Rehabilitation

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Interventions for the treatment, management and rehabilitation of patients with chronic fatigue syndrome/ myalgic encephalomyelitis: an updated systematic review

Chronic Fatigue Syndrome (CFS), myalgic encephalomyelitis (ME), Fibromyalgia (FM) Irritable bowel syndrome (IBS) and many other outcome labels are applied to persons with unexplained muscle pain, fatigue, depression, sleep disturbance, inattention and headaches. Early on the illness was called neurasthenia. Loss is characterised by bed confinement, sickness absence or use of a wheelchair.

Many patients regard a particular precipitating event as significant, even though reports of precipitating events regularly identify at least a dozen possible pre events with reported increased prevalence. Some regard involvement in a road traffic accident a significant, and compensation claims have been made accordingly.

Predisposition to a syndrome such as these includes female gender, previous history of unexplained symptoms (taken to their GP), and history of psychiatric ill health.

Occasionally the effective treatment of a condition can reveal something about pathogenesis and causation.

This review finds that cognitive behavioural therapy (CBT) is effective.

CBT is a highly structured therapy based on the assumption that prior learning is currently having maladaptive consequences (e.g. maintaining an avoidance of work). The purpose of therapy is to reduce distress or unwanted behaviour by undoing this learning or by providing new, more adaptive learning experiences. Methods used may involve behavioural experiments (e.g. thinking through other scenarios) to test irrational thoughts (e.g. obsession or catastrophising), graded exposure to feared situations (e.g. driving again), (consensual) target setting and activity scheduling. The cognitive component attempts to reduce dysfunctional emotions and behaviour by altering individual appraisals and thinking patterns. Methods used include discussion of the cognitive model, diary keeping (e.g. recording an account of the accident event and through repeated reading developing awareness of thoughts, affect, behaviour and physical symptoms), examination of evidence for and against dysfunctional beliefs (e.g. noting that the event was not actually fatal), cognitive rehearsal (e.g. choosing an affirmation such “I have coped with this before”) and the development of skills to challenge negative thoughts and dysfunctional assumptions (e.g. any pain means there is a risk of making the injury worse).

Immunological therapies were on balance not considered effective (side effects were significant), pharmacological therapies did not work, were inconsistent or were of low validity. One study of the effect of homoeopathy showed good results another did not.

Comment

In our view the support for the universal effectiveness of CBT is not yet overwhelming and effect sizes tend to be moderate to weak when compared with “standard care”. I.e. the improvement over “standard care” is usually quite small.

Therapists usually take care to acknowledge the reality of the symptoms and their reported effects described by their patient, this is not to be taken as evidence of actual harm or validity; it is just part of establishing a trusting relationship. Patients often have lengthy histories to rehearse, but often these do not make any biomedical sense.

In our view, that CBT works at all tends to confirm the relative immateriality of factual events such as a viral disease or an RTA in the aetiology of these affective disorders. They are probably illnesses of belief and perception.

It is to be expected that many people in the throes of a compensation claim will reject offers of CBT or would withdraw once they know what it is; its success could be regarded as evidence of remoteness of the alleged precipitating event. [20% of people involved in randomised controlled trials of CBT withdrew before completion]. It is, however, open to the judge to conclude that an egg-shell personality is deserving of a higher degree of care and that an apparently disproportionate, un-diagnosable, subjective outcome is still a valid outcome if he believes the alleged tortious event precipitated it and that corresponding harm has been done.

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Dogged pursuit of a bio-medical explanation for the condition and pursuit of compensation have both been shown to lead to worse outcomes.

The latest evidence relating FM to whiplash shows no increased probability of new onset FM within 2 years of the whiplash event.

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