



Childhood maltreatment and the response to cognitive behavior therapy for chronic fatigue syndrome

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ABSTRACT

Objective: To examine the relationship between a history of childhood maltreatment and the treatment response to cognitive behavior therapy for chronic fatigue syndrome (CFS).

Methods: A cohort study in a tertiary care clinic with a referred sample of 216 adult patients meeting the Centers for Disease Control and Prevention criteria for CFS, and starting cognitive behavior therapy. Main outcome measures changes between pre- and post therapy in fatigue (Checklist Individual Strength fatigue subscale), disabilities (Sickness Impact Profile total score), physical functioning (short form 36 health survey subscale) and psychological distress (Symptom checklist 90 total score).

Results: At baseline, patients with a history of childhood maltreatment had significantly more limitations and a higher level of psychological distress, but were not more severely fatigued. Change scores on the outcome measures after cognitive behavior therapy did not differ significantly between patients with or without a history of childhood maltreatment, or between the different types of childhood maltreatment. However, patients with a history of childhood maltreatment still experienced more limitations and a higher level of psychological distress after CBT.

Conclusions: A history of childhood maltreatment was not related to the treatment response of cognitive behavior therapy for CFS. In patients with a history of childhood maltreatment CFS symptoms can be treated with CBT just as well as those without.

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Introduction

Chronic fatigue syndrome (CFS) is an often long-lasting condition [1], that has profound impact on the daily life of patients [2]. The diagnostic criteria for CFS, as defined by the Centers for Disease Control and Prevention (CDC), include the experience of severe and medically unexplained fatigue for more than six months that causes severe impairment in daily functioning [3,4].

Previous studies have found an increased prevalence of childhood maltreatment in both patients with CFS and chronic fatigue (i.e. any fatigue lasting longer than 6 months but not meeting full CDC criteria). Most of them were nested case–control studies in the general population [5–9], except for one small case–control study conducted in a specialist clinic [10]. Two studies did not find an

increased prevalence of childhood maltreatment in CFS patients [11,12], although one of them did find an increased prevalence in patients with chronic fatigue not meeting CDC criteria. In addition, two studies found that the risk of being a CFS patient increased with a higher exposure to childhood maltreatment [5,6]. So childhood maltreatment seems to make a person more vulnerable to become chronically fatigued.

Cognitive behavior therapy (CBT) is an evidence based intervention for CFS that leads to a significant reduction in fatigue and impairment, as has been shown by two meta-analyses [13,14]. A subgroup of CFS patients shows a complete recovery following CBT [15]. CBT is based on a model that encompasses different fatigue related cognitions and behaviors, thought to perpetuate symptoms in CFS patients [16,17]. These include attributing complaints to a somatic cause, low levels of physical activity, low sense of control over symptoms and focusing on bodily symptoms. During CBT the therapist helps the patient to change these perpetuating factors to become less fatigued and disabled.

Childhood maltreatment seems to predispose patients to develop CFS. According to the model underlying CBT for CFS, predisposing factors only play a role in the development of CFS, not in the continuation of symptoms. It would therefore, at first sight, not seem likely that exposure to childhood maltreatment would have an effect

Abbreviations: CDC, Centers for Disease Control and Prevention; CFS, chronic fatigue syndrome; CI, confidence interval; CIS, Checklist Individual Strength; CM, childhood maltreatment; CTQ SF, childhood trauma questionnaire short form; OR, Odds Ratio; RCT, randomized clinical trial; SCL, Symptom checklist 90; SF36, short form 36 health survey; SIP, sickness impact profile.

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on the response to CBT. However, there are several possible pathways as to how a history of childhood maltreatment could have a negative effect on CBT for CFS. First, childhood maltreatment has been related to psychological distress (e.g. depression, anxiety) in later life [7,18–20]. This has also been found in CFS patients [5–7,10]. Psychological distress might impede changes in fatigue related cognitions during therapy and thus result in a poor therapy response. Second, childhood maltreatment may result in interpersonal problems later in life, such as sensitivity to rejection, unstable or chaotic relationships and problems trusting others [21,22]. These interpersonal problems may also impede the psychotherapeutic relationship between patient and therapist, and thereby the therapy response. Third, Roberts et al. showed that CFS patients with hypocortisolism, i.e. low levels of the stress-related hormone cortisol, do show a poorer response to CBT [23]. Hypocortisolism has been related to childhood maltreatment [24], and Roberts et al. hypothesized that it might be a symptom perpetuating factor in CFS patients.

A poor therapy response of CFS patients with a history of childhood maltreatment could have clinical implications, like adding specific interventions aimed at reducing the level of psychological distress to the currently used treatment protocol to improve outcome for this subgroup. The aim of the current study is to determine whether the treatment response to CBT for CFS is impaired in patients with a history of childhood abuse. As McMahon et al. reported [25], the effect of childhood maltreatment may not appear in the direct treatment response, but rather in long-term results. The factors that lead to a greater vulnerability to become chronically fatigued, might also lead to a greater vulnerability to relapse after successful therapy. So in an exploratory analysis we also included 6-month follow-up data in our study.

Methods

Subjects

The study population was selected from patients referred to our tertiary care CFS clinic for individual CBT. We included the 216 consecutively referred patients starting CBT between March 2008 and June 2009 who fulfilled the CDC criteria for CFS, were between 18 and 65 years of age and were able to read and write Dutch. Patients had to be severely fatigued, operationalized as having a score of 35 or higher on the subscale fatigue of the Checklist Individual Strength [26], and severely disabled, operationalized as having a score of 700 or higher on the Sickness Impact Profile [27–29]. All referred patients received a standard medical examination at the outpatient clinic of our department of internal medicine, to rule out any somatic or psychiatric disorder that excludes the diagnosis of CFS. If patients had already been extensively medically examined prior to referral and somatic and psychiatric disorders that could explain the fatigue had already been ruled out, they were immediately referred to our treatment center. After this, all patients underwent a standard diagnostic procedure, consisting of a set of self-report questionnaires (including the questionnaires used for this study) and an interview with an experienced clinical psychologist. In this unstructured clinical interview, the psychiatric evaluation was extended to rule out current psychiatric disorders that excluded the diagnosis of CFS according to CDC criteria [3]. Patients who were currently applying for a disability claim were excluded until their application was completed, as this has been found to predict a poor therapy response [30].

Treatment

Patients followed CBT for CFS [31,32] according to the protocol that has previously been tested in several RCTs [33–35]. The CBT consisted of 12 to 16 individual 1-hour sessions during approximately 6 months [31]. Patients were encouraged to systematically increase their

activity, while concurrently fatigue perpetuating cognitions were challenged and personal goals, as set at the start of the therapy, were realized.

Baseline assessment

Besides sex and age, the following aspects of psychiatric comorbidity were assessed at baseline through self-report questionnaires: 1) prior treatment by a psychiatrist or psychologist (yes/no) 2) history and treatment of depression, anxiety, alcohol or eating problems (yes/no) 3) use of anti-depressants, anxiolytics or sedatives during the last 6 months (yes/no) and 4) current depressive symptoms as measured with the Beck Depression Inventory for Primary Care (BDI-PC)[36]. This short version consists of 7 of the original questions of the BDI-II (anhedonia, suicidal thoughts or wishes, pessimism, past failure, self-dislike, self-criticalness). A sum score can be calculated, with a maximum of 21 and a cut-off point of 4 defining clinical depression. Validity and reliability (Cronbach's $\alpha=.86$, sensitivity and specificity 82%) are good.

Assessment of childhood maltreatment

Childhood maltreatment was assessed before therapy using the Dutch version of the Childhood Trauma Questionnaire-Short Form (CTQ-SF) [37,38]. This self-report questionnaire, previously used by Heim et al. in their studies on CFS and childhood maltreatment [5,6], consists of 28 items measured on a 5 point Likert-scale. Five dimensions are discerned: 1) Physical Abuse 2) Emotional Abuse 3) Sexual Abuse 4) Physical Neglect 5) Emotional Neglect. Each subscale comprises 5 items and scores range from 5 to 25. For each subscale, cut-off scores for none-to-low, low-to-moderate and moderate-to-severe maltreatment are available. The Dutch version of the CTQ-SF has recently been validated in a sample of clinical and non-clinical patients and showed excellent reliability (Cronbach's α .91 for Physical Abuse, .89 for Emotional Abuse, .95 for Sexual Abuse, .63 for Physical Neglect and .91 for Emotional Neglect) [38].

We used the cut-off scores for moderate-to-severe maltreatment to classify individuals as positive on a given subscale. These are ≥ 13 for Emotional Abuse, ≥ 10 for Physical Abuse, ≥ 8 for Sexual Abuse, ≥ 15 for Emotional Neglect, and ≥ 10 for Physical Neglect [39]. Norms were derived from six samples, three of which comprise 2001 of the 2201 individuals in the CTQ norm group: (a) 1225 all female, mostly White HMO members (b) 378 mostly Black, male inpatient substance abusers; and (c) 398 adolescent psychiatric inpatients.

Assessment of treatment outcome

To assess treatment outcome, patients' levels of fatigue, impairment, and psychological distress were measured both before and after CBT. In addition, fatigue and impairment were also assessed 6 months after therapy. Fatigue was assessed with the subscale fatigue severity of the Checklist Individual Strength (CIS) [40]. This subscale indicates the level of fatigue in the previous two weeks, and consists of eight items on a seven point scale (range 8–56). A score of 35 and higher (i.e. 2 standard deviations above the mean of a healthy control group) indicates severe fatigue. Cronbach's α ranges from .83 to .92 [26,41]. Functional impairment was assessed by the Sickness Impact Profile (SIP) 8 [27–29]. This version of the SIP consists of 8 different subscales measuring limitations in multiple aspects of daily functioning, as well as a total score measuring overall impairment. A total score of at least 700 indicates severe impairment [15,26,34]. The overall Cronbach's α of the Dutch version is .91 [42]. In addition, limitations in physical functioning were measured with the corresponding subscale of the Medical Outcomes Survey SF36[43]. Scores range from 0 (maximum limitations) to 100 (no limitations). The Cronbach's α of the subscale physical functioning of the Dutch

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