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Original Research Article

A comparative study of cognitive behavioural therapy versus relaxation therapy for fatigue and quality of life among teaching professionals with chronic fatigue syndrome

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ABSTRACT

Background: Chronic fatigue syndrome (CFS) is a complex and disabling condition characterized by persistent fatigue, cognitive difficulties, impaired functioning, and reduced quality of life. Cognitive Behavioural Therapy (CBT) and Relaxation Therapy (RT) are non-pharmacological approaches that may support symptom management. This study compared the effectiveness of CBT and RT among teaching professionals with CFS.
Methods: A prospective, randomized, comparative interventional study was conducted among 100 teaching professionals diagnosed with CFS. Participants were equally allocated to CBT (n=50) and RT (n=50) groups. Fatigue, psychological distress, functioning, work and social adjustment, and quality of life were assessed using the Fatigue Severity Scale (FSS), Multidimensional Fatigue Inventory (MFI), Short Form-36 (SF-36), Depression Anxiety Stress Scale (DASS), Work and Social Adjustment Scale (WSAS), and WHOQOL. Structured group sessions were conducted for 8 weeks. Pre- and post-intervention outcomes were compared using appropriate statistical tests, with $p<0.05$ considered significant.
Results: Both groups showed significant improvements in fatigue, psychological distress, physical functioning, work and social adjustment, and quality of life ($p<0.001$). Post-intervention FSS scores were lower in the CBT group than the RT group (3.67±0.52 vs. 4.70±0.51). SF-36 physical functioning (68.84±7.01 vs. 60.78±7.16) and WHOQOL scores (69.76±5.46 vs. 60.56±5.96) were also higher with CBT ($p<0.001$).
Conclusion: Both CBT and RT improved psychological well-being, functioning, and quality of life. CBT may be a useful structured supportive intervention for symptom management in appropriately selected teaching professionals with CFS.

Keywords: Chronic fatigue syndrome, Cognitive behavioural therapy, Relaxation therapy, Fatigue, Quality of life

INTRODUCTION

CFS is a chronic, complex and disabling illness associated with substantial reductions in physical, occupational and social functioning. Characteristic symptoms may include severe fatigue, post-exertional malaise, unrefreshing sleep, cognitive difficulties and orthostatic intolerance. Diagnosis remains clinical and requires careful assessment because there is no single diagnostic biomarker.[1] Teaching professionals may be particularly affected because teaching requires sustained cognitive attention, interpersonal interaction, preparation, classroom responsibilities and, frequently, work outside scheduled teaching hours.

The management of CFS has increasingly emphasized individualized symptom management and multidisciplinary care. Current NICE guidance recommends that CBT may be discussed as a supportive intervention for people with CFS who wish to use it, while emphasizing that CBT is not a cure for ME/CFS.[1] The approach should be delivered by appropriately trained professionals and adapted according to individual symptoms, functioning and priorities.1

CBT is a structured psychological intervention that addresses relationships among thoughts, emotions, behaviours and physiological responses. In CFS, contemporary approaches focus on symptom management, coping, self-management, individualized goals and improvement of functioning rather than assuming that psychological factors are the underlying cause of the illness.1 Recent evidence supports the potential role of CBT in reducing fatigue and related psychological symptoms. A 2024 meta-analysis of 15 randomized controlled trials involving 2,015 adults found that CBT was more effective than control conditions for fatigue, perceived health, depression and anxiety, with relatively low treatment refusal and dropout rates.[4]

More recent evidence further emphasizes that the effect of CBT may depend on its components and delivery format. A 2026 systematic review and component network meta-analysis of 16 randomized trials found that guided self-help and individual CBT were associated with reduced fatigue immediately after treatment. Goal setting, third-wave components and cognitive restructuring were identified as potentially beneficial components.[2] A 2025 meta-analysis similarly highlighted the importance of considering the format and clinical characteristics of CBT when evaluating treatment effects.[3]

Relaxation therapy encompasses techniques intended to decrease physiological arousal and promote psychological relaxation. Common methods include progressive muscle relaxation, diaphragmatic breathing, guided imagery and mindfulness-based relaxation.[1] Earlier comparative work reported greater long-term improvement following CBT than relaxation therapy, although both approaches produced improvement in some participants.[5]

Therefore, present study compares the effects of structured CBT and relaxation therapy on fatigue and quality of life among teaching professionals with CFS.

Aims and objectives

This study aims to assess the level of fatigue among teaching professionals with chronic fatigue syndrome (CFS) before and after cognitive behavioural therapy (CBT) and relaxation therapy. It further aims to compare the effectiveness of the two therapies in reducing fatigue and in improving quality of life, psychological well-being, physical functioning, and work and social adjustment. Finally, it seeks to determine the relationship between fatigue and quality-of-life outcomes among the participants.

METHODS

This study used a prospective randomized comparative interventional to compare Cognitive behavioural Therapy with Relaxation Therapy. A quantitative research approach was adopted. The study was conducted among teaching professionals having chronic fatigue syndrome of Baba educational Institute and nearby educational institutions of Lucknow, Uttar Pradesh, India from May 2025 to November 2025. The study has been conducted after obtaining approval from the Institutional Ethics Committee and written informed consent of all participants. Following ethical approval and informed consent, eligible participants were recruited and baseline information was collected. Participants were allocated to the CBT or RT group. Baseline demographic, occupational, clinical and outcome variables were recorded. The respective intervention was then administered according to the structured programme. Post-intervention assessment was conducted using the same outcome measures. The total of 100 teaching professionals were included in study: Cognitive behavioural Therapy group (CBT): n=50 and Relaxation Therapy group (RT): n=50. Participants were randomly assigned to the CBT or RT group after fulfilling the inclusion and exclusion criteria.

Study variables

Independent variables

Cognitive behavioural therapy, relaxation therapy.

Dependent variables

Fatigue severity, multidimensional fatigue, psychological distress, physical functioning, work and social adjustment, quality of life.

Data collection instruments

Part I: Sociodemographic and clinical questionnaire

A semi-structured questionnaire was used to obtain information regarding age, sex, educational qualification, family income, residence, religion, marital status, type of family, family size, transport, hereditary disease, psychiatric illness, other illnesses, school attendance/work characteristics and related variables.

Part II: Fatigue severity scale

The fatigue severity scale (FSS), developed by Krupp et al., was used to assess the severity and functional impact of fatigue. The source manuscript states that the instrument was adopted and reproduced with formal permission.

Part III: Ferrans and powers quality of life index

The Ferrans and powers quality of life index- CFS version was used to assess quality of life. The source manuscript reports test-retest reliability coefficients of 0.68 for the fatigue severity measure and 0.72 for the quality-of-life measure. The broader outcome assessment in the reported results additionally included MFI, SF-36, DASS, WSAS and WHOQOL. The source study reported test-retest reliability coefficients of 0.68 for the Fatigue Severity Scale and 0.72 for the quality-of-life instrument.

Intervention

Cognitive behavioural therapy group

Participants assigned to the CBT group received a structured mindfulness-integrated CBT programme. The intervention was delivered through group sessions using presentations, discussion, homework assignments, revision and demonstrations. Eight sessions were conducted over 8 weeks, with each session lasting approximately 1 hour. Homework was reviewed at the beginning of sessions and individualized assignments were provided for practice between sessions. Information leaflets and worksheets supplemented the intervention. This approach is consistent with current guidance, which describes CBT for ME/CFS as a structured, collaborative and time-limited intervention intended to support symptom management, functioning and quality of life rather than cure the underlying illness.[1]

Relaxation therapy group

Participants in the RT group received a structured relaxation programme incorporating Jacobson progressive muscle relaxation, breathing exercises, rapid relaxation skills and guided imagery. The programme consisted of eight sessions over 8 weeks, with each session lasting approximately 1 hour. Sessions included revision, demonstration and return demonstration.

Statistical analysis

Data were analyzed using descriptive and inferential statistics. Mean and standard deviation were used for continuous variables, while frequency and percentage were used for categorical variables. Independent-samples t-test was used for comparison between the two groups, paired t-test for within-group pre-post comparisons, and chi-square test for categorical variables. Statistical significance was set at $p<0.05$.

RESULTS

A total of 100 teaching professionals diagnosed with CFS were evaluated and split evenly into the CBT group (n=50) and the RT group (n=50). The mean age of the CBT group was 40.88±9.11 years, compared to 42.72±7.99 years in the RT group. An independent t-test revealed no significant difference in age between the cohorts (t=-1.074, p=0.286). The sample consisted predominantly of females, making up 70% of the CBT arm and 74% of the RT arm, ensuring gender distribution was statistically equivalent (χ^2=0.050, p=0.824).

The baseline prevalence of psychological and physiological comorbidities also showed no significant discrepancies between the groups. Comorbid depression was observed in 44% of the CBT participants and 38% of the RT participants (χ^2=0.165, p=0.684). Both groups exhibited an identical 30% prevalence of comorbid anxiety (χ^2=0.000, p=1.000).

While sleep disorders were reported slightly more frequently in the CBT group (50%) than in the RT group (34%), this variance was not statistically significant (χ^2=2.011, p=0.156). The mean teaching experience was virtually identical between the groups, with the CBT cohort averaging 12.60±6.08 years and the RT cohort averaging 12.78±6.42. years (t=-0.144, p=0.886). Similarly, the weekly workload hours showed no statistically significant divergence; the CBT group worked an average of 37.74±4.73 hours per week compared to 36.82±6.93 hours in the RT group (t=0.776, p=0.440).

Table 1: Baseline demographic and clinical characteristics of study participants.

Variables	CBT group (N=50)		RT group (N=50)		Statical test	P value
	Mean	SD	Mean	SD	't'	'p'
Age (in years), Mean±SD	40.88	9.11	42.72	7.99	1.074	0.286
	No.	%	No.	%	χ^2	'p'
Gender						
Female	35	70.0	37	74.0	0.050	0.824
Male	15	30.0	13	26.0		
Comorbidities						
Depression	22	44.0	19	38.0	0.165	0.684
Anxiety	15	30.0	15	30.0	-	-
Sleep Disorder	25	50.0	17	34.0	2.011	0.156

Table 2: Baseline occupational characteristics of study participants.

Variables	CBT group (N=50)		RT group (N=50)		Student's t-test	P value
	Mean	SD	Mean	SD		
Teaching experience (in years)	12.60	6.08	12.78	6.42	-0.144	0.886
Weekly workload (hours)	37.74	4.73	36.82	6.93	0.776	0.440
	No.	**%**	**No.**	**%**	**χ^2**	**'p'**
School type						
College	23	46	18	36	1.053	0.591
Government	13	26	16	32		
Private	14	28	16	32		

Table 3: Baseline comparison of CFS clinical characteristics.

Variables	CBT group (N=50)		RT group (N=50)		Student's t-test	P value
	Mean	SD	Mean	SD		
CFS Duration (months),	14.90	5.46	15.10	5.27	-0.186	0.853
	No.	**%**	**No.**	**%**	**Chi-sq. test**	**'p'**
CFS Severity						
Mild	7	14.0	7	14.0	0.261	0.878
Moderate	32	64.0	34	68.0		
Severe	11	22.0	9	18.0		

Table 4: Inter-group comparison of pre-intervention (baseline) scores.

Outcome measures	CBT group (N=50)		RT group (N=50)		Student t-test	P value
	Mean	SD	Mean	SD		
FSS (fatigue severity)	6.12	0.40	6.14	0.39	-0.202	0.840
MFI (multidimensional fatigue)	76.56	7.12	77.16	6.38	-0.444	0.658
SF-36 (physical functioning)	45.84	6.35	45.78	6.79	0.046	0.964
DASS (depression/anxiety/stress)	30.46	5.05	32.20	5.26	-1.688	0.095
WSAS (work & social adj.)	27.00	5.21	27.98	4.48	-1.009	0.316
WHOQOL (quality of life)	46.60	4.92	46.52	5.72	0.075	0.940

Table 5: Inter-group comparison of post-intervention scores.

Outcome measures	CBT group (N=50)		RT group (N=50)		Student t-test	P value
	Mean	SD	Mean	SD		
FSS (fatigue severity)	3.67	0.52	4.70	0.51	-9.893	<0.001
MFI (multidimensional fatigue)	53.70	8.23	63.14	7.19	-6.108	<0.001
SF-36 (physical functioning)	68.84	7.01	60.78	7.16	5.687	<0.001
DASS (depression/anxiety/stress)	16.40	5.38	24.98	5.54	-7.858	<0.001
WSAS (work & social adj.)	15.66	6.23	21.60	4.66	-5.401	<0.001
WHOQOL (quality of life)	69.76	5.46	60.56	5.96	8.051	<0.001

Table 6: Intra-group comparison of pre- and post-intervention scores.

Outcome measures	Group	Pre-intervention Mean±SD	Post-intervention Mean±SD	Test statistic (t)	P value
FSS	CBT	6.12±0.40	3.67±0.52	55.863	<0.001
	RT	6.14±0.39	4.70±0.51	34.018	<0.001
MFI	CBT	76.56±7.12	53.70±8.23	62.475	<0.001
	RT	77.16±6.38	63.14±7.19	50.750	<0.001
SF-36	CBT	45.84±6.35	68.84±7.01	-52.071	<0.001
	RT	45.78±6.79	60.78±7.16	-45.185	<0.001
DASS	CBT	30.46±5.05	16.40±5.38	39.099	<0.001
	RT	32.20±5.26	24.98±5.54	34.616	<0.001
WSAS	CBT	27.00±5.21	15.66±6.23	37.402	<0.001
	RT	27.98±4.48	21.60±4.66	31.614	<0.001
WHOQOL	CBT	46.60±4.92	69.76±5.46	-58.598	<0.001
	RT	46.52±5.72	60.56±5.96	-38.494	<0.001

Furthermore, the distribution of participants across different teaching environments (College, Government, and Private institutions) was statistically balanced (χ^2=1.053, p=0.591). The highest proportion of participants in both groups were employed in colleges (46% in CBT and 36% in RT), followed by an even spread across government and private schools. The mean duration of CFS was nearly identical, with the CBT group having experienced symptoms for an average of 14.90±5.46 months and the RT group for 15.10±5.27 months. An independent samples t-test confirmed that this minor variance was not statistically significant (t=-0.186, p=0.853).

In both groups, the majority of participants experienced "Moderate" severity (64% in CBT, 68% in RT), followed by "Severe" (22% in CBT, 18% in RT) and "Mild" (14% in both groups). Statistically, the distribution of baseline CFS severity levels showed no significant disparity between the cohorts (χ^2=0.261, p=0.878). Table 5 demonstrates the baseline equivalence of the CBT and RT groups before the interventions began. For all six outcome measures—FSS, MFI, SF-36, DASS, WSAS, and WHOQOL—the independent samples t-tests yielded p values vastly exceeding the 0.05 significance threshold. This indicates that there were no statistically significant differences between the CBT and RT participants regarding their baseline levels of fatigue, physical functioning, psychological distress, social adjustment, or overall quality of life. The randomization was highly successful across all primary metrics. At the conclusion of the therapies, independent t-tests revealed highly significant differences (p<0.001) across all variables. The CBT group reported significantly lower severity of fatigue (FSS, MFI) and dramatically lower psychological distress and social impairment (DASS, WSAS) compared to the RT group. Conversely, on scales where higher scores indicate positive outcomes, the CBT group demonstrated significantly greater physical functionality (SF-36) and overall quality of life (WHOQOL) than the RT group. The results indicate that both therapies are highly effective independently. Whether tracking the decrease in negative symptoms (FSS, MFI, DASS, WSAS) or the enhancement of positive health indicators (SF-36, WHOQOL), every single metric in both the CBT and RT groups showed highly significant pre-to-post improvements (p<0.001).

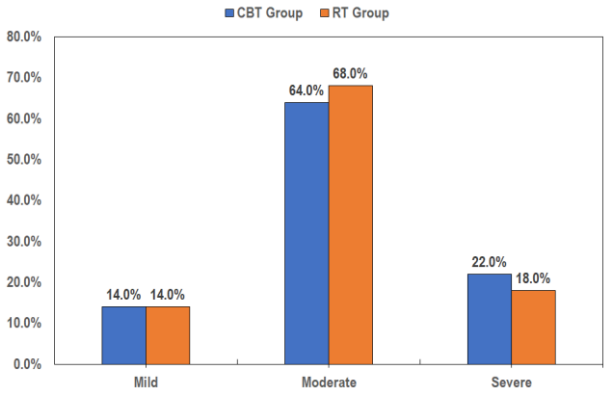


Figure 1: The distribution of the study participants according to severity of CFS.

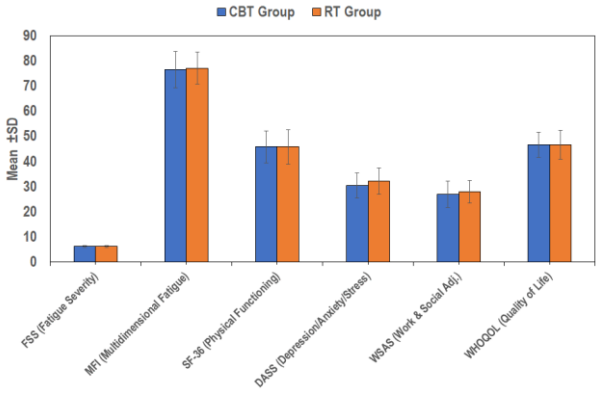


Figure 2: The mean fatigue and QoL levels pre-intervention.

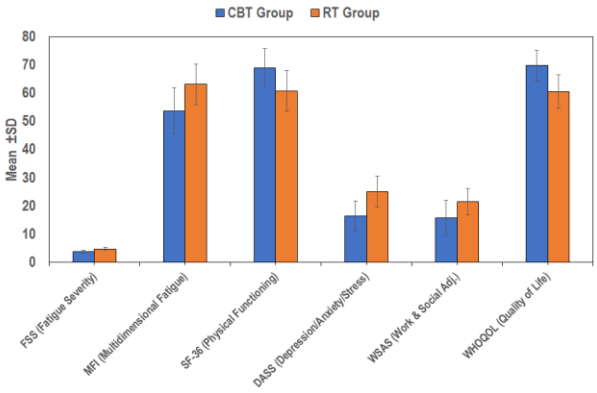


Figure 3: The mean fatigue and QoL levels post-intervention.

DISCUSSION

The present study compared CBT with RT among 100 teaching professionals diagnosed with CBT. Baseline characteristics between the two groups, suggesting that the intervention groups were broadly similar before treatment. There were no significant differences in age, sex, psychological comorbidities, teaching experience, workload, duration of illness or baseline CFS severity.

The principal finding was that both CBT and Relaxation Therapy were associated with significant improvement in fatigue and quality of life. However, the magnitude of improvement was greater in the CBT group. The between-group differences were statistically significant. These findings are broadly consistent with the published comparative study by Mozhi et al which reported greater improvement following CBT than relaxation therapy among teaching professionals with CFS.[6] The long-term study by Deale et al also reported greater improvement following CBT than relaxation therapy at five-year follow-up.[5]

The findings are also consistent with recent systematic evidence. A 2024 meta-analysis including 15 randomized controlled trials and 2,015 adults reported that CBT was more effective than control conditions for fatigue, perceived health, depression and anxiety.[4] A 2026 component network meta-analysis found that goal setting, third-wave components and cognitive restructuring may contribute to improvement in fatigue and physical functioning.[2] These findings provide a contemporary evidence base for the present observation that a structured CBT programme may have broader effects than relaxation techniques alone. Psychological distress also improved significantly in both groups. In the present study, the post-intervention DASS score was substantially lower in the CBT group than in the RT group. CBT may influence psychological distress through structured coping strategies, identification of unhelpful thoughts and behavioural adaptation. Importantly, current NICE guidance emphasizes that CBT in CFS should not be presented as a cure or as evidence that the illness is caused by abnormal beliefs rather, it may support symptom management, functioning and reduction of distress.[1] Physical functioning was also significantly better after CBT. The SF-36 physical functioning score was 68.84±7.01 in the CBT group compared with 60.78±7.16 in the RT group. Improvement in functioning is particularly relevant for teaching professionals because fatigue can affect preparation, classroom performance and participation in occupational and social activities. Work and social adjustment also improved, with a lower post-intervention WSAS score in the CBT group. The original study similarly reported greater improvement in work-social functioning after CBT. Burgess et al previously demonstrated the feasibility of CBT delivery in different formats, including face-to-face and telephone approaches.[7] Quality of life was one of the important outcomes of the present investigation. WHOQOL scores were 69.76±5.46 in the CBT group and 60.56±5.96 in the RT group following intervention. Improvement in quality of life is clinically important because CFS affects multiple domains of daily functioning rather than fatigue alone.

RT nevertheless demonstrated meaningful benefit. Relaxation techniques such as progressive muscle relaxation, breathing exercises and guided imagery may reduce physiological arousal and support sleep and coping. Current NICE guidance also recognizes relaxation techniques as potentially helpful during rest periods for people with CFS.[1] However, the results should not be interpreted as indicating that CBT cures CFS. Current clinical guidance specifically cautions against describing CBT as curative.[1] Recent literature emphasizes the need to distinguish symptom-management interventions from treatments directed at the underlying biological mechanisms of the disease.[8]

Therefore, nursing and healthcare professionals should use CBT and relaxation interventions as components of individualized multidisciplinary care rather than as substitutes for medical evaluation, energy management and appropriate symptom management.

Limitations

The study was conducted among a relatively limited occupational population, which may restrict generalizability. The follow-up period reported in the manuscript does not establish the long-term sustainability of treatment effects. Most outcome measures were self-reported and may therefore be influenced by response bias. Objective measures of sleep, physical activity or physiological functioning were not reported. The manuscript provided insufficient information regarding the precise randomization sequence and allocation concealment.

CONCLUSION

Both cognitive behavioural therapy and relaxation therapy produced significant improvements in fatigue,

psychological distress, physical functioning, work-social adjustment and quality of life among the teaching professionals. However, CBT demonstrated significantly greater improvement across the reported outcome measures. RT also demonstrated beneficial effects and may be considered a useful intervention for relaxation, stress reduction and supportive symptom management.

Clinical and nursing implications

Nurses can play an important role in identifying fatigue, functional impairment and reduced quality of life among individuals with CFS. Nurses can provide education regarding appropriate rest, sleep hygiene, individualized activity management and relaxation techniques. Nurses working within multidisciplinary teams can support referral to appropriately trained psychological professionals when CBT is indicated and desired by the patient. Relaxation techniques such as diaphragmatic breathing, progressive muscle relaxation and guided imagery can be incorporated into supportive nursing care where appropriate.

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