

Cognitive Behavior Therapy for Relatively Active and for Passive Chronic Fatigue Syndrome Patients

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In chronic fatigue syndrome (CFS), facilitating, initiating, and perpetuating factors are distinguished. Although somatic factors might have initiated symptoms in CFS, they do not explain the persistence of fatigue. Cognitive behavior therapy (CBT) for CFS focuses on factors that perpetuate and prolong symptoms. Recently it has been shown that, based on their level of activity, two groups of patients can be distinguished. For so-called “relatively active” CFS patients, the main perpetuating factors are nonaccepting and demanding cognitions leading to bursts of activity. For so-called “passive” CFS patients, their fear that activity might worsen their symptoms (which results in an avoidance of activity) is the most important perpetuating factor. These differences in perpetuating factors result in separate treatment manuals for relatively active and for passive CFS patients. Before describing the treatment manuals, we outline basic assumptions, considerations before starting CBT for CFS, and ways to determine the activity pattern.

CHRONIC FATIGUE SYNDROME (CFS) is characterized by a clinically evaluated, unexplained persistent or relapsing chronic fatigue that is of new or definite onset (i.e., not lifelong); lasts for at least 6 months; is not the result of ongoing exertion; is not substantially alleviated by rest; and results in substantial reduction in previous levels of occupational, educational, social, or personal activities (Fukuda et al., 1994). Several reviews of randomized controlled trials showed that cognitive behavior therapy (CBT) is an effective treatment for CFS (Afari & Buchwald, 2003; Price & Couper, 2000; Reid, Chalder, Cleare, Hotopf, & Wessely, 2000; Whiting et al., 2001).

In CFS, facilitating, initiating, and perpetuating factors can be distinguished. Somatic factors, such as viruses, are often cited as initiating chronic fatigue. Some prospective studies showed that 10% to 17% of the patients with a viral infection fulfilled CFS criteria after 6 months (Cope, David, Pelosi, & Mann, 1994; White et al., 1998). However, patients without a viral infection had the same chance to develop CFS. Although there are some indications that psychosocial problems and life events initiate fatigue (Hatcher & House, 2003; Theorell, Blomkvist, Lindh, & Evengard, 1999; Wessely, Chalder, Hirsch, Pawlikowska, & Wallace, 1995), convincing evidence is still lacking. The research literature also mentions psychosocial problems as

facilitating factors. A prospective study showed that psychological problems are a predictor of chronic fatigue (Wessely et al., 1995). Premorbid overactivity might also facilitate the development of CFS (van Houdenhove, Onghena, Neerinx, & Hellin, 1995). However, little is known about initiating and facilitating factors in CFS. More evidence is found on the perpetuating factors. According to a model developed by Vercoulen et al. (1998), a strong focus on bodily symptoms, low levels of physical activity, and a poor sense of control contribute to an increase in the severity of fatigue and functional impairment. Strong somatic attributions have an indirect influence on fatigue via lower levels of physical activity. Most factors in this model of perpetuating factors in CFS have been found in other studies as well (e.g., Heijmans, 1998; Wessely, Hotopf, & Sharpe, 1998).

The cognitive behavioral treatment for CFS is based on the model of perpetuating factors (Prins & Bleijenberg, 1999; Prins et al., 2001). CBT for CFS is directed at decreasing somatic attributions and the patient's focus on bodily symptoms, increasing the patient's sense of control over his or her symptoms, and restoring balance in activity patterns.

One of the randomized controlled trials that demonstrated the effectiveness of CBT for CFS was conducted by Prins et al. (2001). This study showed that the treatment manual used was not appropriate for all CFS patients. It seemed that, based on their activity level, three types of CFS patients could be distinguished: pervasively active, moderately active, and pervasively passive CFS patients

(van der Werf, Prins, Vercoulen, van der Meer, & Bleijenberg, 2000).

The protocol used in our effect study did not seem to work for the so-called passive CFS patients (Prins et al., 2001), which is about 25% of the CFS population (van der Werf et al., 2000). Based on these results, the treatment manual for passive CFS patients was adjusted. The main difference is that for pervasively active and moderately active (together so-called *relatively active*) CFS patients, the treatment starts with a focus on a good alternation between rest and activity. For passive CFS patients, the treatment starts with a gradually increasing activity program.

This article will begin with a discussion of basic assumptions of the treatment, including what to consider before starting CBT for CFS. Next, we explain how to determine the activity pattern, describe the treatment manuals for relatively active and for passive CFS patients, and provide suggestions for relapse prevention. We conclude with a discussion of variations in treatment (i.e., treating children). The general treatment outline is shown in Table 1.

Basic Assumptions of CBT for CFS

The first sessions with the patient involve discussing basic assumptions of the treatment, the motivation of the patient, and exploring factors that may interfere with CBT for CFS. It is recommended to have a spouse or other partner involved in these sessions.

Distinction Between Causal and Perpetuating Factors

CBT for CFS is based on the distinction between causal and perpetuating factors. Although somatic factors might have initiated the symptoms, they do not explain the persistence of fatigue. Perpetuating factors make the symptoms endure. Therefore, CBT is focused on these perpetuating factors.

Objective of CBT for CFS

Perpetuating factors in CFS are of a cognitive and behavioral nature. The aim of the treatment is to restructure these cognitions and behaviors in such a way that the patient's complaints return to healthy proportions and that work or other normal daily activities can be resumed. The patient describes the behaviors he or she wants to resume in order to consider him- or herself a healthy person. Recovery is defined in terms of concrete behavior for each particular patient, leading to concrete goals for treatment. The objective of being recovered poses some extra problems. In the case of patients receiving disease benefits, the therapist should discuss the possible negative financial aspects of recovery with the patient and encourage the patient to plan for financial stability (i.e., seeking paid employment). Keep in mind

Table 1
Treatment outline

Introduction and intake	
•Explanation of basic assumptions: -distinction between causal and perpetuating factors -objective is full recovery, defined in concrete individual treatment goals	
•Preconditions: -possible co morbidity can be integrated -no ongoing engagement in legal procedures of disability claims -no concomitant treatments	
•Motivating the patient: discussing attitude and expectancies	
•Individualizing treatment: -determining and defining fatigue-related cognitions and behavior -determining and defining the activity level	
Treatment	
Relatively active CFS patients	Passive CFS patients
•Explanation of perpetuating factors: -non-accepting cognitions -activity peaks	•Explanation of perpetuating factors: -anxious cognitions -inactivity
•Challenging complaint-enhancing cognitions	•Challenging activity-impeding cognitions
•Establishing a base level	•Systematic increase of activity
•Systematic increase of activities -physical activity program -work-resumption or achieving other personal goals	-physical activity program -mental activity program -social activity program -work-resumption or achieving other personal goals
Relapse prevention	
•Encouraging self-activity	
•Getting rid of the patient label	
•Being aware of pitfalls	
•Follow-up and treatment evaluation	

that in becoming healthy the patient loses disease benefits; this may, in some cases, interfere with his or her recovery.

Recovery does not mean that the patient will lead the same life he or she had before the onset of CFS. First, premorbid activity proneness might have been a facilitating factor. Second, the patient may have an unrealistic idea of his premorbid functioning based on incorrect or idealized memories. Finally, the patient may have an unrealistic idea of what "normal" functioning is, based on overly high standards.

Before Starting CBT for CFS

Before starting CBT, the situation of the CFS patient should be analyzed on five dimensions: somatic, cognitive, behavioral, emotional, and social (Table 2). The somatic dimension involves questioning the patient's complaints and impairments. The cognitive dimension involves cognitions concerning fatigue (sense of control, attributions, and daily thoughts and reactions to fatigue). The behavioral dimension concerns the patient's behavioral reaction to his or her fatigue, including actions taken to

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