R 300.81)
Recognizable multi-system profile	Very different profile; symptom list of 35 particular symptoms (of which patients must have 13); does not include fatigue, sleep disorder or decreased concentration.

Table 4:

Characteristics which differentiate CFIDS from other psychiatric disorders:

CFIDS	Other Psychiatric Disorders
	Factitious Disorder (DSM III-R 301.51)
Symptoms are real and genuine	Intentional production or feigning of physical symptoms; presumed

	psychological need to assume the sick role; chronic form is "Munchausen Syndrome" *Malingering (DSM III-R V 65.20)*
Symptoms are real and genuine	Intentional production or feigning of symptoms for external incentives or personal gain

C. There are significant reverberations in the family and school of a child having CFIDS but much can be done to help children manage.

1. In the family:

- Need for acceptance and support, and becoming well-informed
- Impact on the family
- Differentiating normal adolescent issues from CFIDS phenomena
- Pacing, pacing, pacing

2. In the school:

- The importance of diagnosis and becoming informed
- Assessing the child or adolescent's energy level and work capacity
- Arriving at a balance of time in school/home bound instruction

3. Coping with the Sea of Doubt

D. Treatment: Psychiatric medication and psychological management

1. Medication

- For aid with sleep disturbance
- For treatment of associated depression
- For treatment of anxiety
- For energy level assist

2. Supportive therapy for child and family

3. Absolute necessity that helping professionals be well informed

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