Chronic fatigue syndrome is an illness characterized by profound disabling fatigue lasting at least 6 months and accompanied by numerous rheumatological, infectious, and neuropsychiatric symptoms (Fukuda K. et al.1994). As the name implies, chronic fatigue syndrome is a symptom-based or clinical diagnosis without distinguishing physical examination or routine laboratory findings. Infectious, immunological, neuroendocrine, sleep, and psychiatric mechanisms have been investigated; however, a unifying etiology for chronic fatigue syndrome has yet to emerge. Regardless of the pathogenesis, persons with chronic fatigue syndrome, like those with other chronic diseases, have a substantially impaired functional status that results in significant personal and economic morbidity (Bombardier C.H.& Buchwald D. 1996; & Buchwald D. et al.1996).

Bell D.S. in 1995 has defined chronic fatigue syndrome (CFS) as, "A complex symptom pattern, characterized by functional limitations and dominated by debilitating fatigue". As a result of a lack of explicit laboratory markers to diagnose CFS, the diagnosis is strictly clinical (Bell D.S., 1995; & Smith M.S. et al.1991). The major criteria consist of fatigue persisting for at least 6 months, seriously interfering with the patient's daily activities, and without evidence of organic or psychiatric illnesses that can produce chronic fatigue. Minor symptom criteria include impaired memory or concentration, sore throat, tender cervical or axillary lymph nodes, muscle pain, multi joint pain, new headaches, unrefreshing sleep, and post exertion malaise (Fukuda K. et.al.1994).

Chronic fatigue syndrome (CFS), otherwise known as myalgic encephalomyelitis or post-viral fatigue syndrome, is an illness characterized by persistent debilitating fatigue of uncertain origin. A multiplicity of other symptoms are associated with CFS such as muscle and joint pain, fever, sleep disruption, and impaired memory and concentration. Prevalence rates for this disorder have been quoted between 7.4 and 37 per 100,000, depending on the sampling procedures and diagnostic criteria used (Gunn, Connel & Randall, 1993; Lloyd, Hickie, Boughton, Spencer & Wakefield, 1990; Price, North, Wessely & Fraser, 1992). The average age of onset is approximately 30 years, with well-educated white women being over represented in patient samples (Gunn et al., 1993). CFS in adolescence mostly has an acute onset, presenting as a flu- or mononucleosis-like image, e.g., Epstein-Barr virus infection (Bell D.S.1995; Smith M.S. et al.1991; Jordan K.M. et al.1998; & Carter B.D. et al.1995). In ~25% of cases, the onset is insidious. Depending on the diagnostic criteria and age ranges used, prevalence estimates for adolescents vary from 23/100 000 to 116.4/100 000 in children from 6 to 19 years old. In the literature a predominance is reported of CFS in adult women (ratio 4:1 for women vs. men) and this also seems to be the case in pediatric CFS (Bell D.S.1995; Jordan K.M. et al.1998; & Kennedy J.L. Pearce J.B.1995). Although in young children the distribution seems to be more equal, after puberty adolescent girls seem to outnumber adolescent boys. The middle and upper socioeconomic classes are slightly overrepresented in research on chronically fatigued patients (Jordan K.M. et al. 1998; Carter B.D. et al. 1995; & Kennedy J.L. & Pearce J.B.1995).

Fatigue is the hallmark of chronic fatigue syndrome. Patients often report excellent pre-illness physical fitness and energy (MacDonald et al.1996) and an abrupt onset of fatigue, typically with a flu-like illness (Salt I.E. 1997 & Schluenderberg A. 1992). After illness onset, however, patients indicate that physical exertion tends to exacerbate the fatigue. Many patients with chronic fatigue syndrome also often experience anorexia, nausea, drenching night sweats, dizziness, and intolerance to alcohol and other pharmaceuticals that affect the central nervous system (Komaroff A.L. et al.1996). Finally, those with chronic fatigue syndrome have significant functional impairment. Nearly all patients with chronic fatigue syndrome note a decrease in social relationships in addition to other unwanted consequences of illness (Sharpe M.C. et al.1991); about one-third are unable to work, and another one-third can only work part-time (Bombardier C.H. & Buchwald D.1996).

The idiopathic nature of CFS has resulted in a decade-long debate about whether the aetiology of this disorder is organic or psychological. Those favouring an organic cause have linked CFS to viral pathogens, muscle abnormalities and immunological disorders (Buchwald & Komaroff, 1991). Advocates of the psychological position have suggested that CFS is a psychiatric syndrome, such as depression, which presents with prominent somatic features (Kruesi, Dale & Straus, 1989; Manu, Lane & Mathews, 1988, 1993). Inconclusive results in both these fields have led others to propose that CFS may be caused by an interaction of both physical and psychosocial factors (Ray, 1991; Ware, 1993). In accordance with this thinking, Wessely and his colleagues have developed a model of CFS which suggests that a cycle of cognitive and behavioural responses mediates between the acute organic illness and the chronic syndrome (Butler, Chalder, Ron & Wessely, 1991; Wessely, Butler, Chalder & David, 1991).

There is some support for this model of CFS. Investigations into CFS patients’ symptom experience have frequently demonstrated that subjective reports of cognitive difficulties and neuromuscular symptoms are incongruent with objective test results (e.g., Altay, Toner, Brooker, Abbey, Salt & Garfinkel, 1990; Grafrnan, Schartz, Dale, Scheffers, Houser & Straus, 1993; Lloyd, Hales & Gandevia, 1988). These studies suggest that CFS patients have distorted perceptions of effort and sensation which may contribute to their functional disability. Other investigators have focused on coping styles and beliefs about CFS. Two longitudinal studies of patients with chronic fatigue found that patients who strongly believed their condition was caused by a physical agent were more functionally impaired (Sharpe, Hawton, Seagroatt & Pasvol, 1992; Wilson et al., 1994). Sharpe et al. (1992) also established that coping with chronic fatigue by avoiding exercise was predictive of disability. A cross-sectional study of coping in CFS reported that patients who coped with the illness by maintaining high activity had higher levels of functioning, while focusing on symptoms and accommodating to the illness were associated with greater functional impairment (Ray, Weir, Stewart, Miller & Hyde, 1993).

The history of chronic fatigue syndrome (CFS, also known by many other names) is thought to date back to the 19th century and before. Several descriptions of illness resembling those of chronic fatigue syndrome have been reported for at least two hundred years (Lorusso L. et al. 2009). In the 19th century neu-
The DSM-IV-TR (American Psychiatric Association, 2000) classifies chronic fatigue syndrome as 'undifferentiated Somatoform disorder,' with the following diagnostic criteria:

A. One or more physical complaints (e.g., fatigue, loss of appetite, gastrointestinal or urinary complaints). B. Either: 1) After appropriate investigation, the symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance (e.g., a drug of abuse, a medication). 2) When there is a related general medical condition, the physical complaints or resulting social or occupational impairment is in excess of what would be expected from the history, physical examination, or laboratory findings. C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The duration of the disturbance is at least 6 months. E. The disturbance is not better accounted for by another general medical condition (e.g., another Somatoform Disorder, Sexual Dysfunction, Mood Disorder, Anxiety Disorder, Sleep Disorder, or Psychotic Disorder). F. The symptom is not intentionally produced or feigned (as in Factitious Disorder or Malingering).

Although the intent is that each disorder can be classified in only one place in the ICD-10 classification system (WHO, 2007), in practicality 96% of the symptoms of Chronic Fatigue Syndrome overlap between two codes in the diagnostic classification. The recommendation currently is that Chronic Fatigue Syndrome is classified as G93.3 (Benign myalgic encephalomyelitis), however the description of the other relevant code (F48) has been included below for reference. G93.3 Benign myalgic encephalomyelitis - to be used where specific trigger such as a viral disease and/or where the symptoms do not fulfill the criteria for F48.0 (World Health Organization - UK Collaborating Centre, 2004).

F48.0 Neurasthenia – which has the following diagnostic features: A. Either persistent and distressing complaints of increased fatigue after mental effort, or persistent and distressing complaints of bodily weakness and exhaustion after minimal effort. B. At least two of the following: feelings of muscular aches and pains; dizziness; tension headaches; sleep disturbance; inability to relax; irritability & dyspepsia; C. Any autonomic or depressive symptoms are not sufficiently persistent and severe to fulfill the criteria for any of the more specific disorders in this classification.

In DSM-5 (APA 2013) chronic fatigue syndrome has been categorized under ‘Somatic Symptom Disorder’ 300.82 (F45.1), with the following diagnostic criteria: A) One or more symptoms that are distressing or resulting in significant disruption of daily life. B) Excessive thoughts, feelings, or behaviors related to the somatic symptom or associated health concerns as manifested by at least one of the following: 1) Disproportionate and persistent thoughts about the seriousness of one’s symptoms. 2) Persistently high level of anxiety about health or symptoms. C) Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

Specific if: With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptom predominantly involves pain. Specific if: Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months). Specific current severity: Mild: Only one of the following symptoms specified in criterion B are fulfilled. Moderate: Two or more of the symptoms specified in criterion B are fulfilled. Severe: Two or more of the symptoms specified in criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom)