EMDR as a Therapeutic Treatment for Chronic Fatigue Syndrome (CFS)

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Chronic fatigue syndrome (CFS) is a condition characterized by a new and persistent fatigue unexplained by other conditions and resulting in a substantial reduction in the individual's activity levels. Current treatment includes psychotherapeutic procedures such as cognitive–behavioral therapy, pharmacological interventions, and graded exercise therapy. This article considers the effectiveness of eye movement desensitization and reprocessing (EMDR) for the condition of CFS. The case study describes the use of EMDR with a 49-year-old male client who had suffered debilitating CFS for nearly 5 years despite accessing other treatment methods. After 9 sessions, the client indicated that his energy levels were significantly higher, his need for sleep had reduced (from 15–20 hours to 9.5 hours in a 24-hour period), and he was able to resume employment. Results suggest that EMDR may be useful in treating CFS within a personalized treatment plan.

Keywords: chronic fatigue syndrome; EMDR; treatment efficacy; adaptive information processing; case study

According to the Centers for Disease Control and Prevention, chronic fatigue syndrome (CFS) affects over 1 million people in the United States (Centers for Disease Control & Prevention, 2007). Figures from the Myalgic Encephalopathy (ME) Association (2007) reveal that CFS and related ME affect around 250,000 people in the United Kingdom. CFS is described as a "clinically evaluated, unexplained persistent or relapsing chronic fatigue that is of new or definite onset, is not the result of ongoing exertion, is not substantially alleviated by rest, and results in substantial reduction in previous levels of occupational, educational, social, or personal activities" (Centers for Disease Control & Prevention, 2008). In addition, a diagnosis of CFS requires the concurrent occurrence of four or more associated symptoms (see Table 1).

CFS can affect all ages, from the very young to the elderly, but the peak age tends to be between 20 and 40 (CDC, 2007). Severity can differ widely among people, ranging from getting unusually fatigued following stressful events to being completely disabled. It is suggested that 6% of any CFS sample will recover over a 6-month period without intervention (Thomas et al., 2006). However, where intervention is required, the National Institute for Clinical Excellence recommends three options for treatment (NICE, 2007):

- Pharmacological interventions, including antidepressants and corticosteroids
- Graded exercise therapy (A sustainable baseline of physical activity is set. The duration of the activity is then gradually increased in a planned way that is tailored to the person. This is followed by an increase in the activity when the person is able.)
- Cognitive–behavioral therapy (CBT) suggesting that psychological processes are a major contributor to CFS

Studies suggest that CBT not only helps some CFS patients cope with the impact of a chronic illness but can also help manage the symptoms and improve the patient's level of functioning (Antoni & Weiss, 2003; Bazelmans et al., 2005; Deale et al., 1997, 1998; Kroenke & Swindle, 2000; Nezu & Maguth Nezu, 2001; NICE, 2007; Raine et al., 2002; Saxty & Hansen, 2005). However, some research has questioned the efficacy of CBT (Bazelmans & Huibers, 2005; Huibers et al., 2004; Leone et al., 2006; Van Hoof, 2003). Knoop et al. (2007) reviewed the literature surrounding CFS,

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TABLE 1. Associated Symptoms That May Indicate CFS/ME

- Cognitive dysfunction, such as difficulty thinking, inability to concentrate, impairment of short-term memory, and difficulties with word-finding, planning/organizing thoughts, and information processing
- Difficulty with sleeping problems, such as insomnia, hypersomnia, unrefreshing sleep, a disturbed sleep-wake cycle
- Muscle and/or joint pain that is multisite and without evidence of inflammation
- Headaches
- Painful lymph nodes without pathological enlargement
- Sore throat
- General malaise or "flu-like" symptoms
- Dizziness and/or nausea
- Palpitations in the absence of identified cardiac pathology
- Physical or mental exertion makes symptoms worse

From National Institute for Clinical Excellence (2007), p. 13.

taking into account the patient's perception of the fatigue and his or her own health and found that a significant improvement following CBT is probable and a full recovery is possible. They argued that studies of CFS provided high-level evidence for the effectiveness of CBT in challenging dysfunctional cognitions regarding the effectiveness of rest and in stimulating graded activity.

Suraway et al. (1995) suggested that once CFS had established itself within a patient, perpetuating factors might work together to maintain symptoms. This is consistent with the classical CBT model of emotional distress (Beck, 1976) and the cognitive, behavioral, affective, and physiological factors that perpetuate and prolong symptoms. Indeed, factors such as the patient's belief system and dysfunctional cognitions (Abbey, 1996; Deale et al., 1998; Suraway et al., 1995; Taillefer et al., 2002), depression (Taillefer et al., 2002), sociocultural influences (Fennel, 1995; Prins et al., 2004), and stress (Antoni & Weiss, 2003) have been identified as exacerbating and/or maintaining symptoms of CFS. Common themes in psychotherapy with CFS patients include the search for legitimacy, problems of stigmatization, an overextended, overcommitted lifestyle preceding CFS, perfectionism and other maladaptive beliefs (Abbey, 1996). In a theoretical and empirical review of the literature, Deary et al. (2006) examined the evidence for the CBT model for CFS. Through their consideration of a plausible mechanism of symptom generation they concluded that by targeting the cognitive and behavioral factors in CFS, CBT could lead to improvement in physical symptoms. Deale et al. (1998) reported the effect of illness beliefs on outcome in a randomized controlled trial of CBT versus relaxation. Causal attributions and beliefs about exercise, activity, and rest were recorded before and after treatment in 60 patients with CFS. Good outcome occurring in either group was associated with change in avoidance behavior and related beliefs rather than causal attributions.

Because excessive stress, accidents, and traumatic events can be precipitating factors for CFS (Antoni & Weiss, 2003; Crofford, 2007; Heim et al., 2004; Heim et al., 2006), it could be hypothesized that a treatment designed to address psychological trauma and distress would have some benefit for CFS patients. Eye movement desensitization and reprocessing (EMDR), a psychotherapeutic procedure originally designed to treat the psychological consequences of traumatic experiences, is recommended as an effective treatment for posttraumatic stress disorder (Bleich et al., 2002; Bisson & Andrew, 2005; Chemtob et al., 2000; Clinical Resource Efficiency Support Team [CREST, 2003]; Department of Veterans Affairs & Department of Defense, 2004). More recently, EMDR has been used effectively to treat other psychological problems, for example anxiety disorders (Shapiro, 2005), vicarious trauma (Keenan & Royle, in press), body dysmorphic disorder (Brown et al., 1997), nonpsychotic morbid jealousy (Keenan & Farrell, 2000), and phantom limb pain (Schneider et al., 2008).

EMDR's adaptive information processing (AIP) model posits that most psychopathology has its roots in distressing past experiences that have not been adequately processed (Shapiro, 2001). When new information is not processed adequately, the associated thoughts, images, emotions, and physical sensations are incorrectly stored, remaining intrusive or overwhelming and leading to current dysfunctions. According to this model, CFS is viewed as a symptom constellation caused by inadequate processing of earlier distressing experiences.

EMDR is thought to facilitate adaptive processing, which involves forging associations between dysfunctional stored material and more adaptive information. This leads to a reduction in emotional

distress, learning, and "making sense" of an experience (Shapiro, 2001). The standard EMDR protocol (Shapiro, 2001) includes identifying a statement that expresses a maladaptive self-assessment associated with an image. This "negative cognition" represents the client's current interpretation of the self and is generally associated with negative feelings, for example, shame, powerlessness, and incapacity. One of the effects of AIP is the transformation of the negative self-concept, with its associated disturbing material, to a more realistic, appropriate, and adaptive view. As stated previously, research has indicated that the patient's dysfunctional cognitions have the potential to perpetuate CFS symptoms. This therefore provided the rationale for using EMDR with the CFS patient in the following anonymized case study. At the time of writing, searches of PsycINFO and Medline revealed no published studies of the use of EMDR with CFS. This case demonstrates EMDR's applicability to CFS, and the positive treatment effects suggest that further research is warranted in the form of multiple case studies.

Case Presentation

Andy, a 49-year-old married father of two, had been diagnosed with chronic fatigue syndrome in 2002. He spent the next few years being supported by a National Health Service ME/CFS clinic. Treatment methods had included graded exposure therapy and antidepressants, but no progress had been made. Andy had also accessed solution-focused brief therapy in early 2006, and it was this therapist who referred him to the author. Andy's life was severely affected by his hypersomnia and he often slept for 15–20 hours a day, becoming exhausted physically and mentally by general household tasks. Since 2002 he had tried to return to the workplace on two occasions but had relapsed again, becoming completely debilitated by fatigue. He had not been able to work since 2003. Andy's mood was low and he often had angry outbursts directed at his family. Although he had never become violent, managing this anger was his primary treatment goal.

Presenting Complaints

In addition to the hypersomnia, Andy was experiencing cognitive dysfunction. He reported an inability to concentrate, impairment of his short-term memory, and difficulties with word-finding and organizing his thoughts. Mental exertion exacerbated his fatigue, in particular lengthy telephone calls, computer work, and dealing with paperwork. Andy also reported symptoms of irritability, highly intrusive thoughts and images relating to previous work stressors, and unexplained tingling sensations in his legs. His self-evaluation was very negative. Andy told his therapist that he had gone from being highly successful at the top of his career to "a failure" at work. Andy peppered his conversation with negative self-beliefs including "I can't cope," "I'm not in control," and "I can't handle this."

History

Andy had become ill following what he described as an extended period of highly demanding work with excessive hours. This, alongside changes to his professional role within a major corporation, left him feeling unable to meet ever-growing demands. In 2002, following a period of around 7 years in which he worked at overextended levels, physically and emotionally, he had become exhausted, experiencing in his words a "complete physical shut-down." Other significant life events included the death of his father 2 years earlier following a lengthy illness and a time preceding his CFS diagnosis when he lived in fear of losing his employment due to layoffs within his workplace. He reported an uneventful childhood with no other remarkable events or periods of stress. Andy stated that he had never had negative self-beliefs prior to the work-related stress and had perceived himself as confident and capable. Andy's family was reported to be close and supportive.

Assessment

At the assessment session, Andy described himself as "... stressed, causing angry outbursts over small matters and very tired. (My) reaction is totally disproportionate ... also suffering from flashbacks mainly to do with work. Unable to function ... don't have any idea which way to turn to start to recover and am back on antidepressants." He was sleeping for 15–20 hours in a 24-hour period, and the smallest of tasks, such as doing household laundry, left him drained physically and mentally.

Case Conceptualization

Andy was seen for a total of nine sessions over 4 months. Appointments were on a weekly basis, spaced out toward the end of his therapy. In accordance with the eight phases of EMDR treatment (Shapiro, 2001), the first few sessions focused on history-taking and preparing Andy for EMDR. His current coping strategies were clarified and relaxation and breathing techniques were taught. A good rapport and a safe place were quickly established. The treatment plan identified

specific targets for reprocessing. These were the past memories that appeared to have set the pathology in process and the present situations that exacerbated his dysfunction. Andy identified three groups of memories with parallel cues (negative cognitions) that could be clustered for a generalization effect. These were, in chronological order:

1. Andy being overwhelmed at work and trying hard to maintain control by working increasingly longer hours.
2. Andy realizing that, no matter how hard he worked, he could never meet the growing and changing demands.
3. The fear during his medical leave of being pressured back into the workplace and becoming ill again.

Course of Treatment and Assessment of Progress

The EMDR protocol recommends that the earliest disturbing memories be targeted first. Consequently, once Andy was ready to begin the desensitization phase of EMDR, it was agreed to target his memories of being overwhelmed at work. He was asked for one event that represented this entire cluster. The image he had was of standing in the workplace looking "a physical wreck, too much to do," with a negative self-evaluation of "I am a failure." When asked for a positive cognition, Andy settled for "I can be a success" but rated his Validity of Cognition (VoC) as 2 on the scale of 1–7, indicating low validity. Andy said he felt "lethargy, negativity, like a wet lettuce." The physiological reaction to this image was a sensation of his "body vibrating and head spinning." His Subjective Units of Disturbance (SUD) rating was 9 on the scale of 0–10, indicating high distress. Andy was encouraged to think about this image while at the same time being aware of his current physiological reaction and the negative cognition of failure. The therapist then conducted saccadic visual stimulus.

Between eye movement sets, Andy reported a rapid succession of many fragments of memories relating to work, his illness, and his family life. He remarked on "a sense of hopelessness," "no energy," and "seeing myself lying on the bed."

Andy was encouraged just to think about this and the sets continued. This first session was incomplete (although his SUD rating had reduced to 6) and closed with a safety assessment and reminder that processing could continue. Andy was keeping a log of his thoughts, feelings, memories, and dreams between sessions to review changes and processing as well as to identify material for further sessions.

At the next session, Andy reported that his energy levels had increased in the 24 hours after the session and he spontaneously reported instances of capability from the previous week. On re-evaluation, however, Andy was asked to think again of the previously targeted event, and his SUD rating of 9 indicated that the memory should be retargeted. When asked what words best went with the image, Andy immediately said "It's my fault. I should have done something." The image of Andy standing among "stacks of paperwork" led to emotions of "overwhelm, sadness, and guilt" and physical sensations of tingling in legs and light-headedness. Andy's positive cognition was "It's not my fault" with a VoC of 1.

Between eye movement sets in this session, Andy became progressively more positive, stating "it wasn't my fault," "they (the corporation) were the problem, not me."

Although the session was again incomplete, Andy was confident that some form of adaptive information processing had taken place. Indeed, on re-evaluation at the next session, Andy reported that his intrusive thoughts and imagery relating to the workplace had stopped, his SUD was 0, and he could clearly separate responsibility for what had happened. Although there were no significant changes to the fatigue and hypersomnia, Andy felt that he was gaining benefit from the EMDR with respect to his anger and self-image, and he was motivated to continue with the treatment plan.

The final target for desensitization (in session 7) related to his current fear of a return to the workplace and a lack of control and input for his future. Andy had an image of himself looking apprehensive in the workplace, a sense of fear, and the NC "I'm vulnerable." His SUD was 10. It was difficult to ascertain a positive cognition with respect to the image. He did settle on "I can protect myself," which rated 1 on the VoC. The physiological response to the image and negative cognition included "heavy shoulders and a tight chest."

Between eye movement sets Andy reported his fear increasing along with the thought that "they (the corporation) can make me go back to that," "they are pulling my strings."

Between subsequent sets, Andy had the insight that, in the past work situation, sleep had been the only escape from overwhelming demands. Now *not* being asleep was a trigger for expecting overwhelming demands that lead to high anxiety and exhaustion. Further sets led to the inner conflict "I want to prove them wrong (by going back)" versus "If I get better, I'll have to go back," then "I could do it," and "I can't trust them to consider my welfare . . . they really don't care."

Andy explored his future and choices, including a return to what had been described as a "toxic environment." If Andy got better he would have to return, and he had no trust in either his employer or his own ability to protect himself. At this stage, Andy's therapist asked him to consider any small way in which he could take control of his situation, "just to think about that," while further eye movements were administered. During this set, Andy began to realize his power in the situation and that he *was* able to make choices and protect himself. Following this set, Andy visibly relaxed and came up with a self-generated solution to his dilemma. With further sets, he progressed naturally to the belief that he was in control and able to protect himself, and the positive cognition was installed with a VoC of 7.

This was the final breakthrough needed, and Andy's energy levels began to increase dramatically. The final two sessions were spaced over a month, allowing Andy to explore his sense of identity and purpose and to make progressive small changes while continuing with support from his therapist.

Treatment Outcome

Six months on from the end of therapy, Andy was optimistic and active in his life, making changes and plans for the future. Although he chose not to return to his old employer, Andy resumed work in an unrelated environment and was enjoying his new sense of purpose and reinventing his life. His family reported a marked change in him. Andy himself described his situation as "improved beyond my wildest dreams. (While on holiday) I felt so relaxed and normal that I was able to undertake country walks of around 5 miles each without any major fatigue. I did five in 1 week . . . what a great time I had and how good it felt." A longer-term follow-up 12 months after the end of therapy revealed that Andy's sleep level was on average 9.5 hours per night. He had maintained this progress and levels of activity and was enjoying his new employment.

Treatment Implications and Recommendations to Clinicians and Students

This case demonstrated the use of EMDR with one individual who had suffered from CFS for 6 years enabling him to recover his quality of life and feel more empowered about his future. The AIP model underlying EMDR posits that identifying and processing the etiological events will result in the amelioration of symptoms (Shapiro, 2001). The earliest memories reported by Andy were not from childhood or adolescence. Instead they were related to the onset of his feelings of exhaustion and his NC "I'm a failure" prior to his diagnosis of CFS. From the AIP perspective, it appears that these sensations of physical exhaustion and being emotionally overwhelmed were processed inadequately. These experiences had then continued to be intrusive, along with imagery relating to those memories, and had led to the development of his CFS. The AIP model suggests that EMDR enhances the processing of such dysfunctionally stored material. By targeting his memories of exhaustion and feeling overwhelmed, Andy also moved from dysfunctional and symptom-perpetuating negative cognitions to positive empowering ones and helped gain insight into his current situation.

As it is defined by its symptoms, not its underlying cause, CFS could be a number of different conditions, all characterized by similar symptoms (ME Association, 2007). Therefore it is improbable that any one treatment will be a cure-all. This case would lend credibility to the idea that, where excessive stress, accidents, or traumatic events are identified as precipitating factors for CFS, EMDR could be helpful. For patients such as Andy, with negative self-evaluation, intrusive thoughts and images, EMDR may be appropriate for processing maladaptive beliefs and associated somatic symptoms. Andy was seen for a total of nine sessions, proving an efficient therapy in his case. CFS patients who have significant history of prior psychological trauma would require a more comprehensive treatment entailing sequential targeting of earlier, critical experiences in addition to the present symptom-perpetuating situations.

Since this was a case study, a placebo effect cannot be entirely ruled out. However, the fact that Andy's CFS had not returned at the 12-month follow-up would suggest a lasting effect had taken place. More research is required when considering effective treatment options for CFS. This case demonstrates EMDR's applicability to CFS, and the positive treatment effects would suggest that further research in the form of multiple case studies using EMDR as the primary treatment modality is warranted. These studies could focus initially on clients whose CFS appears to have been precipitated by excessive stress, accidents, or traumatic events. Further research into the efficacy of EMDR for CFS needs to consider therapist competence, adherence to the EMDR protocol, and the use of psychometric measures of fatigue (checklist individual strength) and functional impairment (sickness impact profile) as quantitative measures of progress.

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