



S0022-3999(98)00021-X

ILLNESS BELIEFS AND TREATMENT OUTCOME IN CHRONIC FATIGUE SYNDROME

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(Received 13 June 1997; accepted 3 February 1998)

Abstract—Longitudinal studies have shown that physical illness attributions are associated with poor prognosis in chronic fatigue syndrome (CFS). Speculation exists over whether such attributions influence treatment outcome. This study reports the effect of illness beliefs on outcome in a randomized controlled trial of cognitive-behavior therapy versus relaxation. Causal attributions and beliefs about exercise, activity, and rest were recorded before and after treatment in 60 CFS patients recruited to the trial. Physical illness attributions were widespread, did not change with treatment, and were not associated with poor outcome in either the cognitive-behavior therapy group or the control group. Beliefs about avoidance and activity changed in the cognitive behavior therapy group, but not in the control group. This change was associated with improved outcome. These findings suggest that physical illness attributions are less important in determining outcome (at least in treatment studies) than has been previously thought. In this study, good outcome is associated with change in avoidance behavior, and related beliefs, rather than causal attributions. © 1998 Elsevier Science Inc.

Keywords: Chronic fatigue syndrome; Cognitive behavior therapy; Attributions; Illness beliefs; Avoidance; Outcome.

INTRODUCTION

Chronic fatigue syndrome (CFS) is a disabling condition of unknown origin. Despite medical uncertainty over cause, most CFS sufferers seen in specialist clinics believe themselves to have a physical illness caused by a virus [1–9]. Such attributions are of interest because they have been associated with poor prognosis in several longitudinal and naturalistic studies of CFS [7–10].

If physical illness attributions are associated with worse outcome, there may be a case for altering physical illness attributions through treatments such as cognitive-behavioral therapy [9]. A randomized, controlled trial, which found brief graded activity to be ineffective for CFS [11] has been criticized for failing to challenge physical illness attributions [12]. In contrast, another randomized, controlled trial found CBT (cognitive restructuring with graded activity) to be superior to standard medical care [13]. The efficacy of treatment in this study was ascribed to its emphasis on reevaluating illness beliefs. Others have questioned this interpretation, arguing that the attributions of patients in the study did not actually *change* substantially, and the essential therapeutic ingredient was altering avoidance behavior [14].

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This study reports the role of physical illness attributions and beliefs about avoidance of exertion in outcome for CFS patients enrolled in a randomized, controlled trial of CBT versus relaxation [15]. The hypotheses were that: (a) physical illness attributions would not change with treatment, and would not affect outcome; (b) beliefs about avoidance would change more in the CBT group than in the control group, and such changes would be associated with good outcome.

METHOD

Subjects and procedures

Sixty patients attending a fatigue clinic who met criteria for CFS [16, 17] were randomized to 13 sessions of either CBT or a control treatment of relaxation (30 patients per group). Twenty-seven CBT patients and 26 relaxation patients completed treatment, and were followed-up for 6 months after treatment ended. Subjects were typical of CFS patients seen in specialist settings, with long illness duration, marked fatigue, and disability. Full details of the trial have been published elsewhere [15].

The CBT group received a program of planned, graded activity and rest. Causal attributions were not challenged, but a distinction was drawn between precipitating and perpetuating factors. Beliefs about avoidance of exercise and activity were challenged, both in discussion, and through the graded activity program. The control group received a course of relaxation exercises. Causal attributions and illness beliefs were not challenged or discussed in detail.

Treatment outcome

In the main outcome study, a battery of reliable, valid measures of functional impairment, fatigue, and mood were given [15]. The main determinant of outcome was change in the primary outcome measure (the Medical Outcomes Survey physical functioning scale 18) at 6-month follow-up. Patients were categorized as improved or unimproved if they scored over 83 on this scale (ability to carry out moderate activities such as walking, carrying groceries, or bowling without limitations) or increased their pretreatment score by 50 points or more.

At 6-month follow-up, 19 (70%) CBT patients improved using the aforementioned criteria, compared with 5 (19%) relaxation patients (χ^2 11.9, $df=1$, $p<0.001$). Improved patients showed significant reductions in fatigue symptoms and fatigue severity. Between-group comparisons on secondary outcome measures showed that CBT was superior to relaxation in improving functional impairment and fatigue, but not mood (which improved similarly in both groups). Improvements were maintained (and increased) at 6-month follow-up.

Measures of causal attributions and beliefs

Causal attributions and beliefs about activity were measured at pretreatment (immediately after randomization) and posttreatment. The measure used was a brief questionnaire. It included an open-ended question about cause, "What do you think caused your illness?," together with four statements about exercise and activity reduction, which patients were asked to rate on a four-option scale from strongly agree to strongly disagree.

Analysis

As the data gathered were nominal, nonparametric statistics were used. The McNemar test was used to examine within-group changes. Between-group comparisons and relationships between variables were tested using the chi-square test (reported with continuity correction, or Fisher's exact test as appropriate). All statistical tests were two-tailed.

RESULTS

Causal attributions before and after treatment

Answers to the open-ended question, "What do you think caused your illness?" were grouped into the categories shown in Table I. At pre- and posttreatment, around three-fourths of the entire group held physical illness attributions. Some cited a viral illness alone; others cited a virus combined with other factors: failure to rest, stress, overwork, overactivity, and/or lifestyle. One tenth of the group attrib-

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