

Brief Clinical Reports

A COGNITIVE BEHAVIOUR THERAPY GROUP FOR PATIENTS WITH CHRONIC FATIGUE SYNDROME: A PRELIMINARY INVESTIGATION

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Abstract. A number of studies suggest that individual cognitive-behavioural therapy (CBT) is beneficial to patients suffering from Chronic Fatigue Syndrome (CFS). This study investigated the effectiveness of group CBT in reducing fatigue and distress in five outpatients with a diagnosis of CFS throughout therapy and at 3-month follow-up. The nature of the group, treatment outcomes and benefits of this approach are outlined. Group CBT was acceptable to participants and led to improvements in fatigue as well as cognitive functioning.

Keywords: Chronic fatigue syndrome, CBT, group.

Introduction

Chronic fatigue syndrome (CFS) is characterized by persistent or intermittent fatigue of at least 6 months duration. It is associated with marked disability and can persist for many years. The aetiology of this condition has not been firmly established. Clinical features of CFS include physical and mental fatigue, muscle pain, attribution of symptoms to disease, fear of exacerbating symptoms, oscillation between activity and inactivity, frustration and other emotional problems (Sharpe et al., 1991). Despite the uncertainty surrounding the cause of CFS, various psychological factors have been implicated in the perpetuation of the illness, such as patients' beliefs in physical disease, inactivity, depression and fear of re-injury (Wessely,

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David, Butler, & Chalder, 1989), which suggests that CBT can be an effective treatment approach.

Reviewing all randomized controlled trials of CBT, Price and Couper (2000) concluded that CBT significantly improved physical functioning in adult outpatients with CFS compared to routine medical management or relaxation. In addition, a 5-year follow-up study indicated that CBT produced lasting benefits to patients (Deale, Husain, Chalder, & Wessely, 2001). Individual CBT was also superior to support groups and no treatment conditions in a multi-centre trial (Prins et al., 2001).

In terms of group CBT in the treatment of CFS, Price and Couper (2000) concluded that the evidence for the effectiveness of group CBT was unsatisfactory, partly due to methodological problems. For example, Pemberton, Hatcher, Stanley and House (1994) describe an intervention programme for a group of CFS patients facilitated by an occupational therapist, which failed to use orthodox CBT techniques. Söderberg and Evengard (2001) report results from a randomized controlled trial in which 14 women with CFS participated. However, group therapy consisted of supportive counselling; fatigue was not systematically measured and follow-up assessments were not conducted, making it difficult to draw firm conclusions.

This study developed out of an identified gap in the literature concerning the effectiveness of group CBT for individuals with CFS. In line with existing research, which has demonstrated the efficacy of individual CBT for CFS, in addition to the efficacy of group CBT for other medical conditions, it was predicted that participants would experience a reduction in their fatigue and a reduction in depression and anxiety following group CBT intervention.

Method

Participants

All patients with a diagnosis of CFS, who were referred for psychological therapy to the Department of Behavioural Medicine, were screened. Inclusion criteria were that patients had a primary diagnosis of chronic fatigue syndrome identified by a consultant immunologist, using criteria outlined by Fukuda et al. (1994), no primary psychiatric diagnosis, and were willing to attend a group. Attempts to recruit a sufficient sample size to run a randomized, controlled pilot study were unsuccessful during the study phase. Referral rate to the department was higher in the planning stage of the study. Six patients were interviewed for inclusion in the group.

Measures

Chronic fatigue symptoms were rated using the bi-modal scoring system of the Fatigue Scale (Chalder et al., 1993) and the Profile of Fatigue-Related Symptoms (PFRS; Ray, Weir, Phillips, & Cullen, 1992). The latter was employed as it provided a detailed assessment of emotional distress, cognitive difficulty and somatic symptoms as well as fatigue. The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) was also administered to assess distress. All measures were shown to have good reliability and validity. Assessments were completed at pre-, mid- and post-treatment as well as at 3-month follow-up and scored by an assessor blind to assessment stage.

Table 1. Overview of session content

	Content	Rationale
Session 1	Introduction Discussion of group ground rules Exploration of causes and myths related to CFS Introduction to biopsychosocial model (based on Greenberger and Padesky model)	Engagement Introduction to psychological thinking
Session 2	Focus on deconditioning, pain, avoidance behaviours Activity scheduling Pacing and planning Goal setting	Modification of maladaptive behavioural patterns
Session 3	Activity scheduling continued Role of exercise and fears associated with it Applied relaxation training	As for session 2 Modification of maladaptive thoughts in relation to exercise and activity
Session 4	Role of emotions addressed, especially their relationship to behavioural aspects	Insight into the physical symptoms-behaviour-mood link
Session 5	Cognitive therapy: Role of thoughts was addressed using guided discovery Identification of thinking errors Challenging negative automatic beliefs	Modification of maladaptive thoughts and beliefs Insight into the physical symptoms-behaviour-mood-thoughts link
Session 6	Review of complete psychological model, role of sleep and stress management were discussed	Modification continued Coping strategy enhancement
Session 7	Review of psychological model continued, role of memory/concentration, use of external memory aids and problem solving/planning were addressed	Modification continued Coping strategy enhancement
Session 8	Relapse prevention and review	Maintenance of achievements was emphasized

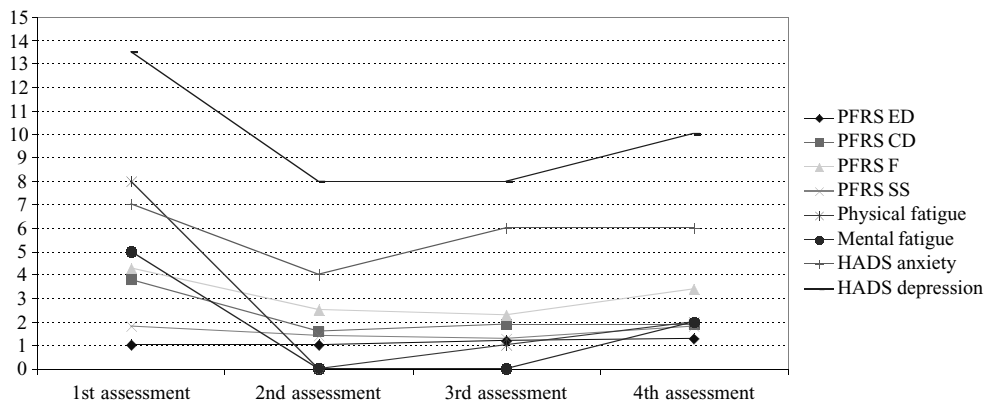
Treatment

The group was facilitated by two clinical psychology trainees (AW and KT), who developed the content of the sessions, with supervision from a senior psychologist (HLR). The group ran for 8 consecutive weeks, with each session lasting 1½ hours, which included a 15-minute break to allow participants to socialize and to discuss their experiences in the absence of the two facilitators. The group was closed to other patients with CFS.

The content of each session was based on CBT principles and is outlined in Table 1. Particular reference was made to individualized graded task assignments, activity scheduling and cognitive strategies. All sessions had clearly defined objectives, which were followed up with appropriate homework tasks and detailed handouts. Constant reference was made to the interaction

Table 2. Median scores and ranges for main outcome measures at different assessment stages

Measure	Pre-treatment (n = 4)	Mid-treatment (n = 4)	Post-treatment (n = 5)	3-month follow-up (n = 5)
Physical fatigue	8 (0–8)	0 (0–4)	1 (0–2)	2 (0–8)
Mental fatigue	5 (0–6)	0 (0–6)	0 (0)	2 (0–5)
PFRS emotional distress	1 (0–5)	1.03 (1)	1.2 (1–3)	1.3 (1–5)
PFRS cognitive difficulty	3.8 (1–6)	1.6 (1–2)	1.9 (2–5)	1.9 (1–5)
PFRS fatigue	4.3 (3–5)	2.5 (2–3)	2.3 (1–4)	3.4 (1–4)
PFRS somatic symptoms	1.8 (1–4)	1.4 (1–2)	1.3 (0–3)	1.8 (0–3)
HADS anxiety	7 (1–17)	4 (0–9)	6 (2–7)	6 (2–14)
HADS depression	13.5 (10–15)	8 (5–10)	8 (1–14)	10 (2–14)

**Figure 1.** Graphical illustration of HADS anxiety and depression, PFRS symptoms and physical and mental fatigue over time (n=5)

of symptoms, mood, cognitions and behaviour as proposed by Greenberger and Padesky (1995). Following group treatment, a 3-month follow-up and booster session was offered.

Results

Patient characteristics

Of the six patients on the departmental waiting list at the time of this study, all six met inclusion criteria and consented to partake. All group members were female, with an age range from 25 to 52 years and a median age of 43 years. The duration of symptoms varied from 2 to 7 years, with a median of 3.8 years. Two participants worked. One participant had returned to full-time employment, while another worked part-time on a phased return. One participant attended for two consecutive sessions, then dropped out from the group programme due to transport difficulties. Four of the five participants attended the follow-up session. One participant was unable to attend due to college commitments, but she returned the follow-up assessment questionnaires

Outcome findings

Given the small sample size, descriptive statistics are presented only. Table 2 outlines median scores and ranges for the main outcome measures at different assessment stages. Figure 1

illustrates the changes over time for all outcome measures. The results suggest that group CBT led to reductions in physical and mental fatigue as measured by the Fatigue Scale (Chalder et al., 1993), with improvements largely being maintained at follow-up. These improvements, with scores below clinical caseness, were particularly striking during group therapy as participants appeared to experience less fatigue at mid- and post-treatment compared to their initial median scores. This reduction in fatigue was supported by participants' scores on the PFRS Fatigue subscale. Participants' degree of emotional distress appeared relatively stable throughout, with some improvements being apparent at mid- and post-treatment. Finally, significant reductions in cognitive difficulties on the PFRS were noted. These were supported by the improvement in mental fatigue. Anecdotal evidence also suggested some improvements in functional abilities following the group treatment: one participant returned to walking, one resumed gardening, one offered to mind her grandchild and one enrolled on a college course.

Discussion

The findings largely support the hypothesis that group CBT leads to improvements in fatigue ratings. The differentiation between physical and mental fatigue suggests that group CBT was particularly beneficial to participants in terms of physical fatigue, given their initial median scores, which were comparable to other studies (e.g. Deale, Chalder, Marks, & Wessely, 1997). In addition, they experienced marked improvements in their cognitive functioning as indicated on the PFRS Cognitive Difficulty subscale, which suggests that participants' mental fatigue had also significantly improved. However, given the small sample size, it is impossible to comment on the statistical significance of these improvements.

The hypothesis that group CBT would lead to a reduction in anxiety and depression was not supported, although the data suggested a trend towards reduction. Given the initial low levels of emotional distress in this sample and the relative stability of their mood, further improvements would have been difficult to achieve. However, the relative stability of mood was also observed by Deale et al. (1997). Interestingly, depression scores had a wider range at post-treatment and at follow-up compared with their pre-treatment median scores, suggesting that group CBT contributed to greater variability in depression scores.

Despite these encouraging findings, this study had a number of limitations. Due to an absence of CFS referrals to the department at the time this study was conducted, no adequate comparison group could be recruited. This control group would have received eight sessions of relaxation training to control for contact time and impact. A replication of the present study using a larger sample size in a randomized, controlled trial needs to be conducted. In addition, it would have been useful to assess the impact of group CBT for CFS on functional impairment, especially as individual CBT appears to lead to significant improvements in this area (Deale et al., 1997). However, participants in this study reported to engage in a wider range of physical activities following group CBT.

Following the programme, participants were encouraged to provide verbal and written feedback on the sessions and the general group format. They reported that they valued the introduction to a biopsychosocial model, which accounted for their physical symptoms. They appreciated being introduced to graded tasks assignments within a pacing and planning context and being oriented towards the identification and modification of maladaptive cognitions. Differences in stages of adjustment were an advantage in this group, because more disabled participants were encouraged to practise a range of coping techniques that had facilitated the

return to work of some group members. All five participants rated the group format, timing and session content as highly acceptable and suggested that this intervention should be made available to newly diagnosed CFS patients.

The present study represents, to the authors' knowledge, the only study to date that has attempted to systematically evaluate the effectiveness of a CBT group for individuals with CFS. The preliminary results are encouraging and suggest that not only is this format acceptable to individuals with CFS, but it also leads to a reduction in distressing symptoms, especially fatigue. From a clinical management point of view, there are a number of benefits in terms of the effective management of waiting lists and the economic use of the therapist's time.

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