PRACTICE

Diagnosis of psychiatric disorder in clinical evaluation of chronic fatigue syndrome

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SUMMARY

The overlap of symptoms in chronic fatigue syndrome (CFS) and psychiatric disorders such as depression can complicate diagnosis. Patients often complain that they are wrongly given a psychiatric label. We compared psychiatric diagnoses made by general practitioners and hospital doctors with diagnoses established according to research diagnostic criteria. 68 CFS patients referred to a hospital fatigue clinic were assessed, and psychiatric diagnoses were established by use of a standardized interview schedule designed to provide current and lifetime diagnoses. These were compared with psychiatric diagnoses previously given to patients.

Of the 31 patients who had previously received a psychiatric diagnosis 21 (68%) had been misdiagnosed: in most cases there was no evidence of any past or current psychiatric disorder. Of the 37 patients who had not previously received a psychiatric diagnosis 13 (35%) had a treatable psychiatric disorder in addition to CFS.

These findings highlight the difficulties of routine clinical evaluation of psychiatric disorder in CFS patients. We advise doctors to focus on subtle features that discriminate between disorders and to use a brief screening instrument such as the Hospital Anxiety and Depression Scale.

INTRODUCTION

When patients complain of persistent, disabling and distressing fatigue and no medical explanation is forthcoming, doctors face a diagnostic dilemma[1]. The process of diagnosis is complicated by an overlap in symptoms of chronic fatigue syndrome (CFS) and those of some psychiatric disorders, particularly depression and anxiety. Shared symptoms include changes in sleep and appetite, lack of energy, poor concentration, low mood and worry. Thus, one doctor's CFS can be another's severe depression[2]. The diagnostic process may also be affected by the views of doctors and patients. When physical symptoms arise in the absence of identifiable disease, some doctors prefer a psychiatric diagnosis to one of CFS. In contrast, CFS patients are often fiercely resistant to psychiatric diagnoses[3–6]. However, no group has yet examined whether or not psychiatric disorder is overdiagnosed in routine clinical practice. In the present study we compared the psychiatric diagnoses made by general practitioners (GPs) and hospital doctors in normal clinical practice with 'gold-standard' diagnoses established according to research diagnostic criteria.

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METHODS

We studied 68 patients who met UK criteria for CFS[7], referred by GPs or consultants to a fatigue clinic in King's College Hospital. All patients completed a questionnaire that asked for details of any psychiatric diagnoses or labels given during the course of their illness. This was cross-checked against information in referral letters and medical notes. A psychiatric diagnosis was judged to have been given if it was mentioned in both the patient's self-report and the referral letter or case notes.

Patients had a standardized structured interview with a consultant psychiatrist experienced in CFS, including a full medical, psychiatric, family and personal history. CFS was diagnosed according to UK criteria[7]. Gold-standard psychiatric diagnoses were made by using an abbreviated version of the Schedule for Affective Disorders and Schizophrenia (SADS)[8]. This is a standardized psychiatric interview designed to provide current and lifetime research criteria, which were then rated by use of the *DSM III-R* classification system. To control for overlap between symptoms of depression and CFS, fatigue was excluded as a criterion for psychiatric diagnoses.

The psychiatric diagnoses previously given to patients were compared with research diagnostic criteria diagnoses. Patients were classified as misdiagnosed if there was no evidence of any past or current psychiatric disorder, or if they had a current psychiatric disorder that differed from the one originally diagnosed.

RESULTS

The patients' mean age was 38.3 years (SD 9.8). 43 (63%) were women and 45 (66%) were in social classes I or II (Registrar General's classification). The mean illness duration was 4.2 years (SD 4.9). All believed themselves to have a physical illness called myalgic encephalomyelitis. These characteristics are typical of CFS patients seen in specialist settings.

Psychiatric diagnoses

Of the 68 patients, 31 (46%) reported that they had been given a psychiatric diagnosis or label, most commonly depression. These diagnoses were made by GPs (19), hospital doctors (7) and neurologists (5). On assessment according to research diagnostic criteria, 23 (34%) of the 68 patients were found to have a psychiatric disorder, most commonly depression. 45 (66%) did not meet *DSM III-R* criteria for either current or past psychiatric disorder.

Clinical versus research diagnoses

Diagnoses made by GPs or hospital doctors were compared with gold-standard diagnoses. 10 (32%) of the 31 patients who had been given a psychiatric diagnosis by a GP or hospital doctor were judged to have been correctly diagnosed. Of these, 7 met *DSM III-R* criteria for a current psychiatric disorder and 3 were found to have had a major depressive illness earlier in the course of their illness which had either remitted or been successfully treated by the time they reached the CFS clinic. 21 (68%) of the 31 patients previously given a psychiatric diagnosis were found to have been wrongly diagnosed. Of these, 17 did not meet criteria for either past or present psychiatric disorder, and 4 met criteria for a psychiatric disorder other than the one they had been labelled with. 37 of the 68 patients had never previously been given a psychiatric diagnosis. Of these, 13 (35%) met research diagnostic criteria for treatable psychiatric disorder, present for at least six months.

The sensitivity and specificity of psychiatric diagnoses made by GPs or hospital doctors were compared with the gold standard diagnoses (Table 1). Clinical psychiatric diagnosis had a sensitivity of 44% and a specificity of 53%.

Table 1 **Comparison of gold-standard versus clinical psychiatric diagnoses**

	Gold-standard psychiatric diagnoses	
	Present	***Absent***
Clinical psychiatric diagnoses		
Given	10	21
Not given	13	24
Totals	23	45

DISCUSSION

In this study of 68 CFS patients referred to a hospital fatigue clinic, nearly half had previously received a psychiatric diagnosis from a GP or hospital doctor. Two-thirds of them had been incorrectly diagnosed, with most showing no evidence of past or current disorder. In contrast, one-third of those who had never been given a psychiatric diagnosis actually had a treatable psychiatric disorder in addition to CFS.

One explanation for the present findings is that the psychiatric status of some patients changed (for better or worse) in the interval between their last consultation with a doctor and their assessment at the CFS clinic. However, this seems unlikely to account for all cases of missed diagnosis or misdiagnosis. In fact, the findings should not come as a surprise. The doctors making the diagnoses had no specialist training or experience in CFS or psychiatry, and had limited access to patients' histories. Their patients were probably particularly complex: CFS patients seen in specialist settings are usually severely disabled, with high levels of psychological distress and strongly held physical illness attributions[9]. These patients are not representative of the wider population of CFS patients, and the rates of over and under diagnosis of psychiatric disorder in this sample may not apply to primary care settings. Nevertheless, the present findings suggest that, for CFS patients referred to specialist settings, routine clinical evaluation of psychiatric disorder by GPs and hospital doctors carries a high false-positive rate and also fails to detect many true positives.

These findings highlight the difficulties of assessing psychiatric disorder in patients presenting with medically unexplained fatigue. Most CFS patients fulfil at least some of the criteria for depression or anxiety. The difficulties of measuring psychiatric disorder through clinical interview alone may be offset by paying greater attention to the relatively subtle features that discriminate between disorders. For example, CFS and depressed patients report a range of somatic symptoms, but these are more marked in CFS[10]. Low self-esteem, hopelessness, anhedonia, and suicidal ideation are not characteristic of CFS but are frequently found in depression[11]. Similarly, avoidance behaviour or activity reduction is present in CFS, anxiety disorders and depression, but in CFS it may be driven by lack of energy rather than fear or loss of interest. Self-rated screening questionnaires may also be helpful. The Hospital Anxiety and Depression rating scale[12] is a valid and efficient screening instrument for anxiety and depression—brief, acceptable to CFS patients and sensitive to change[13].

Misdiagnosis of psychiatric disorder can be as serious as misdiagnosis of physical disorder. An undiagnosed psychiatric disorder means that treatable conditions are overlooked, while an inappropriate psychiatric diagnosis is likely to be rejected by patients and may irretrievably damage the doctor–patient relationship[1]. We recommend that, in the sensitive circumstances of CFS, doctors pay particular attention to accuracy and clarity in the making of psychiatric diagnoses.

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