

Managing Fatigue

Guiding patients to find hope and wellness

Reji Mathew

Posted on: April 23, 2010

[View Comments \(0\)](#)

[Print Article](#)

[Email Article](#)

[Share](#)



Vol. 26 • Issue 9 • Page 38

Fatigue is a symptom that cuts across a wide range of medical conditions. Types of fatigue vary—central fatigue, chronic fatigue, neuromuscular fatigue, and others—but all forms present challenges to the patient's quality of life. For many chronic rehabilitation patients who are prone to this symptom, fatigue can impact self-care capacity and the ability to engage meaningfully in functional goals.

Understanding fatigue holistically involves recognizing its functional and mental health aspects in treatment planning. Psychiatrist Dr. Fred Maynard advises practitioners to understand fatigue symptoms broadly. "I look at fatigue from several different aspects: neurological, musculoskeletal, mechanical capacity of the muscle, nutritional issues, co-morbidity, what else is going on, health habits and psychosocial factors," he stated, "There is no specific cause to fatigue as the triggers vary within diagnostic groups."

Rehabilitation interventions offer a range of options to work with fatigue symptoms. What are often under recognized and under treated, however, are the mental health risks—frustration, discouragement, anxiety or depression—that fatigue symptoms can generate. These concerns can narrow a patient's life and prevent him from engaging in steps toward restoring function. Not only can fatigue compromise a patient's functionality or self care but it can diminish the person's sense of self and self efficacy.

Maynard recalled a mobility-impaired patient who formerly had a high level of functioning, who presented to his office with increased anxiety and decreasing mobility. The patient was "spending most of his day in bed," he noted. During the assessment, Maynard learned that the patient had fallen on his front porch during the winter. No one was available to help; so after lying there for quite some time, he finally maneuvered himself back into his home on his own.

"This physical trauma led to an emotional downward spiral of anxiety, lack of energy, and decreased mobility and increased fatigue," Maynard explained. "Neither he nor his family pinpointed this fall as the turning point. After gathering a full assessment, we worked with him to regain his strength and restore his function."

Maynard advises OTs to assist patients with the psychosocial effects of fatigue—emotional reactions to changes in mobility, disease processes and physical traumas. A holistic model to help patients manage fatigue includes discerning where patients' fears lie, and activities they struggle with or avoid. These emotional concerns can be included when teaching the patient appropriate exercise activities; equipping patients with behavioral techniques for dealing with fatigue, or helping patients discover a functional approach to co-existing with fatigue. Elements of this model are described below, focusing on the needs of patients who are prone to fatigue due to neurological deficits.

Exercise

Medical interventions for fatigue can include medication (Provigil, among others), nutritional supplements, alternative treatments such as acupressure/acupuncture and massage, heat management, proper sleep, and diet and energy conservation.

In addition to these interventions, Maynard emphasizes the critical role of rehabilitative exercise in managing fatigue. Patients may think exercise is counter-intuitive, but establishing appropriate levels of movement, stretching or assistive exercise is critical to preserving and maintaining function.

It is important to start by counseling patients on the mind-body connection and engaging their motivation. Maynard uses cognitive techniques, he explained, "to both educate and engage the patient to participate in exercise; the aim is to find the appropriate level of exercise that does not aggravate fatigue, but enough to improve energy sources within the body" (see "Anxiety Management Training," May 26, 2008, and "The Mind-Body Connection," Sept. 29, 2008).

Where do you start? First, ascertain "what is the patient's one best effort?" Maynard explained. Go with 30 percent of that effort; if the patient feels pain, cut it to 15 percent.

Maynard also advises counseling patients on the benefits of interval training. Research shows that the benefits of interval training are maintained between intervals of exercise.

Stretching, deep breathing and relaxation techniques are also critical to managing fatigue. "Tightness and contractures can lead to localized pain and fatigue, which makes stretching also critical to managing fatigue, along with deep breathing and relaxation."

In cases where exercise can trigger fatigue or inflammation, such as in multiple sclerosis, Maynard advises adding exercises intermittently over time so patients do not get discouraged.

Behavioral Skills

Since fatigue directly impedes daily functioning, it is critical to equip patients with a wide range of behavioral techniques to restore and establish routines, work toward goals and gain balance despite fatigue. Have patients keep a fatigue log to help them pinpoint their triggers, sources and patterns of fatigue; you can use this information to develop goals together.

Maynard noted, "From a medical rehab perspective, I ask what does the fatigue prevent a person from doing? Try to understand the nature of the fatigue—each patient's report of fatigue is different. When does it occur, when does it improve?"

In my own counseling work, teaching patients behavioral skills involves two components: expanding their behavioral repertoire (toolkit/skills) and increasing their behavioral response capacity (ability to problem solve independently when presented with functional challenges).

Behavioral skills can be divided into main domains (see "Integrating Behavioral Skills," March 31, 2008), including:

- *Self-monitoring skills (how to tune in and assess needs through out the day):* self-monitoring fatigue, gauging sub-fatigue levels, and identifying the energy required to perform a task.
- *Task completion skills (how to go about completing a task based on energy level):* breaking down tasks into parts, rating a task by energy required, breaking tasks down, working in intervals, behavioral analysis (understanding the aspects of a goal and ways to break it down), and breaking up a day into behavioral units.
- *Planning skills (how to approach a goal or activity during the day with awareness of limits):* outsourcing difficult tasks, asking for help, using assistive devices, rating days of the week based on energy level, planning for exercise levels by season, problem solving/brainstorming, and scheduling "time outs."

A Functional Model of Living with Fatigue

Behavioral skills can be considered as micro skills focused on specific tasks. The second aspect of managing fatigue is learning functional skills, which could be considered as macro skills in this model. Patients who are chronically prone to fatigue need guidance in establishing a broader model of macro skills related to work, personal goals and social activities.

In counseling patients on this macro level of fatigue management, I guide them to experiment with a model of living based on the interplay among activity, pacing, rest and recovery. The interplay among these realms varies by individual, so establishing a plan requires trial and error.

First, work with the patient to list a set of desired activities. Next, explore behavioral strategies that provide pacing and rest options during each activity. Finally, plan recovery time. In this model, recovery is defined as giving the body time to refuel and restore itself after a pattern of active exertion. For example, some patients must plan an entire day for recovery; others may be able to recover in an afternoon.

Incorporating additional behavioral and stress-management strategies can enhance this functional approach. A number of these strategies have been discussed in previous articles (see "Stress Management," April 28, 2008, and "Relapse Prevention," Oct. 26, 2009).

For example, teaching the A-B-C (activity - behavior - consequence) technique can get patients curious about patterns of conditioning and factors that impede or promote function. Relapse-prevention skills can aid in recognizing warning signs that may lead to fatigue cycles.

Stress-management skills can help patients tap into resources that energize them when they are struggling, such as power naps, mental or emotional stimulation, sunlight or relaxation techniques.

Lastly, since fatigue is both subjective and individual, it is critical to counsel patients to not compare themselves to others. Instead, encourage them to compare their current function to where they were when they started treatment.

Fatigue is complex. A comprehensive perspective is essential to guiding patients in finding hope and wellness.

Dr. Reji Mathew, PhD, is a psychotherapist/clinical instructor at New York University. She is a disability advocate and freelance writer. The main focus of her work is to promote coping skills education for persons with chronic illness and disability. Her clinical expertise is in integrative psychotherapy, particularly cognitive behavioral skills training. Reach her at her Web site: rejimathewwriter.com.