



# The role of the therapeutic relationship in cognitive behaviour therapy for chronic fatigue syndrome



Marianne J. Heins\*, Hans Knoop, Gijs Bleijenberg

Expert Centre for Chronic Fatigue, Radboud University Nijmegen Medical Centre, 4628, PO Box 9101, 6500 HB Nijmegen, The Netherlands

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## ABSTRACT

Cognitive behaviour therapy (CBT) for chronic fatigue syndrome (CFS) can reduce fatigue and impairment. Recently, it was found that changes in fatigue-perpetuating factors, i.e. focusing on symptoms, control over fatigue, perceived activity and physical functioning, are associated with and explain up to half of the variance in fatigue during CBT for CFS. The therapy relationship, e.g. outcome expectations and working alliance, may also contribute to treatment outcome. We aimed to examine the role of the therapy relationship in CBT and determine whether it exerts its effect independently of changes in fatigue-perpetuating factors. We used a cohort of 217 CFS patients in which the pattern of change in fatigue-perpetuating factors was examined previously. Fatigue, therapy relationship and fatigue-perpetuating factors were measured at the start of therapy, three times during CBT and at the end of therapy. Baseline outcome expectations and agreement about the content of therapy predicted post therapy fatigue. A large part of the variance in post-treatment fatigue (25%) was jointly explained by outcome expectations, working alliance and changes in fatigue-perpetuating factors. From this, we conclude that positive outcome expectations and task agreement seem to facilitate changes in fatigue-perpetuating factors during CBT for CFS. It is therefore important to establish a positive therapy relationship early in therapy.

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## Introduction

Chronic fatigue syndrome (CFS) is characterised by severe and medically unexplained fatigue that lasts longer than 6 months and results in severe limitations in daily life (Fukuda et al., 1994; Reeves et al., 2003). Cognitive behaviour therapy (CBT) for CFS can effectively reduce fatigue and impairment (Castell, Kazantzis, & Moss-Morris, 2011; Chambers, Bagnall, Hempel, & Forbes, 2006; Price, Mitchell, Tidy, & Hunot, 2008). Even full recovery, defined as no longer being severely fatigued, being able to resume all activities, and having a perception of health and fatigue that is similar to healthy persons, is possible for a subgroup of patients (Knoop, Bleijenberg, Gielissen, van der Meer, & White, 2007). Several models underlying CBT for CFS assume that there are certain fatigue-related beliefs and behaviour that perpetuate symptoms (Fry & Martin, 1996; Gaab, 2004; Surawy, Hackmann, Hawton, &

Sharpe, 1995; Vercoulen et al., 1998; Wessely, David, Butler, & Chalder, 1989). One of these models is that of Vercoulen et al. (1998). It is the only model that was statistically tested and it states that a high level of somatic attributions and focusing on symptoms and a low level of physical activity and low perceived control over symptoms lead to perpetuation of fatigue.

Recently, Wiborg, Knoop, Prins & Bleijenberg (2011); Wiborg, Knoop, Frank & Bleijenberg (2012); Wiborg, Knoop, Stulemeijer et al. (2010) used mediation analyses of previous randomised controlled trials (RCTs) to test whether 1) CBT indeed leads to a change in these fatigue-perpetuating factors and 2) whether this change was related to the reduction in fatigue. Their studies showed that changes in focusing on symptoms and sense of control over fatigue indeed mediate the change in fatigue during CBT for CFS (Wiborg, Knoop, et al., 2012; Wiborg, et al. 2011). However, it is not the actual change in physical activity, but the perceived increase in activity that mediates the decrease in fatigue (Wiborg, Knoop, et al., 2012; Wiborg, Knoop, Stulemeijer, Prins, & Bleijenberg, 2010). Heins et al. furthered their work by studying how these fatigue-perpetuating factors change during CBT for CFS. Their study showed that these variables change in the same period in which fatigue decreases. Changes in fatigue-perpetuating factors explained up to half of the variance in fatigue during CBT for CFS (Heins et al. submitted for publication). So although these studies

*Abbreviations:* CAL, causal attribution list; CBT, cognitive behaviour therapy; CFS, chronic fatigue syndrome; CIS, Checklist Individual Strength; SF36, Medical Outcomes Survey Short Form 36; SIP, sickness impact profile; WAI-s, Working Alliance Inventory – Short Form.

\* Corresponding author. Tel.: +31 243610046; fax: +31 243610041.

E-mail addresses: [m.heins@nkv.umcn.nl](mailto:m.heins@nkv.umcn.nl), [marianne\\_heins@hotmail.com](mailto:marianne_heins@hotmail.com) (M.J. Heins).

provided insight into the changes that lead to a decrease in fatigue, these changes could only partly explain the treatment outcome of CBT for CFS.

Besides specific treatment techniques, extant research suggests that the therapy relationship, i.e. “the feelings and attitudes that therapist and client have toward one another and how these are expressed” (Norcross, 2001), is also an important contributor to treatment outcome in a variety of psychotherapies. A recent task force on evidence-based therapy relationships even concluded that “the therapy relationship accounts for why clients improve (or fail to improve) at least as much as the particular treatment method” (Norcross & Wampold, 2011). Wampold and Budge recently proposed a model of the therapy relationship, which consists of the bond between patient and therapist, setting of goals and tasks and expectations with respect to treatment outcome (Wampold & Budge, 2012). This model thus includes outcome expectations and three elements of the working alliance as proposed by Bordin: task, goal and bond (Bordin, 1979). Tasks are what therapist and patient agree that needs to be done to reach the patient’s goals. Goals are what the patient hopes to gain from therapy. Bond is the trust and confidence in the therapist.

Although both outcome expectations and working alliance are considered empirically supported relational attributes across studies of various therapies (Constantino, Arnkoff, Glass, Ametrano, & Smith, 2011; Fluckiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath, Del Re, Fluckiger, & Symonds, 2011), their application is developed and maintained in different ways within different therapeutic models and protocols (Hatcher & Barends, 2006; Ulvenes et al., 2012; Wampold & Budge, 2012). We’ll therefore briefly discuss the application of outcome expectations and working alliance in CBT in general and CBT for CFS specifically.

In the protocol used for this study, recovery is considered the highest achievable outcome of CBT. Patients, however, may be hesitant to believe that full recovery is possible and may only expect to learn to cope with their chronic fatigue. Both the aetiology of CFS and its treatment are hotly debated (Action for ME/Association of Young People with ME, 2008; Kean, 2010; Working group on CFS/ME (Chronic Fatigue Syndrome/Myalgic Encephalomyelitis), 2002). Many CFS patients attribute their symptoms to a physical cause, such as a viral infection or immunological disorder (Deale, Chalder, & Wessely, 1998). Patients with strong somatic attributions will, understandably, not immediately have faith in a cognitive behavioural therapist and the rationale of CBT. Indeed, the placebo response, which is strongly related to outcome expectations (Di Blasi, Harkness, Ernst, Georgiou, & Kleijnen, 2001), is lower in psychological interventions for CFS than in somatic interventions (Cho, Hotopf, & Wessely, 2005). Furthermore, in a recent large RCT only 57% of the CFS patients allocated to CBT indicated that they were confident about the treatment (White et al., 2011). The fact that patients are often referred for CBT after they have had symptoms for several years (see for example the study of Prins et al. (2001) with a median symptom duration of 4.9 years) may further lower outcome expectations.

The working alliance in CBT is mainly reflected in collaborative empiricism, i.e. patient and therapist collaborating to uncover negative automatic thoughts through Socratic reasoning and homework assignments (Dattilio & Hanna, 2012). Although in the theory underlying CBT it is assumed that a good working alliance in itself is insufficient to bring about change (Clark, Beck, & Alford, 1999), a good alliance is considered necessary and has been related to positive treatment outcome (Horvath et al., 2011). The working alliance in CBT for CFS may not always be good as some CFS patients will have a different view than the CBT therapist about the cause of CFS (e.g. a somatic versus a cognitive behavioural

model of CFS) and the goal of treatment (e.g. recovery versus coping with a chronic illness). The first objective of this paper is to determine whether outcome expectations and working alliance contribute to the reduction in fatigue during CBT for CFS. A second objective is to determine whether they have a direct effect on treatment outcome, independently of changes in fatigue-perpetuating factors or exert their effect (also) indirectly through changes in fatigue-perpetuating factors.

## Methods

### Patients

We assessed the effect of the therapeutic relationship in the same cohort of patients in which the pattern of change in fatigue-perpetuating factors was previously examined (Heins et al., submitted for publication). In this study, consecutively referred patients who started CBT at our tertiary CFS specialist care centre between April 2008 and September 2010 were eligible to participate if they:

- Met the criteria for CFS as stated by the US Centers for Disease Control and Prevention. These include the experience of severe and medically unexplained fatigue for at least six months that brings about severe impairment in daily living and is accompanied by four out of eight specific additional symptoms (Fukuda et al., 1994; Reeves et al., 2003). These are by far most often used in studies on CFS (Christley, Duffy, & Martin, 2012). Severe fatigue was defined as a score of  $\geq 35$  on the Checklist Individual Strength (CIS), subscale fatigue severity (Vercoulen et al., 1994), and severe functional impairment was defined as a total score  $\geq 700$  on the Sickness Impact Profile (SIP) (Bergner, Bobbitt, Pollard, Martin, & Gilson, 1976; Jacobs, Luttik, Touw-Otten, & de Melker, 1990; Knoop et al., 2007; Pollard, Bobbitt, Bergner, Martin, & Gilson, 1976). If patients had not been extensively medically examined prior to referral, they first received a standard medical examination at the outpatient clinic of our department of internal medicine, to rule out any somatic disorder that excludes the diagnosis of CFS.
- Were at least 18 years old. There is a separate treatment protocol for adolescent patients at our centre.
- Were able to read and write Dutch.

Patients were excluded if they were currently engaged in a legal procedure for a disability claim until this procedure was completed.

The study was conducted according to the Helsinki declaration as revised in 1994, and approved by the ethical committee of the Radboud University Nijmegen Medical Centre. All participants gave written informed consent before participation.

### CBT

The protocol of CBT for CFS used in this study (Bleijenberg et al., 2003; Knoop & Bleijenberg, 2010) consists of approximately 12 sessions during 6 months. First of all, illness attributions are discussed with the patient, bearing in mind that a somatic cause for the symptoms has not been found in previous medical examination. The way through which thoughts and behaviour can lead to the persistence of symptoms is explained and the patient formulates his or her goals of therapy. These goals usually include the resumption of work, hobbies and other activities that imply recovery for the patient. Recovery is named as the maximal attainable goal of therapy, although patients are told that not every patient will reach this goal. After the formulation of treatment goals, bedtimes are regulated to stop disruption of the circadian rhythm.

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