Childhood experiences of illness and parenting in adults with Chronic Fatigue Syndrome

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Abstract

Objective: There are many similarities between chronic fatigue syndrome (CFS), the somatoform disorders and problems otherwise known as "medically unexplained symptoms." There is some evidence to suggest that a combination of inadequate parenting and early illness experience may predispose the individual to develop medically unexplained symptoms in adult life. The aim of this investigation was to compare the contributions of childhood experiences of illness and parenting in adults with CFS with a fracture clinic control group. **Method:** A retrospective case control design was used. Thirty patients with a diagnosis of CFS and 30 patients attending a fracture clinic in an inner London teaching hospital completed questionnaires measuring parental care and protection and were interviewed about childhood experiences of illness. **Results:** There were no differences in childhood experience of illness in the two groups. However, logistic regression revealed that maternal overprotection and depression were associated with the diagnosis of CFS. **Conclusion:** The findings may represent risk factors for the development of CFS in adult life. It is possible that maternal overprotection in particular is related to the formation of belief systems about avoiding activity that operate to adversely influence behaviour in patients with CFS. © 2003 Elsevier Science Inc. All rights reserved.

Keywords: Chronic fatigue syndrome; Childhood experiences; Maternal overprotection; Parenting

Introduction

Chronic fatigue syndrome (CFS) is a poorly understood condition that is characterised by severe mental and physical fatigue and is associated with muscle pain and sleep disturbance. The prognosis for patients with CFS is poor without effective intervention [1] and no single cause of CFS has yet been established. While the biomedical search for a cause is important, the cognitive behavioural model of fatigue has provided one of the most useful contributions to date. This is because a cognitive behavioural approach is inclusive of a range of influences and incorporates a temporal perspective. Physical emotional, cognitive, social and behavioural factors are synthesised to provide a coherent explanation of vulnerability to, onset and maintenance of CFS [2]. As a result, analysis of the difficulties encountered in CFS has been translated into an effective treatment [3,4]. Overall, however, predisposing factors are poorly understood and require further investigation.

Given that the somatoform disorders are characterised by "physical symptoms that suggest a general medical condition... and are not fully explained by a general medical condition" [5], the similarities between CFS, the somatoform disorders and other analogous problems, usually described as "medically unexplained symptoms," are immediately apparent.

Exposure to early illness experience, either directly or within the family, has been linked to the development of medically unexplained symptoms both in childhood [6,7] and adult life [8–12]. Hypochondriacal anxiety in adult life has been linked to parental over concern and solicitude in childhood [9,13], and it is thought that iatrogenic factors such as hospitalisation at key developmental stages may be influential in the development of chronic forms of medically unexplained symptoms [14–16].

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It is possible that the available evidence about the effect of early illness experience and parenting in somatoform disorders and "medically unexplained symptoms" is relevant to the development of CFS. This study, therefore, hypothesized that patients with CFS would report more early illness experience than the fracture clinic controls and that there would be differences in parental care and protection between the two groups.

Method

Subjects

One hundred and fourteen patients with a diagnosis of CFS on the waiting list for cognitive behaviour therapy at a tertiary referral unit in an inner London teaching hospital were contacted by post and invited to take part in the study. Thirty patients were recruited over an 11-month period. All patients had undergone a standard psychiatric assessment prior to being placed on a waiting list for cognitive behaviour therapy. By necessity, each patient would have been asked briefly about both parents, but the main focus of the interview was on current difficulties, and we feel that this would have been unlikely to have primed them in any way for recall of particular aspects of their history.

Thirty patients, matched on gender, were recruited as controls from patients attending seven fracture clinics in the same hospital over a 1-month period. Fracture clinic patients are also hospital outpatient attenders, have a medically explained condition and discrete illness 'episode,' i.e., the fracture.

All patients were aged between 18 and 60 years. Exclusion criteria for both groups included a history of drug or alcohol dependence and/or severe mental illness. Two further exclusion criteria for the fracture clinic group were added: a history of CFS or Fibromyalgia and no access to a telephone.

Informed, written and witnessed consent was obtained from each patient before taking part and local ethical approval was obtained for both groups of patients prior to the start of the study.

Measures

Details on age, sex, marital status and socioeconomic status were collected for all subjects. Each patient was interviewed using the Childhood Development Interview [17]. All of the information that is collected relates to the respondent's experience during years 0–16. Subjects are asked to report on the physical and psychological health of their parents, their own and their siblings' physical health. The information provided is rated by the interviewer according to four criteria. A score of 1 represents no or trivial illness, with no impact on child; 2 represents short illness with some disability but good recovery; 3 represents illness with lasting moderate impairment; 4 represents severe or recurrent illness with enduring impairment. Particular importance is given to illness that impairs the ability to parent adequately. There are further categories that relate to other areas of adversity, e.g., parental separation. The instrument was originally developed for use with patients with a diagnosis of somatisation disorder and, with some modifications, some components of it are currently being validated for use with other populations. Severe, enduring impairment is reflected in a higher score.

Each patient also completed the following.

The Parental Bonding Instrument [18] is a 25-item self-report questionnaire that measures perceived parental behaviour and attitudes in relation to care and protection during years 0–16. The Parental Bonding Instrument measures the presence of care as characterised by emotional warmth and intimacy, and overprotection is characterised by intrusion and control. Thus, it is possible for respondents to report a parent who was very unlikely to talk to them in a warm and friendly voice, and to appear emotionally cold, which would indicate low care, while also identifying responses such as the invasion of privacy and actively fostering dependence on the parent, as an ongoing and parallel style of parenting, indicating overprotection.

The Fatigue Questionnaire [19] is an 11-item self-report questionnaire that measures physical and mental fatigue. Fatigue symptoms are rated on a four-point ordinal scale ranging from *less than usual* to *much more than usual*. Excessive fatigue or "caseness" is defined by a score of 4 or above.

Table 1
Demographic variables

Patient characteristics	CFS group ($n = 30$)	Fracture clinic controls ($n = 30$)	Statistic and P value
Age (mean and 95% CI)	39.6 (35.9472–43.2528)	35.9 (31.7942–40.11392)	*t*-test, $P = .18$
Sex (male:female)	6:24 (20:80)	8:22 (26.7:73.3)	$\chi^2 = 0.37$, $df = 1$ $P = .54$
Marital status: categories combined (%)			
Married/cohabiting	15 (50)	15 (50)	$\chi^2 = 0.61$, $df = 1$, $P = .44$
Single/divorced/separated	15 (50)	15 (50)	
Occupation (%)			
I and II	11 (36.7)	8 (28.6)	$\chi^2 = 0.43$, $df = 1$, $P = .51$
III or below	19 (63.3)	20 (71.4)	