

5785 words

## **Myalgic Encephalomyelitis/Chronic Fatigue Syndrome and early maladaptive schemas: A single case study**

**Background/Aims:** Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) is a complex illness, one that is devastating and life changing for many people. Early maladaptive schemas (EMS), as described by Young et al., (2003), have been observed in some patients with ME/CFS; seemingly adversely impacting on psychological and physical well-being. This study explores the experience of working at schema level with a woman with ME/CFS and endorsed EMS. It provides an overview of the therapeutic treatment, with the aim of adding to the limited research in this area.

**Method:** The instrumental single case study takes place within a clinical context. The client received 20 sessions of therapy. Standard cognitive behavioural therapy (CBT) was initially utilised to work with the client's depression; once reduced, schema work commenced. Beck's Depression Inventory (BDI-II) was used to measure mood, and Young's Schema Questionnaire (YSQ-S3) was employed to measure schemas.

**Findings:** By the end of therapy only two schemas from the nine schemas that the client had endorsed at the start of therapy remained at a level of 'therapeutic significance'; three schemas diminished once the depression had been treated. The client reported that her quality of life had improved and that she had taken up part-time paid employment.

**Conclusion:** The results appear to offer some support for working at schema level with people that have ME/CFS and also endorse EMS. However, treating existing depression first is recommended.

**Keywords:** early maladaptive schemas, myalgic encephalomyelitis, chronic fatigue syndrome, psychotherapy.

### **Introduction**

Schemas have been defined as 'core beliefs' (Padesky, 1994) and 'internally focused constructs' (Gilbert, 1992): they are viewed as unconsciously biasing information processing. Similarly, early maladaptive schemas (EMS), which Young et al., (2003) describe as 'broad pervasive themes that pervade an individual's life', are also viewed as prejudicing cognitions, emotions and behaviour (2003, p.61). They have been identified as having an adverse impact on psychological and physical well-being (Saairho et al., 2010). Young et al., (2003) postulate that EMS are formed principally, but not exclusively, from

early adverse childhood experiences. Based on clinical observations, Young (1999) catalogued 18 EMS, classifying each into one of five domains that relate to an unfulfilled emotional need.

According to Young et al., (2003) from an early age coping styles develop, usually out of awareness, in reaction to the disturbing schemas. Three coping styles; schema overcompensation, schema avoidance, and schema surrender are identified relating to the threat responses: fight, flight and freeze, respectively. Although viewed as a healthy survival mechanism when young, the coping styles become dysfunctional as the individual matures. It is proposed that the coping style needs to be altered in order to facilitate 'healing' of the schema (Young et al., 2003). Despite Young et al.'s theory having consistency with attachment theories and being supported by clinical observations (Mason et al., 2005), it does not seem to explain schema formulation in later periods.

Whilst research into the contribution of EMS and disorders is increasing (Simmons et al., 2006), little is known about how they relate to ME/CFS. ME/CFS is a complex illness. The lack of understanding and consensus surrounding the aetiology and maintenance of ME/CFS contributes to the uncertainty and controversy that surrounds it. Indeed, whilst CBT is a treatment recommended by the National Institute for Health and Care Excellence (2007) for ME/CFS, its relevance is questioned (Carruthers et al., 2003). The CBT model of CFS (Surawy et al., 1995) takes into account predisposing, precipitating and perpetuating factors. It depicts unhelpful thoughts and beliefs as contributing to the maintenance of the illness. However, the ME Association fervently disagrees with this, finding such accusations as 'offensive' (Reply to the Department of Work & Pensions Guidance on ME/CFS, 2007, p.2).

Fisher and Chadler (2002) point out that there is a deficit of knowledge in predisposing factors assumed by the CBT model of ME/CFS. Schemas are one of the predisposing factors considered by the model. Even though schemas akin to EMS as described by Young et al. (2003) have been observed in some patients with ME/CFS (Kinsella, 2007; Le Bon et al., 2007), a review of the literature suggests that research into the relationship between EMS and ME/CFS is limited. However, a preliminary study found that the schemas 'unrelenting standards' and 'self-sacrifice' had the highest endorsement in a ME/CFS group; 47.5% and 27.5% respectively (Stalmeisters & Brannigan, 2011).

Frustration is expressed at the government's investment in the psychological causation of ME/CFS rather than in biomedical research (Shepherd, 2011). However, psychological aspects affecting other chronic medical conditions have been documented (White, 2001). Within the context of ME/CFS specifically, research has identified the contribution of stress to immune system dysregulation (Heim et al., 2009). Importantly, a meta-analysis (Segerstrom & Miller, 2004) found that optimism and coping moderated immunological responses to stress in a number of studies. Additionally, a preliminary study (Lopez et al., 2011) found cognitive behavioural stress management reduced stress levels and symptoms, improving the quality of life of people with chronic fatigue syndrome. Moreover, the findings from a qualitative study (Stalmeisters, 2012) suggest that the individual's continual obscuring of their own needs, associated with engaging in schema-driven behaviours, or even the 'desire' to fulfil the behaviours, may increase stress levels in people who are physically challenged, arguably compromising the hypothalamic-pituitary-adrenal axis and potentially depleting energy levels. Given this, it would seem important to explore the relationship between EMS and ME/CFS from a therapeutic perspective.

## **Method**

As a critical realist (Bhaskar, 2011), both quantitative and qualitative methods are critically appreciated. Both sit comfortably within this case study. Together, the measures used, plus the voice and experience of the participant, bring depth to the study. Despite case studies being criticised for their lack of generalisability and subjective nature (Spinelli, 2003), the benefits of good case studies have been identified in psychotherapy training (Mackrill & Iwakabe, 2013). Case studies are viewed as strengthening scientific knowledge in the social sciences (Flyvbjerg, 2006). Whilst this case could be considered of interest in itself, and therefore fall in the domain of an 'intrinsic case study', the intention was to illustrate and advance understanding of a particular area. Therefore, an 'instrumental case study' was chosen (Stake, 2005). The case study, set within a clinical context, was part of a larger research project examining the relationship between EMS and ME/CFS.

Measures: Beck's Depression Inventory [BDI] (Beck et al., 1996) and Young's Schema Questionnaire [YSQ-S3] (Young et al., 2003) were employed. The YSQ-S3 measures 18 schemas. It has a total of 90 questions, 6 relating to each schema; for a schema to be

seen as 'therapeutically significant' at least two of the questions must be strongly identified with.

Participant: Kate, a pseudonym, volunteered to participate in the study. Kate heard about a research project being conducted by the author into ME/CFS from a participant in an earlier study. Kate approached the author to participate. Kate, a 47-year-old white British woman, met the conditions to participate. She had received a diagnosis of ME/CFS from a medical practitioner and endorsed EMS on YSQ-S3 at a therapeutically significant level (Table 1).

### **Insert Table 1 here**

The therapeutic sessions took place within a university's clinical suite. Twenty therapeutic sessions were negotiated, which included two assessment sessions plus one follow-up session. Initially sessions were on a weekly basis, but as therapy progressed, the intervals between sessions increased. All sessions were recorded

#### *Ethical considerations*

The researcher held a dual role within the study as both researcher and therapist. Although the research was important, respecting the principles connected with Deontology (Israel & Hay, 2006) meant that the participant was not seen as a means to an end, even though in principle an 'instrumental' case study might imply this. Mindful that there is an inherent power imbalance between researcher/participant and therapist/client (Etherington, 2001), it was made clear to the participant that she had control, in that she could choose to withdraw from the study at any time and therapy would still be available to her. Ethical clearance was obtained from the University of Derby ethics board.

#### *Background of participant*

Kate had received a diagnosis of ME/CFS from a medical practitioner a year earlier. According to epidemiology data, women are afflicted more than men by ME/CFS (DoH, 2009). Kate's mobility had reduced considerably since she had become ill: she walked slowly and fatigued easily. Kate was also receiving medication for depression; her mood had lowered since her illness; increased levels of 'secondary' depression are found in people with ME/CFS (Duff, 2003).

### *Immediate precipitating factors of the illness*

Kate had a demanding job. She said she had been committed to working long hours; she supposed that 'if you work hard, you have value'. By all accounts, Kate appeared to have a propensity for 'striving' behaviour at work, which is consistent with Van Houdenhove et al., (2006) findings, suggesting 'action proneness' was sometimes evident prior to the onset of ME/CFS. Kate received a diagnosis of ME/CFS sometime after having severe flu. Kate's experience is congruent with the research of Zhang et al., (2000), in that ME/CFS can occur at a time when viral infections are most vigorous.

### *Personal and social history*

Kate described her childhood as 'fine, nothing outstanding'. However, she reported that her relationship with her father had been difficult; she described him as 'domineering and controlling'. Kate described herself, in the social context, as 'always going along with everyone else, a bit of a walk over'. Her compliant behaviour with friends and family contrasted with her assertiveness at work.

Kate had enjoyed a good relationship with her live-in partner, Tom (pseudonym). Kate in fact summed up her life prior to her illness as 'fun'. However, this completely changed as the illness progressed. Kate experienced a great degree of disruption to her life. From being highly active, she had become passive. Loss became a theme in her life. Tom left her, and her employment was terminated. The latter is consistent with many people's experience with ME/CFS: work-related issues are common (Taylor & Kielhofner, 2005).

Kate had a great number of negative cognitions. She felt that whatever she did, it was not good enough, and she felt she constantly had to give more. She perceived herself to be a failure and, as she could no longer work, a poor role model for her children. Kate felt ME/CFS had taken over her life and she was out of control. Additionally, she stated that she needed to 'put on an act so much of the time'. Kate's explanation for this was, 'I don't want others or can't let others see the real weakness in me.' This is consistent with Dickson et al.'s (2008) study which found that people with ME/CFS pretended to be like their 'old self'.

### **Course of therapy**

### *The therapeutic relationship*

Kate demonstrated a high level of motivation to engage in the therapeutic process. I found it easy to feel comfortable with Kate; however, it was important to be mindful that Kate had a tendency to be compliant with some people, and that she might parallel this process in therapy. A strong rapport developed over the sessions between Kate and myself based on empathy, warmth and genuineness (Rogers, 1986).

### *Interventions*

As it is possible that working with schemas can initially deepen a depressed mood (James & Barton, 2004), Kate's depression was treated first, using traditional CBT (Padesky & Greenberger, 1995). After the third session Kate announced: 'I have a sense of hope that things could change.' This became a reality. By session nine, Kate's BDI score reduced to 13, indicating only mild depression, it therefore appeared feasible to commence schema-focused work. To note - a number of schemas ceased to be at a level 'therapeutically significant' (Table 1).

### *Schema-focused work*

The schema-focused approach employed integrated cognitive theory (Padesky, 1994), and schema-focused therapy (Young et al., 2003) with gestalt techniques, such as 'two chair work', as advocated by schema therapy (Rafaeli et al., 2011, p.92).

In session nine, in keeping with working collaboratively, Kate was asked which schemas she would like to concentrate on. She confirmed that she would like to explore the schemas defectiveness/unlovability and unrelenting standards. As Kate had been very self-critical, we had already begun to examine issues related to her feelings of self-blame, worthlessness and inferiority, significant aspects of the defectiveness/unlovability schema, using traditional CBT techniques. At this point, I was pleased to hear Kate rationalise, 'I must be worth something as people have stood by me this year.' Kate's self-worth was growing.

In a following session, we sensitively explored a hurtful comment made by her father which Kate had interpreted to mean that she was not good enough. Initially, working with imagery, Kate described this situation, using the first person, connecting with the event emotionally. We moved on to using the 'two chair' technique). This work involved

imagining her father was present in the room, sitting on a chair. Kate was able to dialogue with his internalized critical voice. Initially, she looked as if she was in the lonely, frightened child mode, but, I witnessed her strength develop as she transferred to the healthy adult mode (Young et al., 2003), appearing more confident. This work enabled Kate to express the perceived impact his comment had on her life. Remarks made to her 'father' included, 'You made me feel it was my fault', 'I hurt too much', 'I tried, tried and tried', 'I can't pretend any longer'. Actively listening and expressing the warmth and admiration I felt for Kate seemed to help her move to a position of empowerment.

Over time Kate recognized the double standards she operated with, enabling her to be more compassionate with herself. Kate was able to reconstruct her belief 'I do my best but it's not good enough' to, 'as long as I do my best, it will always be good enough'. In session, as we worked with this belief, Kate stopped talking and put her hand over her mouth. When she spoke again she said, 'I do my very, very best but it's not good enough isn't true!' This was a startling and emotional revelation for Kate. I felt moved. We celebrated and appreciated the moment.

From Kate's narrative it was apparent that her main coping style in relation to the schemas was 'surrendering'. Surrendering had the potential to have a particularly adverse effect in the context of the illness; for example, Kate felt she should work hard even though unwell (surrendering to the schema unrelenting standards). This resulted in a sense of frustration with herself and at times increasing the extent that Kate pushed herself; 'boom and bust' behaviour (Moss-Morris & Petrie, 2000) was thus evident. This behaviour is contrary to pacing, which involves the regulation and balancing of activity and rest, as advocated in the treatment of ME/CFS (Kinsella, 2007). Kate's belief that she was defective seemed to motivate her relentless behaviour and to put other people's needs before her own, resulting in self-sacrificing behaviour. She considered that if she put others first, these people would keep in contact with her.

Through challenging thoughts and using homework experiments, the accuracy of these cognitions was tested and they were found to be false. The cost-and-benefit analysis of her self-sacrificing behaviour was useful for rationalizing the appropriateness of this behaviour and its impact in the context of ME/CFS.

Various techniques were employed to challenge Kate's unrelenting standards; these included experimenting with leaving housework unfinished, and carrying 'flash cards', cards with positive statements written on them, such as, 'Nothing is urgent', stressing the positive effects of not pushing herself. Slowly she began to accept that it was okay to do less and that things do not have to be done perfectly. Hearing Kate say, 'I can lower my standards without feeling like a failure' confirmed this.

Over the weeks that followed, Kate developed a greater understanding of how her compliance with the schemas obscured her needs in relation to the illness

### *Outcome*

At session 20, the follow-up session, I was pleased to hear about Kate's progress, moreover to see her looking and sounding stronger. She was in paid employment, 15 hours a week, and planned to increase this to 18 hours, at which point her disability benefit would cease. She felt in control of her social life, choosing when to join in activities. She also described that she was able to leave tasks half unfinished and felt comfortable about this. I felt positive that Kate would continue to manage her life with ME/CFS. In a post-therapy interview she stated:

'I would say that my own needs were definitely obscured by unrelenting standards and self-sacrifice. My needs 'should', that famous word that mustn't be used, have been to focus on myself and do everything I needed to do to get well, which included putting myself first and taking the time to rest and recover. I always felt that I had to spend time with friends and family to suit their requirements when I was exhausted and feeling ill when the best thing for me to do would be to rest and take care of me. Unrelenting standards meant that I would always push myself to have everywhere clean and tidy, again when I was too ill to even be thinking about the state of the house. It was too difficult for me to ask for help as this would have been admitting that I couldn't cope, letting myself and other people down'.

### **Discussion**

In Britain assessment of ME/CFS is often made using the Fukuda et al., (1994) case definition. However, its terminology has been criticised for being vague (Jason et al., 2005), and it purportedly fails to exclude adequately people experiencing fatigue as a symptom of a psychiatric problem (Shepherd, 1998). Moreover, whilst counselling



psychologists are concerned with behaviour embedded within a context, and understand that diagnostic labels can be negative, reductionist and impersonal (Spinelli, 2003), Kate felt the diagnosis helped her make some sense of her perplexing experience.

The YSQ-S3 questionnaire was fundamental to this study. Whilst it is a validated measure, it is a self-report measure and therefore relies on the individual's capacity to report their feelings. Furthermore, the YSQ-S3 assumes that people can remember how they felt over the past year. It is worth noting that people with ME/CFS sometimes have memory problems and this might influence the way the questions are answered. However, this did not seem to be a problem in this case study. Similarly, the BDI is also a self-report measure, and requires the participant to have an awareness of their feelings and behaviour. Using such measures enables collecting limited information in a short space of time, but the counselling psychologist needs to be aware that the client's ability to introspect will affect the measures' usefulness.

People with depression have been found to endorse a range of EMS as therapeutically significant (Simmons et al., 2006). Furthermore, increased levels of secondary depression are found in people with ME/CFS, not only because of the disability experienced, but also due to the social stigmatization that shrouds the illness (Duff, 2003). It might not have been surprising then that Kate had a large number of EMS at the start of therapy. However, by the end of her CBT treatment for depression the following EMS were no longer at a level of therapeutic significance; social isolation, abandonment and emotional inhibition. Social isolation and abandonment are in what Young et al., (2003) described as belonging to the 'Disconnection and Rejection' domain. According to Young et al., (2003) this domain relates to the individual's expectation that their basic need for 'security, safety, stability, nurturance, empathy, sharing of feelings, acceptance, and respect will not be met in a predictable manner' (p.14). With this in mind, it could be argued that the strong therapeutic alliance that developed helped meet some of these emotional needs. Great importance was placed on the therapeutic relationship throughout, adopting an I-thou stance (Buber, 1958) rather than a predominantly I-it relationship; the latter position leads to the client being objectified, whereas an I-thou relationship validates and affirms both in the relationship.

It would seem that the empathic relationship, based on unconditional acceptance, helped to 'hold' Kate, metaphorically, so that she could explore and directly challenge the schemas once they were openly brought into the therapy session. Seemingly this helped her to understand, in both a cognitive and an experiential way that she did not have to continue surrendering to the schemas, and the associated behaviours, to be accepted. It is possible that the therapeutic work at the relationship level was connecting with the schemas at a non-verbal level.

The therapeutic relationship may be particularly important when working with EMS. Early maladaptive schemas are mainly rooted in insecure early attachments (Young et al., 2003); the neurochemical basis of such attachments has been highlighted for some time (Panksepp, 1998). More recently Cozolino (2006) identified that secure attachments develop the brain, strengthening 'network integration, autonomic arousal, and positive coping responses' (p.147). Indeed, developments in neuroplasticity suggest that the therapeutic relationship may be instrumental in increasing neural integration and hence well-being (Badenoch, 2008). This, together with Heim et al.'s (2009) research findings that people with CFS who had experienced childhood trauma, including emotional abuse and emotional neglect, also experienced neuroendocrine dysfunction, perhaps suggests the importance of developing a strong therapeutic relationship with this client group.

Kate recognized self-sacrificing and unrelenting standards as typical behaviours she engaged in before becoming ill. They were not a product of ME/CFS. However, it is possible that these schemas are perpetuated or amplified, to a certain degree, by the marginalization that this controversial and unpredictable illness elicits.

Despite adverse consequences for her health, it was evident that surrendering to the schema[s] and maintaining her unrelenting standards and self-sacrificing behaviour generated some positive feedback for Kate. Kate said it helped her feel respected. It could be argued in the negative context of ME/CFS that feeling respected is a pleasant and potentially infrequent experience. This is consistent with previous research (Stalmeisters, 2012) that engaging in pre-illness behaviours, which included surrendering to the schemas, appeared to help the participants maintain a sense of 'normality', a sense of 'continuity', facilitating self-acceptance and self-worth. However, literature concerning adjustment to the illness highlights the requirement for the acceptance of change (Whitehead, 2006).

By the end of therapy most scores on the YSQ-S3 reduced (Table 1). Scores for the schemas entitlement/superiority and insufficient self-control increased slightly. It might not be unexpected that entitlement increased, as an aim of the therapy was to develop Kate's self-worth and encourage her to recognize that it was acceptable to get her needs met. Furthermore, in therapy Kate had been encouraged to express her emotions more spontaneously, which might have affected her scoring for the schema insufficient self-control. Taking these factors into account, the increased scores for these schemas can be viewed as positive, potentially indicating an improved sense of self.

Kate had become physically more able and appeared happier. Her perception of herself, others and the world had changed positively (Table 2). In the follow-up session Kate stated that she felt 'normal'. It appeared Kate had been able to re-evaluate her situation and reprioritize her needs, consistent with research conducted into adaptation to the illness. Kate achieved this in a relatively short space of time in comparison with the participants in a nine-year longitudinal study who received only standard medical care (Anderson et al., 2007).

### **Insert Table 2 here**

However, at the follow up session I was concerned that Kate's scores for the unrelenting standards schema had increased slightly. She had returned to work. Given that Young et al. (2003) commented that it is not unusual for people who endorse the schema unrelenting standards to be 'workaholics' (Young et al., 2003, p.265), it is feasible that the work environment might stimulate this schema. The increase in this schema has implications for the management of the illness and for ME/CFS treatment strategies that involve 'pacing' - regulating activities (Kinsella, 2007). In view of this, it would be important to incorporate strategies into the relapse prevention plan to deter this.

Therapy had been a successful, constructive process for Kate. Young et al. stress that 'schema healing is often arduous and long' (2003, p.32), so it might seem somewhat surprising that Kate's schemas adapted so quickly. However, Kate was highly motivated to change her situation, partially evidenced by her seeking to take part in the research. Young et al., (2003) use the term '[to] wage war with the schema' (p.32), and certainly both Kate and myself engaged fully in the therapeutic process. Furthermore, to speculate, Kate's schemas might have been less extreme and rigid than the clients Young et al.,

(2003) based their work on, perhaps because her childhood was less toxic than those experienced by Young et al.'s clients. Additionally, Kate was open to a biopsychosocial model of ME/CFS, linking together biological, psychological and social factors. Her ability to embrace the biopsychosocial perspective possibly hastened her engagement with therapy and her improvement. Witnessing Kate's vulnerability and pain, yet also her growing strength and well-being was a moving experience. However, counselling psychologists need to remember that not all people with ME/CFS have EMS (Stalmeisters & Brannigan, 2011). Indeed, people with ME/CFS are not a homogeneous group. Research suggests that ME/CFS diagnosis inappropriately clusters together people who would be better helped divided into sub-groups (Jason et al., 2005).

## **Conclusion**

This study contributes to the few case studies that have been conducted into EMS, and to the paucity of research conducted into the relationship between EMS and ME/CFS. It seemed that the schema-focused interventions facilitated the 'visibility' of Kate's own needs, and her well-being. Developing an awareness of the schemas helped her to negotiate the schemas and moderate the behaviours associated with them; behaviours that seemed to exacerbate ME/CFS. However, further research comparing case studies would develop understanding in this area. Within the context of ME/CFS, giving up behaviours associated with EMS that the client may see as necessary requires the counselling psychologist to be empathically challenging and ever patient.

Table 1. EMS and BDI measures taken at initial session, at mid-point and at the end of therapy, as well as at follow-up

	Initial session	Mid-point	End of therapy	Follow-up session
Beck's Depression Inventory	42	13 (off medication)	4	3
Early Maladaptive Schemas				
Emotional Deprivation	23 **	21 **	17 **	11
Abandonment	18 **	14	11	6
Mistrust	14	11	7	7
Social Isolation	22 **	13	10	10
Defectiveness/unlovability	25 **	17**	11	10
Failure to Achieve	19	10	7	5
Practical Incompetence/Dependence	17	10	9	7
Vulnerability to harm	9	5	5	5
Enmeshment	8	5	5	5
Subjugation	19 **	19 **	19 **	16
Self-sacrifice	29 **	28 **	24 **	21**
Emotional Inhibition	12 **	9	7	5
Unrelenting Standards	30 **	23 **	17 **	22**
Entitlement/Superiority	6	9	9	10
Insufficient Self-Control/Self-Discipline	11	6	8	7
Admiration/Recognition Seeking	13	5	9	11
Pessimism/Worry	16	6	6	5
Self-Punitiveness	30 **	22**	20	14
Total of therapeutically meaningful EMS	9	6	4	2

(\*\* reached level of therapeutic significance)

Kate's views of self, others and the world

	Start of therapy	End of therapy	Follow up session
View of self	I am a failure. I am unhappy. I am unloved. I am tired and unable to do what I want	I'm alright now.	I am normal. Life is good.

	to do.		
View of others	Others are successful. Others are getting on with their lives and are happy. Some are friendly, and others are not as friendly as I thought.	Others are how they used to be. People have problems which they can't sort out.	People have problems, sometimes I can help them, sometimes they have to get on with it themselves. People are responsible for their problems.
View of the world	The world is detached from me. I am not part of the world. I am isolated and cut off. It is a scary, lonely place.	The world is not as hectic. I am part of the world, a smaller part of the world. My power has changed in the world, it's more personal	The world is my oyster. I can do whatever I want. The only person that is stopping me - is me.

## References

- Anderson, M., Premin, H. & Albrecht, F. (2004). Illness and disability in Danish chronic fatigue syndrome patients at diagnosis and 5 year follow ups. *Journal of Psychosomatic Research*, 56, 217-229.
- Badenoch, B. (2008). *Being a brain-wise therapist. A practical guide to interpersonal neurobiology*. London: W.W. Norton & Company.
- Beck, A., Steer. R., Brown, G. (1996). *Manual for the Beck Depression Inventory-II*. San Antonio: Psychological Corporation.

- Bhaskar, R. (2011). *Reclaiming reality. A critical introduction for philosophy*. Oxon: Routledge.
- Buber, M. (1958). I-thou. In W. Heard (1991), *The healing between. A clinical guide to dialogical psychotherapy*. San Francisco: Jossey-Bass Publishers.
- Carruthers, B., Jain, A., Peterson, D., Klimas, N., Lerner, A., Bested, A., Flor-Henry, P., Joshi, P., Powles, A., Sherkey, J. & van de Sande, M. (2003). Myalgic encephalomyelitis: clinical working case definition, diagnostic and treatment protocols. *Journal of Chronic Fatigue Syndrome* 11(1), 7-115.
- Cozolino, L. (2006). *The neuroscience of human relationships. Attachment and the developing brain*. London: W.W. Norton and Company.
- Duff, K. (2003). Social effects of chronic disorders. In L. Jason, P. Fennell & R. Taylor (Eds.) *Handbook of chronic fatigue syndrome*. New Jersey: John Wiley & Sons, Inc.
- Department of Health. *Publications policy and guidance. Annex 1: Epidemiology of CGS/ME*. Retrieved 18 January 2009 from <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance>.
- Dickson, A., Knussen, C. & Flowers, P. (2008). 'That was my old life: it's almost like a past – life now': Identity crisis, loss and adjustment amongst people with chronic fatigue syndrome. *Psychology and Health*, 23(4), 459-476.
- Edwards, C., Thompson, A. & Blair, A. (2007). An overwhelming illness: Women's experience of living with chronic fatigue syndrome/myalgic encephalomyelitis. *Journal of Health Psychology*, 12(2), 203-214.
- Etherington, K. (2001). Writing qualitative research a gathering of selves. *Counselling and Psychotherapy Research: Linking Research*. 1(2), 119-125.
- Fisher, L. & Chalder, T. (2002) Childhood experiences of illness and parenting in adults with chronic fatigue syndrome. *Journal of Psychosomatic Research*. 54, 439-443.
- Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry*. 12 (2), 219-245.
- Fukuda, K., Straus, S., Hickie, I., et al., (1994). The chronic fatigue physiotherapy syndrome: a comprehensive approach to its definition and study. *Annals of International Medicine*. 1221, 939-953.

- Gilbert, P. (1992). *Depression: the evolution of powerlessness*. Hove: Lawrence Erlbaum Associates Ltd.
- Heim, C., Nater, U., Maloney, E. et al., (2009). Childhood trauma and risk for chronic fatigue with neuroendocrine dysfunction. *Archives of General Psychiatry*. 66(1), 72-80.
- Israel, M. & Hay, I. (2006). *Research ethics for social scientist*. London: Sage.
- James, I. & Barton, S. (2004). Changing core beliefs with the continuum technique. *Behavioural and Cognitive Psychotherapy*. 32(4), 431-42.
- Jason, L., Corradi, K., Torres-Harding, S. et al., (2005). Chronic fatigue syndrome: the need for subtypes. *Neuropsychology Review*. 15(1), 29-58.
- Kinsella, P. (2007). *Cognitive behavioural therapy for chronic fatigue syndrome. A guide for clinicians*. London: Routledge.
- Le Bon, O., Cappeliez, B., Neu, D. et al., (2007). Personality profile of patients with chronic fatigue syndrome. *Journal of Chronic Fatigue Syndrome*. 14(1), 55-68.
- Lopez, C., Antoni, M., Weiss, D. et al., (2011). A pilot study of cognitive behavioural stress management effects on stress, quality of life and symptoms in a person with chronic fatigue syndrome. *Journal of Psychosomatic Research*. 70(4), 328-334.
- Luck, L., Jackson, D. & Usher, K. (2006). Case study: a bridge across the paradigms. *Nursing Inquiry*. 13, 103-109.
- Mason, O., Platts, H. & Tyson, M. (2005) Early maladaptive schemas and adult attachment in a UK clinical population. *Psychology and Psychotherapy: Theory, Research and Practice*. 78 (4), 549-565
- Mackrill, T. & Iwakabe, S. (2013). Making a case for case studies in psychotherapy training: A small step towards establishing an empirical basis for psychotherapy training. *Counselling Psychology Quarterly*. 26(3-4), 250-266.
- Moss-Morris, R. & Petrie, K. (2000). (Eds). *Chronic fatigue syndrome*. London: Routledge.
- NICE (2007) *Clinical Guidelines: 53*. Retrieved 12 September 2011 from: [www.nhsplus.nhs.uk/providers/image/files/guideline](http://www.nhsplus.nhs.uk/providers/image/files/guideline).
- Padesky, C. (1994). Schema change processes in cognitive therapy. *Clinical Psychology and Psychotherapy*, 1(5), 267-78.



- Padesky, C. & Greenberger, D. (1995). *Clinician's guide to mind over mood*. London: The Guilford Press.
- Panksepp, J. (1998). *Affective neuroscience. The foundations of human and animal emotions*. Oxford: Oxford University Press.
- Rafaëli, E., Bernstein, D. & Young, J. (2011). *Schema Therapy*. London: Routledge.
- Rogers, C. (1986). A client-centred/person-centred approach to therapy. In I. Kutash & A. Wolf (Eds), *Psychotherapist's casebook*. San Francisco: Jossey-Bass.
- Saariaho, T., Saariaho, A., Karila, I., & Joukamaa, M. (2010). Early maladaptive schemas in Finnish adult chronic male and female pain patients. *Scandinavian Journal of Pain*. 1, 196-202.
- Segerstom, S. & Miller, G. (2004). Psychological stress and human immune system: a meta-analytic study of 30 years inquiry. *Psychological Bulletin*. 130(4), 601-630.
- Simmons, J., Cooper, M., Drinkwater, J. & Stewart, A. (2006). Cognitive schemata in depressed adolescent girls. *Behavioural and Cognitive Psychotherapy*. 34(2), 219-232.
- Shepherd, C. (1998) *Living with M.E. the chronic/post-viral fatigue syndrome*. London: Vermilion.
- Shepherd, C. (2011) *Governments investment in psychological causes*. Retrieved 18 November from:<http://www.meassociation.org.uk/?tag=dr-charles-shepherd>
- Spinelli, E. (2003). The existential –phenomenological paradigm. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of counselling psychology*. (2nd edn.) London: Sage Publications.
- Stake, P. (2005). Qualitative case studies. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research*. London: Sage Publications.
- Stalmeisters, D. (2012). Towards a schema understanding of myalgic encephalomyelitis/chronic fatigue syndrome: A grounded theory approach. *Counselling Psychology Review*, 27(3), 29-39.
- Stalmeisters, D. & Brannigan, C. (2011). A preliminary exploration into the prevalence of early maladaptive schemas in a group of people with myalgic encephalomyelitis/chronic fatigue syndrome. *Counselling Psychology Review*, 26, 34-42.

- Surawy, C., Hackmann, A., Hawton, K. & Sharpe, M. (1995). Chronic fatigue syndrome: A cognitive approach. *Behavioural Research Therapy*. 33(5), 535-544.
- Taylor, R. & Kielhofner, G. (2005). Work-related impairment and employment focused rehabilitation options for individuals with chronic fatigue syndrome. A review. *Journal of Mental Health*. 14(3), 253-267.
- Van Houdenhove, B., Bruyninckx, K. & Luyten, P. (2006). In search of a new balance: can high 'action-proneness' in patients with chronic fatigue syndrome be changed by a multidisciplinary group treatment? *Journal of Psychosomatic Research*. 60, 623-625.
- White, C. (2001). *Cognitive therapy for medical problems. A guide to assessment and treatment in practice*. New York: Wiley and Sons Ltd.
- Whitehead, L. (2006). Quest, chaos, and restitution: living with chronic fatigue syndrome/myalgic encephalomyelitis. *Social Science and Medicine*, 62(9), 2236-2245.
- Young, J. (1999). *Cognitive therapy for personality disorders: a schema-focused approach*. (3rd edn.) Sarasota: Professional Resource Press.
- Young, J., Klosko, J. & Weishaar, M. (2003). *Schema therapy: a practitioner's guide*. London: The Guilford Press.
- Zhang, Q., Natelson, B., Ottenweller, J. et al., (2000). Chronic fatigue syndrome beginning suddenly occurs seasonally over the year. *Chronobiology International*, 17(1), 95-99.