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# Cognitive behavior therapy for chronic fatigue syndrome: a case study

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## Abstract

The case of a 26-year old woman with Chronic Fatigue Syndrome (CFS) is presented. Multidimensional assessment showing severe debilitating fatigue and considerable psychological, social and occupational impairment confirmed the diagnosis. Cognitive behavior therapy (CBT) was based on a tested causal model of CFS and individual behavioral analyses. Key elements in CBT were process variables from the CFS model, like sense of control, causal attributions, physical activity and focusing on bodily functions. Goals were recovery from fatigue, returning to work and relapse prevention. The course of therapy is described in detail to illustrate difficulties in treating CFS. Assessments were made five times, at baseline and at 8, 14, 21 and 33 months. Comparison of the pretest, post-test and follow-up scores of the outcome variables, fatigue and functional impairment and of the process variables showed clinically significant improvement from the range of CFS patients to the range of healthy controls. © 2000 Elsevier Science Ltd. All rights reserved.

*Keywords:* Chronic fatigue syndrome; Cognitive behavior therapy

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## 1. Introduction

Chronic fatigue syndrome (CFS) is characterized by persistent or relapsing unexplained chronic fatigue of new or definite onset and lasting for at least six months. Fatigue is not the result of an organic disease or ongoing exertion, it is not alleviated by rest and it results in substantial reduction in previous levels of occupational, educational, social and personal activities (Fukuda, Straus, Hickie, Sharpe, Dobbins, Komaroff & the international CFS study group, 1994). In clinical, microbiological

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and immunological research, causes for CFS have not been found (Swanink, 1996). Longitudinal research pointed out that most patients do not recover (Wilson et al., 1994a; Vercoulen, Swanink, Galama, Fennis, van der Meer & Bleijenberg, 1996a). No pharmacological treatments have proven to be effective (Wilson, Hickie, Lloyd & Wakefield, 1994b; Vercoulen et al., 1996b).

Cognitive behavior therapy (CBT) seems to be the most promising treatment of CFS (Wessely, Hotopf & Sharpe, 1998). Obscurity about the cause of physical complaints is not necessarily an obstruction for an effective treatment. The effect of CBT was also proved in other somatic complaints without a known course, like irritable bowel syndrome (Payne & Blanchard, 1995; Dulmen, Fennis & Bleyenberg, 1996). However, several of the studies on CBT for CFS suffer from methodological shortcomings. One of the difficulties is the definition of the outcome variables. Most studies report effects of CBT on functional impairment, health status or self-reported improvement, but hardly on fatigue, the main complaint of patients with CFS. In an uncontrolled study Butler, Chalder, Ron and Wessely (1991) showed the effect of CBT in 22 of 27 CFS patients. CBT was directed at increasing self-efficacy and performing activities that were avoided for a long time. In 80% of the treated patients this effect was sustained over four years (Bonner, Ron, Chalder, Butler & Wessely, 1994). In a randomized controlled trial of Sharpe and colleagues CBT was compared to medical care (Sharpe et al., 1996). CBT consisted of 16 sessions within four months. Therapy was directed at changing cognitions and gradually building up activities. Twelve months later, at follow-up, 73% of the CFS patients treated with CBT showed significant improvement in daily functioning as measured by the Karnofsky scale, a global rating of the performance status. Perhaps the short duration of CBT may explain the absence of a post-test effect. A period of four months seems rather short to extend the building up of activity to work on rehabilitation. The rating of the Karnofsky scale is largely determined by being active in work. A controlled study of Deale, Chalder, Marks and Wessely (1997) has ascertained that effects of CBT may not be solely attributed to non-specific treatment factors. CBT and relaxation therapy, both consisting of 13 sessions within six months, were compared. Patients treated with CBT improved more on functional impairment and fatigue than those treated with relaxation therapy. Improvements were sustained over six months of follow-up. A major methodological limitation of this study was that one therapist performed all therapies of both kinds. In a randomized controlled study Fulcher and White (1997) found a specific effect in the treatment of CFS patients. They compared graded exercise with flexibility exercises and relaxation therapy, both consisting of weekly sessions in a period of 12 weeks. Patients treated with graded exercise showed significantly more self-reported improvement than the patients treated otherwise. However, striking in this study was a selection-bias of the patients. Forty-one percent was treated preceding the study as a result of psychiatric comorbidity. Further, it was not possible to establish the effects of therapy at follow-up, because more than half of the patients crossed over from flexibility exercises to graded exercise. CBT in a format of six sessions is less effective for CFS patients when it is combined with immunologic therapy or placebo (Lloyd et al., 1993). CBT developed for depression is also not effective for CFS patients (Friedberg & Krupp, 1994). The latter finding is not surprising. Although it has been suggested that depression plays a pathogenic role in CFS and even that CFS

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