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Case study: Cognitive behavioural therapy for the treatment of neurastenic disorders

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Abstract

Neurasthenia is a neurosis disorder that is included in the diagnostic category of other neurotic disorders in PPDGJ III. Patients with neurasthenia disorders have dysfunctional assumptions that are the result of the interaction of behavior, emotions, symptoms and thoughts. This study aims to determine the effect of cognitive-behavioral therapy on patients with neurasthenic disorders. This study uses a qualitative method with a case study approach to one research subject. The research subject is a 43-year-old man who works as a computer teacher and head of a computer lab in a junior high school. The subject for the last 2 months experienced symptoms of chronic fatigue when carrying out work activities, the mind became chaotic and the body weak, and was worried that something would happen to him when these symptoms appeared while on the road. These symptoms make the subject often do not come to work or leave early from work. The results showed that cognitive-behavioral therapy helped subjects understand their dysfunctional systematic thinking, find the root of negative thoughts that made them experience chronic fatigue, find positive thoughts to replace negative thoughts, start showing efforts to carry out light work activities and reduce excessive rest patterns.

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INTRODUCTION

Dirgagunasa (in Kuntjojo, 2009) revealed that neurosis disorder is a disorder that occurs only in part of the personality, so that people who experience it can still do ordinary daily tasks and rarely require special treatment in the hospital. Neurotic patients feel depressed and show symptoms that interfere with daily activities, although they are not so severe compared to other mental disorders (Semium, 2006). Meanwhile mental health is defined as a good state in which every individual realizes his potential alone, can cope with the pressures of life normal, able to work productively and useful and can provide contribution to himself or his community (Fauziah & Kesumawati, 2021).

Prevalent in America, Britain, Europe, and Asia, neurasthenia lacked a clear anatomical or physiological basis, and presented no reliable objective findings, and so it was considered ‘a purely functional disturbance, knowable only by its multiple symptoms’ including weakness and fatigue, headaches, insomnia, pain, nervous dyspepsia, palpitations, neuralgia (Nicholls, 2021). Auxiliary symptoms included a persistently downcast mood, frequent headaches, indigestion, insomnia, and assorted aches. Symptoms could be widespread or focused within a particular bodily system and

some physicians viewed the symptoms as associated with dysfunction of a particular organ (Overholser & Beale, 2019). Paciaroni & Bogousslavsky (2014) added that attached to there were a set of 'psychic' symptoms which were perceived as further manifestations of this nervous weakness, such as inability to concentrate, particularly on mental labor, headache, insomnia, depression, excitability, irritability, and introspective and excessive emotion.

PPDGJ (1993) explained that neurasthenia is one type of neurotic disorder which is included in other neurotic disorders. Neurasthenia is classified into 2 main types which are the basis for determining the disorder. In the first type, the main complaint is fatigue after mental activity which is often accompanied by decreased efficiency of daily tasks. Mental fatigue is typically described as the presence of intrusive thoughts or unpleasant memories, difficulty concentrating and inefficient thinking. In the second type, the main complaints are emphasized on physical or physical weakness and fatigue due to light activities, accompanied by feelings of aches and pains in the muscles and unable to relax. In both types, various unpleasant physical complaints are often found, such as headaches, tension headaches, and feelings of unsteadiness. Concerns are also often raised about declining physical and mental health, irritability or sensitivity, lack of enthusiasm, and various complaints of depression and mild anxiety. Sleep is usually disturbed in the early and middle phases of sleep, but hyperinsomnia can also occur. The hallmark of this syndrome is the patient's emphasis on fatigue, weakness and concern about decreased mental and physical efficiency (in contrast to somatoform, physical complaints and preoccupation with physical illness predominate in the clinical picture). If the neurasthenia syndrome occurs after experiencing a physical illness (especially influenza, viral hepatitis, infectious mononucleosis), the diagnosis of these conditions should also be included.

Neurasthenia was first identified in 1869 by George Beard who was a neurologist in the United States. The nosological criteria for neurasthenia have been arduously debated within the psychiatric epidemiological literature (Molina et al., 2012). Beard attributed the rise of neurasthenia both to a hereditary predisposition as well as the wrenching social upheavals of modernization in the United States at the end of the nineteenth century, as large swaths of the post-Civil War population migrated from slow-paced rural communities to chaotic and bustling cities in the Northeast (Aho, 2018). Beard describ ed that neurasthenia is a series of symptoms consisting of fatigue, anxiety, headaches, impotence, neuralgia and depression. Beard further explained that a series of symptoms as a result of depletion of energy reserves from the central nervous system due to the pressures of an increasingly competitive work life. In the late 19th and early 20th centuries, the diagnosis of neurasthenia-related disorders began to be accepted throughout the world, especially in eastern countries. However, in the 1930s, the use of the diagnosis of neurasthenia in the West began to decline and gradually disappear. Although the use of the diagnosis of neurasthenia is decreasing, the ICD 10 (World Health Organization, 1992), still includes neurasthenia disorders as a diagnostic criterion, complemented by inclusion criteria such as mental

and/or physical fatigue, dizziness, dyspepsia, muscle aches, headaches, irritability, disturbances sleep and inability to relax. DSM-IV (American Psychiatric Association, 1994) also includes neurasthenia disorders in attachments which are defined as locally culturally bound syndromes, for example in Taiwan and China calling neurasthenic disorders as Shenjing Shuairuo (Flaskerud, 2007). Neurasthenia in Japan is known as Shinkeisui-Jaku, which is defined as a nervous disposition. Handling this disorder is recommended by taking rest, consuming adequate nutrition, improving hygiene, improving work patterns and lifestyles, medicines prescribed by doctors and finding a comfortable environment for healing. Treatment of neurasthenia disorders has a long recovery period to be able to restore the individual's social function (Schwartz, 2002). Today, neurasthenia is no longer common as a medical category, but the complaints and symptoms associated with it still survive in other names and categories in psychiatric diagnostics (Slijkhuis & Oosterhuis, 2013).

Research that has been carried out regarding interventions to treat neurasthenia disorders is by examining the effects of the Comprehensive Cognitive–Behavioural Treatment (CCBT) program; compared with courses of mirtazapine and placebo; and a combined CCBT program followed by the administration of mirtazapine and placebo in patients with chronic fatigue. The results showed that the group that received the CCBT program for 12 weeks experienced significant changes as assessed by the Fatigue Scale (P=0.014) and the Global Clinical Impression Scale (P=0.001). Meanwhile, the group that was initially given the CCBT program for 24 weeks and then continued with the mirtazapine drug administration program for 12 weeks showed a significant improvement compared to the other treatment groups on the Fatigue Scale (P50.001) and the Global Clinical Impression Scale (P=0.002). On the other hand, the outcome measures of the three treatments both showed improvement without significant differences between the treatment groups. This study also shows that effective treatment of chronic fatigue syndrome and neurasthenia should be based on a broad and comprehensive approach, namely using and combining treatments. The interventions provided in this study have been shown to be effective, with an emphasis on the timing and sequence of the various interventions, as well as active participation and practice by the study participants (Stubhaug, Lie, Ursin, & Eriksen, 2008).

Suzuki (1989) explains that the use of the term neurasthenia, which had been used in Japan before the Second World War, was later replaced by the term neurosis. This change in terminology, made a shift in popular ideas about minor psychiatric disorders towards a more psychological view. The use of psychological therapy in Japan is unlike in the West where psychoanalysis is a major contributing factor. Suzuki uses Shoma Morita as a psychological intervention that contributes to changes in individuals with neurasthenic disorders. The diagnosis of neurasthenia was then developed using the term shinkeishitsu in Japanese. In theory, the development of shinkeishitsu symptoms is explained in terms of certain psychic dispositions and as a 'vicious circle' of sensation and attention. Suzuki then devised a psychological treatment called Morita therapy, which was very

effective for the condition. Morita's therapy has roots drawn from the Buddhist tradition, where his values and ideas have been redefined and reformulated into a form of therapy that is acceptable to Japanese people.

The cognitive model shows that individuals with neurasthenia disorders have dysfunctional assumptions which are the result of the interaction of behavior, emotions, symptoms and thoughts. Cognitive (conscious thoughts), attribution (beliefs about disease) and behavioral factors play important roles in determining outcomes and mediating dysfunctional assumptions that patients with neurasthenic disorders have. The terms cognitive therapy (CT) and cognitive techniques refer to behaviors therapists engage in that are targeted towards changing the content or process of thoughts, inferences, interpretations, cognitive biases, and cognitive schemas (Lorenzo-Luaces et al., 2016). By cognitive change, we refer to changes in the content of thoughts, inferences, interpretations, and cognitive biases. By behavioral change, we refer to changes in behavior, such as increasing the frequency of selected behaviors (e.g., approaching feared stimuli, engaging with pleasurable activities) or decreasing the frequency of other behaviors (e.g., safety behaviors) (Lorenzo-Luaces et al., 2016). The cognitive theory of neurasthenic disorders explains that certain factors and events are thought to trigger, and perpetuate, the disorder. Cognitive theory explains how certain life stressors can trigger neurasthenic disorders. In addition, cognitive, behavioral, physiological and social factors interact so as to perpetuate disease (Cox, 2002).

Individuals with neurasthenia disorders tend to find it difficult to maintain a positive outlook in the face of prolonged disturbances, restrictions on daily life, and the assumption that there is no medication that can cure the disorder. Feelings such as frustration, anger, irritability, anxiety, demoralization, and profound mood swings, can interfere with recovery. Therefore, cognitive behavioral models are based on the understanding that thoughts, feelings, and actions are interrelated; what one does affects thoughts and feelings; and ways of thinking can influence actions and feelings. Cognitive factors in the form of beliefs about health and disease, while behavioral factors in the form of avoidance as a coping strategy is an important determining factor. In addition, due to the heterogeneous nature of neurasthenic disorders, there is a high probability of a complex interaction of physiological, cognitive, behavioral and affective factors responsible for the development and persistence of the disorder. Cognitive behavioral models take these factors into account and lead to effective treatment. A cognitive-behavioral conceptualization begins with relevant childhood data, which leads to core beliefs, conditional rules/assumptions, which leads to coping strategies (F. M. Dattilio & Hanna, 2012).

This study aimed to determine the effect of providing Cognitive Behavior Therapy (CBT) interventions on individuals with neurasthenia disorders by focusing on the individual's main difficulties, related to the symptoms they experience. Cognitive-behavioral therapy (CBT) refers to a treatment approach that is founded on the premises that (a) cognitive processes are implicated in the development and maintenance of psychopathology, especially emotional distress and impaired

functioning, while also (b) those cognitive processes are likely to be present during the session, and require the therapist to adapt the intervention in order to best assist the patient (Kazantzis et al., 2018). Cognitive behavioral therapy (CBT) helps individuals to develop by improving skills in coping mechanisms, reducing anxiety and increasing self-esteem (Caturini & Siti, 2014). Roth and Heimberg (in Duana & Hadjam, 2012) stated that this CBT approach integrate cognitive, behavioral, and changes in social aspects through the process learn and process information. Susana et al. (2015) mentioned that CBT focuses on information processing and behavior which is depressive. Intervening Aspect is cognition, thought/emotion (including physiological reactions), and behavior. In the realm of cognition, the subject learns to apply techniques to restructure cognition so that his way of thinking becomes more logical and adaptive. At the time of doing identification and restructuring of the mind dysfunctional, the individual must be able to check the automatic thoughts that appear as a psychological symptom not as fact or reality. Beck calls this ability as decentering.

CBT is a therapy based on combining of interventions which is designed to change the way the client thinks about the problem being experienced and understanding the situation, and how to determine behavior so that elicit adaptive reactions in terms of client' cognitive and behavior (Erlando, 2019). The interventions provided aimed to facilitate individuals in gradually increasing tolerance to activities; symptom reduction; and an increase in previously avoided behaviors and activities, so as to help individuals bring about the desired changes in their lives. This research was expected to be an input and source of information for psychological disciplines, especially in the field of clinical psychology, especially in providing treatment for cases of neurasthenic disorders which are relatively rare. CBT techniques that have been known to provide effective results in individuals with neurasthenia disorders, can be an alternative that can be used to treat other cases of neurasthenia disorders. Moreover, despite the evidence suggesting that all treatments intended to be therapeutic are equally efficacious, there is a conjecture that one form of treatment, namely CBT, is superior to other treatments (Baardseth et al., 2013).

METHOD

This research used a case study approach in this study. The research data was obtained by giving psychological tests, interviews and observations. Psychological test tools given are Beck Anxiety Inventory (BAI) and graphic tests consisting of BAUM, DAP, HTP and WARTEGG. Provision of psychological test tools, interviews and observations are carried out with the aim of finding tendencies in the subject so that they can know the diagnostic character for the disorder experienced. The subject in this study was a man with the initials M and 43 years old who for the last 2 months felt tired easily, his body and legs were weak when doing an activity at work, and felt pain in the head when facing work that required thinking hard.

The method of analysis was carried out by conducting a qualitative analysis of the research data obtained. The results of psychological tests, interviews and observations were integrated and then interpreted so that a description of the personality and problems faced by the research subjects can be obtained.

RESULTS AND DISCUSSION

Research Participants

The subject in this study was a man with the initials M, 43 years old and works as a computer teacher and head of a computer lab in one of the Junior High Schools (SMP) in Yogyakarta. Data were collected and analyzed with the 5 P case formulation, namely: 1) Presenting problem, which is to explain the problems experienced or complained about by current research subjects, 2) Predisposing factors, namely explaining the causal factors that influence the emergence of symptoms in research subjects, (3) Precipitating factors, namely explaining the triggering factors that cause neurasthenia symptoms to appear, (4) Perpetuating factors, namely explaining risk factors that perpetuate neurasthenia, and (5) Protective factors, namely explaining healing factors that cause neurasthenia symptoms to decrease or disappear. Here is the explanation:

1. Clinical Overview of Research Subjects

The World Psychiatric Association Group (2002) explains that neurasthenia disorders have symptoms and complaints that are grouped into 5 clinical picture domains. Based on the assessment data conducted on March 6-10, 2019, it was shown that the research subjects experienced symptoms that met the 5 domains, as follows:

Cognitive domain, research subjects experience mental fatigue with their daily activities, excessive worry about the situation at hand, inability to concentrate on the activities they are doing, often easily forget something even though they have just done it, feel their thoughts are full and easily confused, avoid work their duties are often absent from work or leave work early, and have a poor assessment of their own condition.

The emotional domain, research subjects are easily offended by other people's words to themselves, feel uncomfortable when in stressful and demanding situations, experience emotional tension even when faced with small problems, lose interest in activities that were previously liked, feel uncomfortable with their surroundings, and It's easy to get annoyed by little things.

Somatic domain, research subjects experience headaches in the front and back of the head, feel aches and pains in certain areas of the body suddenly and then disappear with intensity for a long time, feel disturbed when encountering noisy and crowded situations, feel legs and feet the body is easily weak even though the condition has eaten, and the heart becomes easy and often pounding.

In the energy domain, research subjects experience symptoms of sudden and excessive fatigue even though they only do small activities, feel physically weak and weak, and do not have the energy to carry out an activity, both light and heavy.

Sleep domain, research subjects showed a desire to continue to rest and sleep excessively, on the other hand the subject also felt that his sleep was disturbed and did not feel fresh even though he had slept long enough and rested.

2. Factors that cause neurasthenia disorders

Based on the data from an assessment conducted on March 6-10, 2019, it was known the factors that caused the research subjects to experience symptoms of neurasthenia. These factors are divided into 2, namely external and internal factors. Here's the explanation:

a. External factors

The World Psychiatric Association Group (2002) states that one of the factors that can cause neurasthenia disorders is related to work pressure. In subject M it was found that his boss gave so much work related to computers, had to manage 100 computers in the laboratory himself for online exam preparation, and friends who asked for help to help them in typing an assignment or inputting data into the application made the subject not can resist and unable to cope.

b. Internal factors

Daradjat (1990) states that the factors causing neurasthenia disorders are influenced by the subject's personality, such as suppressing feelings for too long, inner conflict and anxiety, pent-up desires, and often feeling like a failure when facing competition. In subject M found the following personality tendencies:

Subject M tends to think coherently, concretely and theoretically in doing work. The subject always makes a systematic guide to complete the work as the head of the computer lab. Subject M always makes a plan before acting and then evaluates afterward.

Subject M tends to have difficulty refusing requests from others to help with a job related to their expertise. For example, when the subject is asked by a friend to help input data in a computer application, while the subject feels tired, the subject will help his friend with a heavy heart without showing rejection. In addition, the subject is classified as a person who has high self-actualization. For example, when faced with work related to computer operating systems, the subject will always show his best ability to complete the job. The subject will try his job to show the best results according to the target he has determined.

Subject M tends to show a defensive attitude when encountering problems. The subject's defensive attitude makes him look for reasons to justify his thoughts and behavior. When faced with stressful situations, the subject becomes easily anxious and feels insecure. The work situation at school is currently considered a subject like a burden so that it makes him feel restless, feel uncomfortable and immediately go home. The subject felt that he was able to have skills that he could be proud of such as being able to operate a computer. The skills learned by the subject make

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him feel confident enough to work. This makes the subject less likely to be criticized by others who do not have expertise in their field. The subject feels that he has tried to learn the ins and outs of computers so that he tends to get angry when someone criticizes his work but that person is not an expert in that field. This shows the tendency of anankastic personality traits in the subject of M.

3. Factors that Trigger Neurasthenia Disorders

Beck (in Surawy et al., 1995a) explains that a person's perception of their inability to do something can be considered a "critical incident" that activates their assumptions about achievement, strengths, and personal worth. The dysfunctional assumption is activated when the subject is in a critical incident situation and raises negative automatic thoughts, namely "The work I do must be done well and perfectly" and "I am the only person who can do the work, therefore I must do it perfectly". The following is a description of the psychological dynamics experienced by the subject:

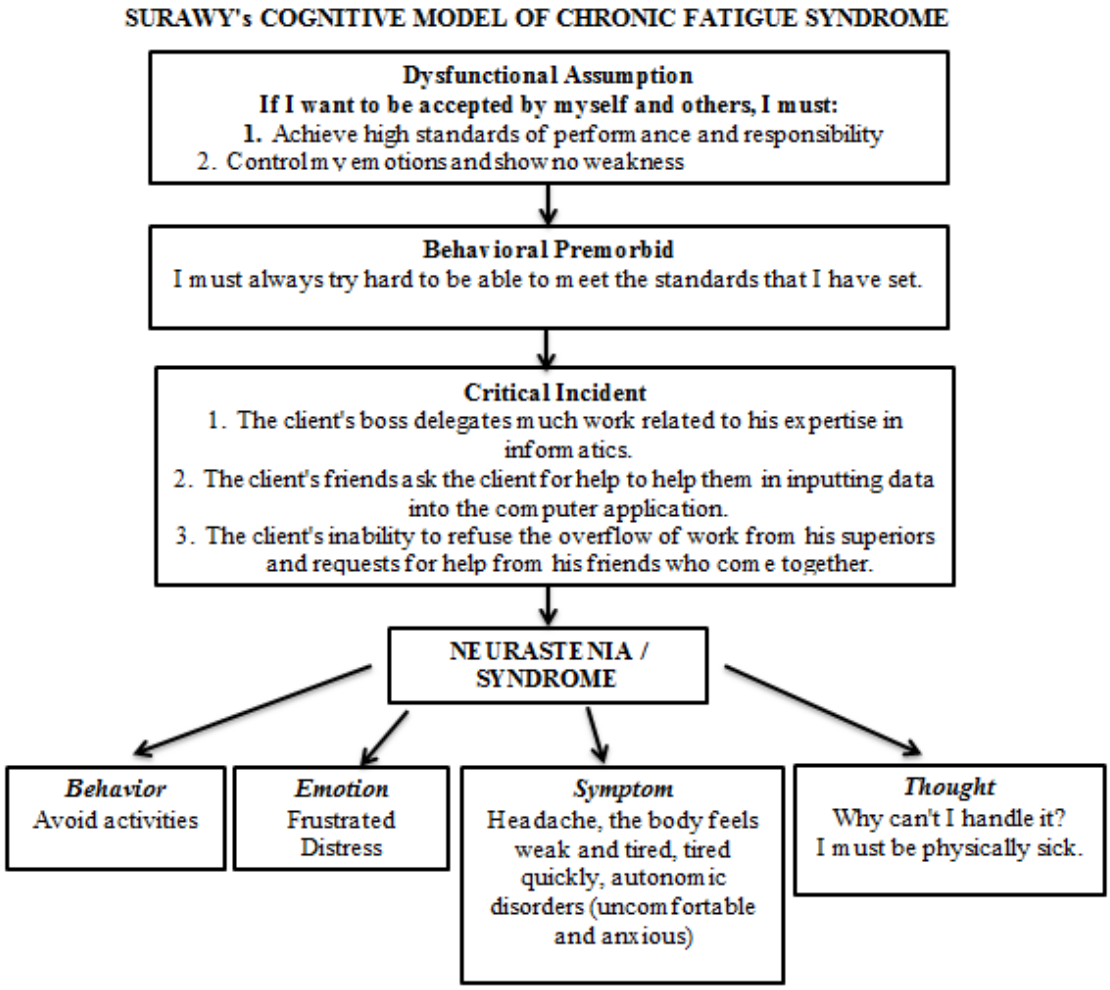

Figure 1. Cognitive Model Chart of the Etiology of Neurasthenia Disorders

Surawy et al. (1995) explains that the typical initial reaction shown by the subject to such a situation is to try harder to meet the target, despite increased fatigue. When the subject applies a strategy to suppress his feelings, but ultimately fails, then the subject enters a condition or gets consequences in the form of chronic fatigue, frustration, and distress. The difficulties faced by the subject require both personal and social explanations. However, when considering possible explanations for the subject's condition, he could not accept what was considered to be the only alternative explanation for his disorder, namely a failure to cope, or a psychological condition such as depression. Alternative possible explanations given to the subject are considered to imply that he is weak or wrong. The explanation that the subject felt was biased, directed him to focus more on the somatic aspects than the emotional aspects related to the disorder experienced, and prefer physical explanations to psychological explanations.

4. Risk Factors Perpetuating Neuroasthenic Disorder

After the subject feels that he is easily tired even though he only does light activities, there are several factors such as cognitive, behavioral, emotional, physiological and social factors that will ultimately "perpetuate" the disorder. Subjects showed symptoms of fatigue, poor concentration and muscle aches (which are usually exacerbated by activity) as a result of the physiological changes that accompany chronic emotional stress. The subject then decided to avoid the activity in the hope of reducing symptoms, but only in the short term. However, in the long-term avoidance actually perpetuates intolerance of physical and mental activity.

The subject himself had the opposite motivation, namely an attempt to avoid the trigger of his condition and the desire to fulfill his responsibilities as a head of the lab. However, the attempts the subject made to do these two things actually failed repeatedly, and the emergence of fear and worry would worsen the disease thereby strengthening the subject's belief that he was suffering from an incurable disease, and causing further emotional distress. A vicious cycle (Surawy et al., 1995) alternating between frustration and ineffective attempts to rest, maintained by the attribution of disease symptoms, traps the subject in chronic illness. The sudden appearance of symptoms in activity precludes achieving healing in the capacity for activity. The focus on the disease distracts the patient from coping with psychological and social difficulties. This cycle is illustrated in the following chart:

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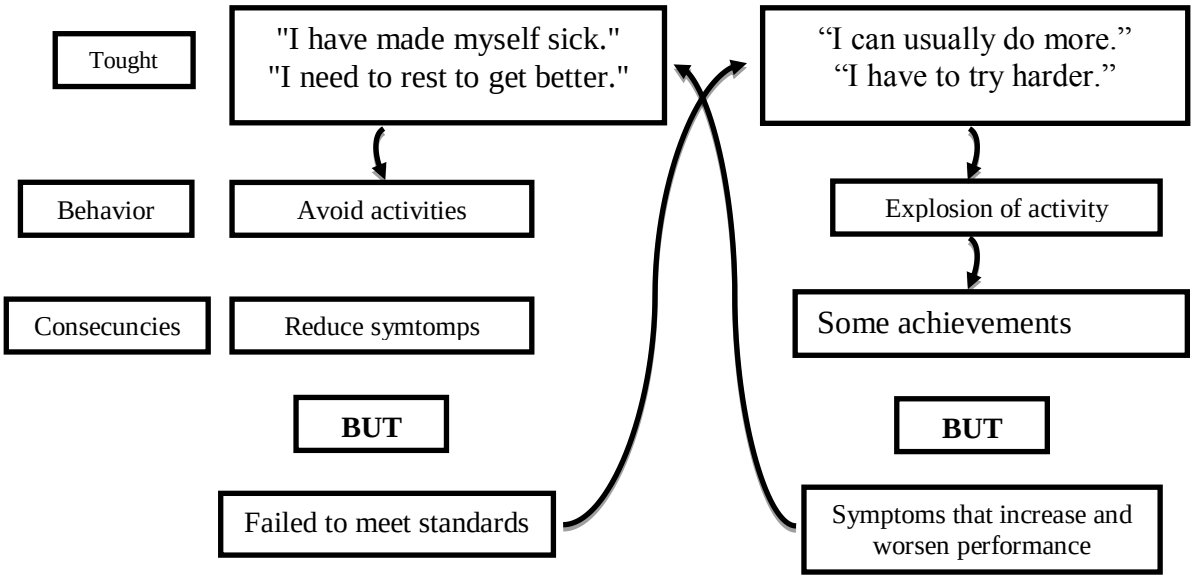

Figure 2. Chart of Patterns of Persistence of Neurasthenia Disorders

5. Factors that can support the healing of neurasthenia disorders

The cognitive model shows that people with neurasthenia disorders have dysfunctional assumptions which are the result of the interaction of behavior, emotions, symptoms and thoughts. The main goal of therapy is to help patients make the desired changes in their lives. Cognitive (conscious thoughts), attribution (beliefs about disease) and behavioral factors play important roles in determining outcomes and mediating dysfunctional assumptions that patients with neurasthenic disorders have.

Surawy et al. (1995) explains that cognitive theories regarding neurasthenic disorders have developed, in which certain factors and events are thought to trigger, and perpetuate the disorder. Cognitive theory explains how certain life stressors can trigger neurasthenic disorders in predisposed people, and how cognitive, behavioral, physiological and social factors then interact to perpetuate the disease. Subject M tends to find it difficult to maintain a positive outlook in the face of prolonged self-weakness, limit daily life, and assume that there is no medicine that can cure the disorder. Subject M tends to become frustrated, angry, irritable, anxious, self-deprecating, and profound mood swings, which can interfere with recovery. Therefore, cognitive behavioral models are based on the understanding that thoughts, feelings, and actions are interrelated; that is, what subject M does affects his thoughts and feelings, similarly, the way subject M thinks then affects his actions and feelings. For example, subject M has thoughts like 'I won't be able to do this properly because it's difficult to even start anything at all'. This affects subject M to feel worried, frustrated, or helpless before or during an activity. These feelings appear to be associated with thoughts such as, 'I can't imagine getting over this' or 'I might be making myself worse', which contribute to feelings of fear or helplessness that are not only stressful but can also hinder healing.

On the other hand, thoughts like 'I won't know if I can handle this until I try' or 'I don't know if I'll feel any worse, and I might even feel better' tend to make a person feel optimistic and in control. In other words, changes in one area will often lead to changes in other areas.

Therefore, Cognitive Behavior Therapy (CBT) is based on the theory that dysfunctional beliefs can influence ineffective coping behaviors, negative moods, social problems, and pathophysiological processes all interact to perpetuate the disorder. The combination of CBT therapy helped subject M to be able to return to activities slowly. Cognitive factors in subject M, namely beliefs about the decline in health that they experienced and behavioral factors, namely avoidance as a coping strategy, are important determining factors. In addition, neurasthenic disorders are most likely to occur because of the complex interaction of physiological, cognitive, behavioral and affective factors responsible for their development and persistence. Cognitive behavioral models take these factors into account and lead to effective treatment.

CBT Intervention on Subjects

Surawy et al. (1995) explains that the experiences and life events of an individual will form a belief in him which can be referred to as premorbid behavior or Beck calls it a core belief. Assumptions can be positive and motivating, but if taken to the extreme they can become dysfunctional assumptions that can make individuals vulnerable to certain events and lead to the production of negative automatic thoughts. According to Beck's model, these maladaptive cognitions include general beliefs, or schemas, about the world, the self, and the future, giving rise to specific and automatic thoughts in particular situations (Hofmann et al., 2012). Negative automatic thought is a concept, opinion or idea that tends to appear suddenly of their own accord, without realizing it. Such thoughts, according to Beck, can lower the mood, which in turn increases the likelihood of negative thoughts and creates a 'vicious circle'. Once formed, negative thoughts can be very difficult to suppress and often appear quite logical and reasonable. Cognitive-behavioral therapy seeks to integrate therapeutic techniques that focuses on assisting individuals in making changes in thinking, beliefs and attitudes (Natal, 2021).

Cognitive models show how dysfunctional assumptions represent the interaction of behavior, emotions, symptoms and thoughts in neurasthenic disorders (Surawy et al., 1995). At the beginning of therapy, a thorough assessment of the history of the disorder was carried out, to find the relationship between cognitive, behavioral, social environment and physiological effects on subject M. Subject M was helped to find the most effective way of managing and overcoming the disorder experienced, by identifying how the disorder could be affected. affect their thoughts, feelings, and behavior.

Cognitive process model (Surawy et al., 1995) for the treatment of subjects with neurasthenic disorders:

1. Make a mutual agreement

Therapists with a psychological approach convey to the subject that they have psychological problems and are responsible for the disorders they experience. The therapist and the subject then developed a common understanding of the problem at hand and emphasized that although a problem in his travel history was partly psychological, it did not cause subject M to have a reprehensible character. In addition, the therapist demonstrates to the subjects that high standards of performance and responsibility make them vulnerable in the face of intolerable demands.

2. Develop a common understanding of the problems faced

In this session, subjects will often start with a simple physical description of their symptoms, eg "All my symptoms are caused by a virus". The therapist tries to reduce it by stating "All your symptoms are caused by depression." The first step is to separate out what is causing the disturbance to be rapid and lasting. The second is to introduce the idea that cognitive and behavioral factors have a role in the continuity of the disorder. In this way the therapist and subject can begin to work collaboratively on a cognitive level, focusing on cognitions and assumptions, and creating experiments in which the contribution of these factors can be assessed.

3. Reduction of "turnover" in activity level

Subject M will tend to have a cycle of activities that are usually contradictory, namely between the desire to continue doing activities and the desire to rest because they feel tired. The therapist assisting the subject to schedule activity, with an emphasis on reducing efforts to continue resting and avoiding obligatory activities, is a helpful way to stabilize activity levels in the early stages of treatment.

4. Negotiate simple and attainable goals

The therapist helps the subject to negotiate an achievable target, namely avoiding excessive rest.

5. Recognizing excessive obedience

The therapist helps the subject to express the thoughts and feelings they have been holding back for so long. Subjects are trained to be able to realize the patterns of behavior that they have been doing as a direct consequence of assumptions about what they need to do to achieve acceptance.

6. Assumptions that challenge and protect self-esteem

Successful therapy requires the therapist to know the subject's assumptions and help them modify them. Evidence for operating assumptions can come from the subject's proposed goals for treatment and their relationship with the therapist, as well as from common themes in expressed cognition.

Results of CBT Intervention on Subjects

The results of the intervention showed a significant change, both in terms of thoughts, feelings, and behavior. The subject shows an effort to do activities little by little at school. Subjects who initially tended to go home from work early, i.e. around 9, 10 or even just came to school to be absent, gradually returned to work at school even though they still came home at 12 or 1 in the afternoon. The subject realized that the chronic fatigue condition he experienced was due to previous situations. The subject admits that he tends to suppress his feelings in doing work at school. The subject felt that previously he could not refuse a job that was not actually his job desk. In the end the subject tries to be more assertive in doing his work at school.

The following table compares the clinical picture of subject M before and after being given the Cognitive Behavior Therapy intervention:

Table 1. Clinical Description of Subject M Before and After the Intervention *Cognitive Behavior Therapy*

Clinical Description	Before Therapy	After Therapy
Thought	- The work I do must be done well and perfectly. - I am the only person who can do the job therefore I have to do it perfectly.	- I work according to my ability. - I can ask for help from my co-workers, if the work is burdensome for me. - I will refuse a co-worker's request for help, when indeed I am not able to do it simultaneously with other work.
Emotion	- Frustrated - Distress	I feel happy, relieved, comfortable and more relaxed at school.
Behavior	Avoiding activities	Starting to teach eventhough while sitting in class.
Symptom	Headaches, body feels weak and tired, tired quickly, autonomic disturbances (discomfort and anxiety)	I don't have a headache anymore, my body is also gradually neither feeling weak nor tired.

Based on the table above, it can be concluded that the clinical picture of subject M who experienced neurasthenia disorders experienced changes after being given CBT intervention. The clinical picture related to thoughts, emotions, behavior and physical symptoms experienced by subject M has gradually changed, although not as a whole as before the appearance of symptoms. Subject M began to be able to change his views regarding the work that is his responsibility and relations with his co-workers. Subject M began to be able to change his emotions of frustration and distress with breathing exercises so that it helped him relax more when faced with his work. Subject M, who initially tended to avoid work activities by not coming to work or leaving early, began to be able to teach again even if only while sitting. Physical symptoms such as headaches, body feeling weak and tired, tired quickly, feeling uncomfortable and easily anxious, gradually reduced in intensity.

Evaluation

The CBT intervention given to the subject proved to be quite effective in helping to reduce the symptoms of chronic fatigue experienced previously. The cooperative attitude of the subject in following the intervention helped change in himself, both from thoughts, feelings and attitudes. The intervention that had been given helped the subject to provide insight into the problems he is currently facing. The subject realized that the chronic fatigue condition he experienced was due to the feelings he had suppressed so far. When chronic fatigue appeared, the subject then tended to avoid activities at school because they think that with rest their fatigue will subside. However, the fact was chronic fatigue was not handled and there was an obsession to continue to rest. The CBT intervention given made the client try to change negative thoughts in the form of an obsession to rest excessively with positive thoughts, namely seeing the work as fun. In addition, the client also added to his daily schedule by exercising every afternoon. Based on the prognosis predicted that the subject had a developmental disorder that leads to a good recovery. The results of the intervention showed that the subject was gradually able to overcome the psychological disorders he was experiencing.

The subject is expected to continue the positive things that have been obtained during the intervention process such as relaxing or taking a moment to examine negative thoughts and warning themselves to stop these thoughts and then replace positive thoughts such as "I will be good and healthy when I am in bed." school and do work". The subject is expected to learn to act assertively when working at school, if the job is not his job desk and he cannot help the client, he can give a good refusal. In addition, the subject is also expected to be able to maintain his new activity, namely exercising every afternoon and adding other positive activities that can increase his enthusiasm in living life.

CONCLUSION

Every human being has assumptions that are formed from his life experiences. Someone who tends to hold assumptions to the extreme will lead to dysfunctional assumptions. Dysfunctional assumptions will shape premorbid behavior and the emergence of automatic negative thoughts. Subjects who have been formed on the orientation of achievement, perfectionism and high standards for performance, responsibility and behavior control shape it into a person who has a perfectionist nature in doing a job. When faced with a stressful situation and also a pile of pent-up feelings makes the subject unable to deal with it. Feelings of excessive fatigue, anxiety and headaches when faced with work are the effects felt by the subject. On the other hand, when the subject has experienced the effects of fatigue, thoughts arise to continue to work and the desire to rest excessively. This makes the subject face internal contradictions which in the end creates a 'vicious circle' that keeps on repeating between the desire to keep working and resting, so that in the end they feel like a failure because they can't meet the standards. Cognitive Behavior Therapy

(CBT) helps subjects to recognize, understand and change cognitions and behaviors that do not help them. CBT helps the subject to reduce the perception of helplessness, understand the emergence of symptoms when doing activities, and develop tolerance for physical symptoms that are felt. This study concludes that CBT can help the subject understand and then change the dysfunctional assumptions they have previously.

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