Rheumatology 2001;40:348–349

Fibromyalgia—monotheories, monotherapies and reductionism

Sir, we wonder if the study by Ramsay et al. [1] might be the death knell for exercise programmes as a monotherapy for fibromyalgia. Even studies that have involved highly motivated research teams in intensive programmes have shown limited benefits. In a similar view, intervention studies based on analgesics, antidepressants or hypnotics, in isolation, have been disappointing [2].

Reductionism involves an explanation based on a single causative factor, and it is our belief that reductionist theories and therapies are unlikely to bear fruit in our attempts to better understand the syndrome. We agree with White et al. [3] that we need to embrace a biopsychosocial model if we are to develop more sophisticated models of understanding symptom onset and health-seeking behaviour. For instance, we need to understand the reciprocal relationships between symptoms, attributions relating to these symptoms, psychological distress and the decision to consult a health professional.

Looking forward, we anticipate that programmes involving a range of tailored interventions are more likely to be successful. We need to consider exercise programmes that are linked to interventions addressing motivation for change and distorted patterns of thinking in relation to symptoms (e.g. cognitive–behavioural
therapy, CBT). There is a suggestion that exercise programmes that are linked to educational packages are more likely to be successful [4]. Educational packages should give an explanation of symptoms, a rationale for treatment and should address compliance with the programme, which is a major problem. CBT would have an educational component in addition to its wider remit.

As part of a multifaceted package, consideration should be given to symptomatic relief of pain, psychological distress and sleep abnormalities, together with a consideration of the social context in which the symptoms occur.

Our fear is that, if there isn’t a rethink of our approach to fibromyalgia in the UK, we are going to continue to see our rheumatology clinics full of dissatisfied patients and frustrated clinicians.

S. M. Earnshaw, G. MacGregor¹, J. K. Dawson¹

Department of Child and Adolescent Psychiatry, North Sefton and West Lancashire Trust, ¹Department of Rheumatology, University Hospital Aintree, Liverpool, UK

Accepted 2 September 2000

Correspondence to: J. K. Dawson, Department of Rheumatology, University Hospital Aintree, Lower Lane, Liverpool L9 7LJ, UK.