Group cognitive behaviour therapy for chronic fatigue syndrome

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Letter to the editor

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Group Cognitive Behaviour Therapy for Chronic Fatigue Syndrome

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Dear Editor,

We have read the article entitled Randomised Controlled Trial (RCT) of Cognitive Behaviour Therapy (CBT) Delivered in Groups of Patients with Chronic Fatigue Syndrome (CFS) by Wiborg, van Bussel, van Dijk, Bleijenberg, and Knoop (2015) with much interest. The authors report that their RCT showed that group CBT can be effectively delivered in adults suffering from CFS, independent of group size. [1] In the Antwerp University Hospital we have been administering group CBT for CFS since 2002 in the context of the University Reference Centre for CFS (2002-2012) [2] and the Behaviour Therapy Division for Fatigue and Functional Symptoms (since 2012). We were hence happy to read that the authors found support for the effectiveness of group therapy for CFS as this is in line with our own experiences.

However, we think it is important to note that the interventions in question were delivered by highly motivated therapists in an expertise centre, which may partially account for the effect sizes reported. Moreover, the authors did not elaborate on the fact that exclusively participants who were willing to receive group therapy were included in the trial, which may likewise have positively affected outcomes. The participants in the group interventions may have been a highly motivated subgroup, while the participants allocated to the waiting list for individual therapy may have become demotivated. We also wonder whether personality might have been of influence on the patients' readiness to participate in group therapy. As to this, we are planning to conduct a study on the effects of personality dimensions on the short- and longer-term outcomes of group CBT. In that respect, it has recently been found that high levels of neuroticism at baseline were associated with a larger improvement in mental quality of life after group CBT for CFS whereas no correlations were found with physical quality of life [3].

Furthermore, in the baseline characteristics of the Wiborg et al. study sample we noticed that the secondary outcome measure, i.e. psychological distress as measured with the Symptom Checklist 90 (SCL-90), was low compared to the baseline value we obtained in our own population receiving treatment in a tertiary CFS centre [4], whilst the scores on the Checklist Individual Strength (CIS) were comparable for the two samples (see Table 1). We accordingly wonder whether the results of the Wiborg et al. study are representative of the daily practice in tertiary settings given that research has already shown that RCT outcomes are superior to those obtained in routine clinical practice, where the disparity may be explained by patient selection [5].

Table 1. Baseline characteristics of the two study samples

	Wiborg et al., 2015 (n=204) [1]	Van Den Eede et al., 2013 (n=149) [4]
Fatigue severity (CIS)	50.9 (4.7)	51.26 (5.316)
Physical functioning (SF-36)	55.4 (18.8)	43.86 (20.796)
Psychological distress (SCL-90)	166 (37.4)	206.60 (45.682)

Scores are means with standard deviations in parentheses. CIS = Checklist Individual Strength, SF-36 = Short Health Survey 36, SCL-90 = Symptom Checklist 90

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