Chronic Fatigue Syndrome (CFS / ME)

Problem Specific Competences for Cognitive Behavioural Interventions (High Intensity)

(Rimes, Wingrove, Moss-Morris and Chalder, 2014)

These competences are designed to be used in conjunction with "basic" and "specific" CBT competences, and generic therapeutic competences and metacompetences (Roth and Pilling, 2007).

Knowledge

- Diagnostic criteria for chronic fatigue syndrome (CFS / ME)
- Common co-morbid problems associated with CFS / ME and how they may interact with fatigue
- Research evidence about development, maintenance and CBT treatment of CFS / ME
- Controversy regarding aetiology, in particular role of psychological factors
- Psychiatric exclusion criteria (e.g. substance abuse problems, psychosis, eating disorders)
- Knowledge that there are NICE-recommended medical tests to exclude other conditions and medical review of such tests is required prior to diagnosis and treatment
- Cognitive behavioural model of CFS / ME including awareness of common unhelpful beliefs in CFS / ME (e.g. around symptoms, activity / exercise / rest, perfectionism, beliefs about unacceptability of negative emotions) and behavioural responses (e.g. avoidance, "boom-or-bust" activity patterns, over-activity)
- Basic knowledge of the other validated treatment (graded exercise therapy; "GET"),and NICE recommendations for treatment
- Understanding of the aim of CBT i.e. helping person become expert in managing their problems with a view to recovery; improvement in functioning not merely management
- Knowledge of prognosis & recovery issues in CFS / ME
- Understanding of common issues around work (e.g. graded return, medical retirement, issues about benefits and permanent health insurance)

Establishing a working relationship

- Convey belief in reality of symptoms and empathy regarding resulting distress and impact
- Eliciting client beliefs & concerns about engaging in this form of treatment
- Discussing possible barriers to treatment
- Developing a collaborative approach to treatment
- Ability to work with multifactorial model that avoids psychological / physical illness dichotomies
- Ability to discuss cognitive and behavioural factors sensitively in language preferred by client
- Ability to work with clients who have a strong physical illness attribution or initial desire to focus on identifying cause or "cure"
- Ability to express empathy regarding any previous lack of understanding from others and to address potential impact of this on the therapeutic relationship
- Awareness of potential beliefs about psychological weakness or expression of emotions that may impact on therapeutic relationship and work on emotional issues in therapy
- Awareness of possibility of heightened perfectionist standards and how may impact on therapeutic relationship and process

Assessment

Generic CBT assessment skills together with an ability to assess the following

- Whether routine clinical investigations necessary prior to CFS / ME diagnosis have been conducted in last six months; contact appropriate medical professional if tests not taken or abnormal
- Detailed verbal assessment of current physical symptoms, their development / onset, course, fluctuations, impact of previous CBT or other treatments
- Typical day including sleep (timing, quantity, difficulties), activity and rest
- Medications, other substances or diets that may affect fatigue (e.g. caffeine, alcohol, supplements, strict exclusion diets, insufficient / irregular eating or drinking)
- Psychological problems that could exclude diagnosis of CFS / ME (e.g. substance abuse problems, eating disorders, history of psychosis) or may require separate treatment
- Depression and role with regards to fatigue including whether severe fatigue is primary or secondary to depression
- Anxiety including components of this (e.g. perseverative thinking, heightened somatic arousal, avoidance behaviours) that may be contributing to fatigue
- Beliefs about development and maintenance of fatigue and related symptoms held by client and also others where relevant (e.g. family, friends, work colleagues, support group)
- Beliefs about meaning of worsening / exacerbation of fatigue and related symptoms
- Shame, embarrassment, social evaluation concerns about symptoms
- Coping behaviours relating to symptoms that may be helping or hindering recovery (e.g. “boom or bust” activity patterns, too much / little activity or rest).
- Avoidance or other potentially unhelpful behaviours relating to social evaluation concerns linked to symptoms
- Impact of behaviour by other people on symptoms, disability or distress (e.g. over-solicitous behaviour, others doing too much or too little, relationship problems, bullying).
- Childhood experiences relevant to CFS / ME (e.g. trauma, illness experiences)
- Work, benefits or income protection insurance issues relating to fatigue symptoms
- Administer and interpret appropriate questionnaires including both outcome measures (e.g. Chalder Fatigue Scale, Physical Functioning Scale of SF-36, Work and Social Adjustment Scale) and appropriate process measures (e.g. Frost Multidimensional Perfectionism Scale or other perfectionism measure, Beliefs about Emotions Scale)

Case formulation

- Ability to construct an individualised multifactorial formulation incorporating and distinguishing predisposing, precipitating and maintaining factors, using client’s own language

- Ability to use cognitive behavioural model of CFS / ME to guide treatment

Explaining the rationale for intervention

- Include in initial formulation client’s own understanding of aetiology and maintenance; not challenging strongly held beliefs but increasing the range of factors included in understanding of symptoms / disability where possible and appropriate
- Discussion of possible role of deconditioning and other physiological effects of reduced activity levels, sleep disturbance, stress, unhelpful thinking patterns and behavioural responses in maintenance of symptoms and /or disability and how addressing these may help

Intervention

Fatigue symptom psychoeducation and Socialisation to the model
• Enable client to understand CFS / ME-related basic physiology e.g. effects of excessive rest on body • Help the client understand how a multifactorial model of CFS / ME that incorporates cognitive and behavioural factors may apply to their symptoms / disability, using guided discovery
Treatment planning
• Collaboratively establish specific, realistic, measurable end of treatment goals
Behavioural Strategies
Generic behavioural competencies
• Problem-solving • Assertiveness training
Monitoring of activity to establish baseline
• Help client learn to use activity diaries to monitor activity and rest • Collaboratively identify activity patterns including boom-or-bust, inadequate resting, inconsistent patterns of activity and rest over the day or week • Conduct guided discovery regarding impact of activity patterns in relation to symptom maintenance
Stabilisation of activity
• Collaboratively identify baseline level of activity and rest • Collaborative exploration of what constitutes rest for the individual • Collaboratively develop programme of activity and rest to be tried as behavioural experiment • Help client understand rationale for rest being planned rather than taken in response to symptoms • Review activity diaries and modify programme if appropriate to help improve stabilisation
Planned increases in activity to work towards specific goals
• Collaboratively identify valued long-term goals (e.g. six months) and related activities that are currently realistic and accessible for the client • Collaboratively identify specific steps towards longer-term goals • Collaboratively set SMART goals for short-term (e.g. week or two weeks) • Convey that temporary increase in symptoms is normal response to increase in activity • Review progress towards targets and set new targets as appropriate
Sleep management
• Use sleep diary to assess sleep onset, number of times waking, insomnia, getting up time, quality • Help client understand rationale for behavioural sleep management methods • Collaborative identification of specific sleep targets, e.g. set getting-up time, not sleeping in day, behavioural methods for dealing with worries in day or at night • Monitoring and adjustment to sleep-related homework tasks if needed
Graded exposure
• Help client understand rationale for and undertake graded exposure with activities now associated with anxiety or reduced confidence as consequence of CFS / ME e.g. social interactions, travelling, work-related tasks

Cognitive strategies
Generic competences – identifying thoughts, moods, thinking biases, using thought records to address unhelpful thoughts
Addressing fearful cognitions about symptoms and activity
• Address fearful cognitions about symptoms, activity, sleep and rest through behavioural experiments and other methods (see generic cognitive competences)
Addressing other unhelpful negative automatic thoughts
• Help client to identify and address other (non-fatigue related) thoughts that may be contributing to general stress and hence indirectly to fatigue or other symptoms
Addressing underlying assumptions
• Guided discovery to identify unhelpful assumptions that may be related to their experience of fatigue either directly (e.g. perfectionist standards) or indirectly (beliefs about importance of not showing psychological vulnerability meaning that social support is not sought at times of stress) • Apply generic CBT skills to address unhelpful underlying assumptions
Core belief work
• If appropriate / necessary, apply generic CBT skills to collaboratively identify negative core beliefs that may be contributing to fatigue problems (e.g. by contributing to chronic stress)
Involvement of family / partner
• Identify whether appropriate family member / friend to act as a co-therapist and to have at least one joint session together to discuss and plan this role • Address unhelpful responses by partner / family
Work
• Liaise with client's work or education or benefits organisations regarding attendance or graded return to work / education if appropriate and agreed with client
Future planning and Relapse prevention
• Help client plan how to continue to work on goals in the future (current goals and new) • Help client to develop plan for monitoring progress • Collaboratively develop set-back plan including triggers or early warning signs • Collaboratively develop relapse prevention plan including triggers or early warning signs
Metacompetences
Convey and deliver the programme in a flexible manner, responding to the issues raised by the client, while also ensuring that all relevant components are included.

Reference

Rimes, K.A., Wingrove, J., Moss-Morris, R. & Chalder, T. (2014). Competences required for the delivery of High and Low-Intensity Cognitive Behavioural Interventions for Chronic Fatigue, Chronic Fatigue Syndrome / ME and Irritable Bowel Syndrome. *Behavioural and Cognitive Psychotherapy*. [For full reference please see journal website: http://journals.cambridge.org/jid_BCP]