

Origin of Chronic Fatigue: Emotional or Physical?

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Abstract

Chronic fatigue is a common complaint encountered by all physicians. In most instances, after intensive testing, no physically demonstrable diseases are found to explain the fatigue, leaving two possible explanations: 1) underlying emotional disorders such as depression and/or anxiety, or 2) a poorly defined condition called “systemic exertion intolerance disease” (previously called “chronic fatigue syndrome”). Dealing with these latter two possibilities presents a challenge to all physicians, and suggestions for recognition and management are presented. In most cases of fatigue without a physically demonstrable origin, studies show that cognitive behavioral therapy, combined with regular exercise, are useful adjuncts to focused psychiatric management of any associated emotional problems.

Keywords: *Chronic Fatigue; Systemic Exertion Intolerance Disease; Chronic Fatigue Syndrome; Myalgic Encephalomyelitis*

One of the commonest complaints general physicians face daily is that of fatigue, estimated to comprise as high as 30% of all patient encounters [1]. Although chronic fatigue can be caused by various physical ailments, it is far more commonly emotional in origin. In order to make this distinction, most physicians begin by performing the usual physical examination, abetted by the necessary complementary tests, to detect various physical causes for fatigue such as anemia, heart disease, cancer, etc. In most instances, all these findings are normal, meaning that underlying emotional problems must be sought, or, additionally, a poorly defined condition, “systemic exertion intolerance disease,” formerly called “chronic fatigue syndrome,” requires consideration, as discussed below.

In the absence of an underlying demonstrable physical disease, fatigue is generally the result of psychological factors such as anxiety, depression, overwork, lack of adequate sleep, or simply boredom, stresses that may be caused by an unhappy marriage, work frustrations, or a myriad of others. Symptoms can also be magnified by the effect of deconditioning in an individual who avoids any physical activities. It defies logic that all such sufferers could be placed into any single category. To arrive at proper conclusions, we must then rely on the subjective complaints to estimate the severity of fatigue, and this is, at best, a daunting task. Complicating matters even further, we are also confronted by a poorly defined “physical” condition, dubbed “systemic exertion intolerance disease”, which could be responsible for fatigue. This name, in replacing the former chronic fatigue syndrome label, seems to indicate—rightly or wrongly—the presence of a physical malady. Another even more sinister label, “myalgic encephalomyelitis,” has sometimes been applied to this condition, confusing matters even further. But since there are at present no objective tests to confirm or refute the presence of a physical origin, we must rely on clinical assessment to make the diagnosis. In analyzing most cases of fatigue, I have found that one helpful means to make this distinction is with the simple question: Is the fatigue relieved after a period of rest or after a satisfactory night of sleep? Fatigue that is not significantly relieved by rest suggests an emotional origin.

The newly labeled condition referred to above, “systemic exertion intolerance disease,” is presumably physical in origin, and relies on the following four criteria for diagnosis [2]:

- 1) Substantial reduction or impairment in the ability to engage in pre-illness levels of occupational, educational, social, or personal activities, that persists for more than 6 months and is accompanied by fatigue, which is often profound, is of new or definite onset (not lifelong), is not the result of ongoing excessive exertion, and is not substantially alleviated by rest
- 2) Post-exertional malaise
- 3) Unrefreshing sleep
- 4) Cognitive impairment; orthostatic intolerance (symptoms when standing upright that are relieved when sitting down again); or both.

These characteristics are, at best, non-specific and overlap considerably with the complaints often encountered that are attributable to underlying emotional problems, often depression with or without anxiety. Multinational studies suggest that 80% of patients with a chronic fatigue syndrome-like illness have a lifetime psychiatric disorder such as depression or generalized anxiety disorder [3,4]. If most of these individuals actually harbor a primary diagnosis of depression, we are then likely providing a disservice by applying a physical disease label. The disadvantages of such a label would include the omission of detailed analyses and therapy for underlying emotional disorders. This classification might also qualify one as being physically disabled, implying the inability to perform even basic physical chores, which would also likely deprive them of the potential benefits of regular graded physical exercise.

But some would argue that, in most instances, depression is the result-rather than the cause-of the chronic fatigue. If this were the case, however, one would expect a similarly high, or higher, prevalence of depression in serious life threatening physical disorders such as cancer. Although cancer may produce depression, a meta-analysis [5] disclosed that the pooled prevalence of major depression in palliative care settings was equal to approximately 16.5%, far below that reported in chronic fatigue syndrome. This alone raises a red flag that challenges the thesis that fatigue alone may account for such frequent and profound depression. In each individual case, the clinician must determine whether the depression seems excessive relative to the apparent severity of fatigue, suggesting that the main underlying problem is that of depression.

Also, I have found that many cases of profound fatigue of emotional origin manifest multiple widespread somatic complaints without associated physical findings [6], and this observation should stimulate the need to seek and address associated psychiatric problems, sometimes referred to as somatoform disorders.

More recently, certain non-professional writers [7] have maintained in the mass media that “chronic fatigue syndrome” is a physical malady and the major cause of all chronic fatigue. Their conclusion was based primarily on their own reinterpretation of a large study [8] that showed a benefit of two of the recommended treatments of this condition-exercise and psychotherapy (cognitive behavior therapy)-as opposed to those who did not. Their reanalysis of the study data-likely confounded by selective bias-suggested that the treatments had no beneficial effect, implying that a treatment failure refuted the conclusion that emotional causes could be operative. However, even if these treatments failed, this would not necessarily establish a physical cause for fatigue. Further undermining their credibility, these authors stated, without supporting evidence, that chronic fatigue patients “routinely report deterioration after a program of graded exercise.” This statement contradicts the findings of a recent large review [9] that concluded that “patients with CFS (chronic fatigue syndrome) may generally benefit and feel less fatigued following exercise therapy.” Moreover, in virtually all systematic studies during the past 60 years encompassing a vast array of persons suffering from illnesses ranging from depression to serious heart and lung disorders, regular graded exercise is either uniformly beneficial or displays no significant deterioration. These authors concluded that, since these two treatment methods were now considered discredited, chronic fatigue syndrome must be physical in origin, and that “doctors and medical organizations must stop recommending these two therapies as treatment options”.

Instead of disparaging current concepts of chronic fatigue, what is needed are studies to seek better means' of objectively making proper categorization of underlying factors that can produce fatigue-physical or emotional-in order to provide personalized decisions about what treatments, if any, should be employed. If some of these patients do indeed harbor physical problems such as some type of chemical imbalance, then counter measures could be designed to attack them in a rational way. Unfortunately, to simply apply a confusing array of labels such as chronic fatigue syndrome, "systemic exertion intolerance disease," "myalgic encephalomyelitis" or any others, are all based upon subjective complaints, and will not provide real clarification of an already complex problem.

In the meantime, management that includes graded exercise and cognitive behavioral therapy, although often less than ideal, are worthwhile options for treatment of fatigue that lacks demonstrably physical causes. Underlying emotional disorders, especially anxiety and depression, must be diligently sought and treated, for, in the last analysis, this may be the most promising means to achieve improvement.

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