

Fibromyalgia syndrome (FMS) is an idiopathic syndrome characterised by widespread musculoskeletal pain. Once diagnosed, the strategy for treating FMS patients usually follows a well established treatment model of medication and exercise. This paper will discuss the emotions of the FMS patient and how they are often misinterpreted by the health care practitioner as anxiety and depression and the effectiveness of a four phase patient-practitioner model as the ideal strategy of care for the FMS patient to adhere to treatment and exercise. In view of the misunderstanding between patient and practitioner about this syndrome, the paper sets out to examine the important issues surrounding communication between the sufferer and his or her treating practitioner. It is anticipated that the analysis of the issues will point to more effective and timely treatment.

I have treated many patients within my clinic who have been diagnosed with FMS through the use of soft tissue therapy and exercise therapy. They present with muscle ache, general fatigue, myofascial pain and also with various psychological conditions including depression and anxiety. My findings are consistent with Wolfe's (1990) studies into FMS. Wolfe postulates that FMS is characterised by widespread pain, hypersensitivity to palpation at specific body locations (tender points) and a range of physical symptoms and functional limitations, including persistent fatigue, sleep disturbances, stiffness, headaches and irritable bowel disorders. Patients also report cognitive impairments and general malaise.

Like other complex chronic illnesses, including chronic fatigue, chronic pain, and myofascial pain, there is an absence of physical findings to provide an adequate explanation for the symptoms (Wolfe 1995). This absence of physical findings evokes confusion within the FMS sufferer. In my experience of these patients, their general practitioner (GP) has initially overlooked the diagnosis of FMS. Their GPs have

prescribed exercise therapy for them because the patients are generally overweight and de-conditioned. The GP will in addition almost always prescribe anti-depression medication. When exercise therapy has not relieved their symptoms patients seek a second opinion, which may result in a diagnosis of FMS. As a whole GPs now have a better understanding of FMS and a diagnosis is usually made earlier. However the complexity of the condition continues to make FMS difficult to treat. (Henningsson 2003, Henriksson 2005). In my experience with FMS patients, long term remedial massage is more effective in treating the various symptoms, than mechanistic physiotherapy. The latter being disliked by patients who mistrust the conventional physiotherapy of tens machines and heat packs.

Due to the relative new diagnostic approach of FMS, strategies for pain relief are varied, however many patients continue to be treated as a homogenous group, which Thieme et al. (2004) report as unsuitable. Hughes (2006) opines that patients are treated inappropriately, and fail to receive or are offered appropriate alternative treatment.

The majority of sufferers of this disease are women who have been diagnosed in their fourth and fifth decade of life (Hughes 2006). Usually when a patient with FMS presents themselves to an allied health professional the health professional's initial reaction is that the patient is anxious and depressed due to their pain and discomfort. Bowman (2001) explains that depression and anxiety are the main reactive emotions to acute illness. FMS patients can have acute episodes of pain flare ups, at which time they usually seek treatment. The FMS patient is treated as having endogenous and not reactive depression.

Bowman postulates that anxiety and depression may not be an accurate description of the emotions of someone with a complex chronic illness, rather they are

just diagnostic labels given to describe a symptom or reaction to the underlying illness. Schliefer et al (1989) as cited by Bowman (2001) liken the reaction to an illness as grief and is short term and self limiting. Patients may suffer a feeling of loss until adjustment to the illness is achieved.

I also have labelled patients with FMS as anxious, however they did not display the acute symptoms of anxiety, such as motor tension, and autonomic overactivity (Huynh et al 2008). They have however displayed some forms of apprehension which may be due to being treated by a new health practitioner. On subsequent visits this anxiety had diminished leaving a relatively calm person who has muscular pain.

If a FMS patient is not depressed or anxious, why do health care professionals including my colleagues and myself, diagnose them in this manner? Bowman postulates that one of the reasons for this label, is that patients do not have the knowledge or insight concerning the diagnosis or treatment of their condition and hence agree to prescribe treatment as a patient of the usual medical model. Once diagnosed with FMS, the course of action by a GP is to prescribe anti depressive and anticonvulsive medication, which implies that they are depressed and or anxious. The next course of action is usually to refer the patient to a physiotherapist who will fix aches and pains.

In my opinion and with the experience of treating FMS patients, very few of them achieve positive pain relief within the acute injury clinic (i.e. Physiotherapy). They describe their treatment in a physiotherapy clinic as often rushed with the patient having no time to really explain how their body is reacting to the illness. Bowen indicates that emotions and the underlying illness are generally ignored in a clinical practice because of their 'highly theoretical nature, difficulties in

measurement, lack of pharmacological interaction, and our lack of ability to control'. Due to time constraints within a clinical setting, the FMS patient is poorly understood, whereas in a massage therapy setting the patient has more time to discuss the various factors of the illness.

Misinterpreting a FMS patient's emotional response to their chronic illness is possible due to how the individual reaction may differ on important variables. These variables, such as mood, adaptation to symptoms as well as presenting symptoms, cause the health professional to not effectively understand what the patient needs, to help them adapt and cope with their chronic illness. The health professional needs to identify the dominant emotion and the effect it has on the patient. It is only at this point that the health professional can assist the patient to self regulate and adapt strategies which helps them to self manage emotionally with their physical illness (Bowman 2001). One of the more common dominant emotions which I have observed in FMS patients is that of frustration. This frustration is often related to the opinion of others who deny the severity of the illness. This correlates closely with the suggestion by some (Shapiro 2003, Netter 1998) that FMS is a psychogenic disorder because, of the lack of clinical physical symptoms. However, others (Huynh et al 2007), believe FMS patients present as being complex due to the complex nature of the pathogenesis of FMS, and the interplay between the central nervous system, peripheral nervous system, and the endocrine system. This interplay may lead to the patient having diminished cognitive function, including short term memory loss, decreased mental alertness, and poor multitasking performance in addition to symptoms of light-headedness or dizziness, which may stem from a disease of the regulation of the autonomic nervous system. With this in mind some FMS patients who have severe symptoms may not be able to convey the level and experience of pain to the health

professional in a logical manner. In this regard the patient can be comparable to a patient with cognitive and verbal impairments. These difficulties are evident as the health professional is left to interpret the varying emotions of the patient into some form of accurate diagnosis on that particular day. The methods of assessment that Buffum et al (2007) recommends that, the health professional may need to obtain the input of family or friends about the patient's pain history, and to further investigate appropriate treatment for the patient.

The fact of a specific diagnosis of FMS by the patients GP can help the overall strategy of management, as guided by the health professional. Huynh et al report that patients who have their symptoms explained by a specific diagnosis report fewer symptoms and decreased symptom intensity over time. Furthermore, they argue that the patient and their families benefit from the health professional's acknowledgement that FMS is a chronic illness that may affect their quality of life at times, but not necessarily affect their life expectancy. This acceptance by the patient and practitioner, of the patient's condition is the first positive step towards productive patient-practitioner collaboration.

Barr & Threlkeld (2000) describe a contemporary approach to patient practitioner care such that it is deemed a partnership rather than the practitioner having a directive role, overseeing the solutions prescribed for pain management. The model of patient –practitioner collaboration (Jensen et-al 1997, cited in Barr and Threlkeld 2000) is a novel strategy to manage the complex nature of FMS. The model has four phases which are used to describe the patient and the interactions. In the initial phase of the model, the health practitioner must establish a relationship in which the patient feels comfortable sharing his/her goals and beliefs about their illness. Verbal and non-verbal cues can be made focusing on displaying a friendly,

warm open posture. In this phase of the model the practitioner would take a full medical history as well as listen to and acknowledge the patients concerns about future treatment to further enhance the establishment of the therapeutic relationship.

In addition to the physical examination of the FMS patient, the practitioner must focus on learning the patient's beliefs and behaviours related to their condition and their attitude towards past and future treatments. This is phase two of the model. In my experience FMS patients believe that they cannot exercise at all due to pain, and most of them have had negative experiences with past treatments. Huynh et al suggest that nonpharmacological therapy is initially preferred in the management of FMS patients. Exercise graded to the threshold of patients pain and fatigue promotes adherence. FMS patients must be informed and led to accept that improvement may take many months and symptoms may worsen at times, but overall the symptoms will reduce as the months' progress.

In the third phase of the process, practitioners are required to prescribe specifically tailored treatment for the chronic illness (Stewart et al 1995 cited in Barr and Threlkeld 2002). In many acute practices FMS patients are treated as a homogeneous group indicating all patients have the same symptoms and react in a similar nature to those symptoms. Turk and Flor (1989) argue that FMS patients are a heterogenous group of people who differ in important variables such as mood, presenting symptoms and adaptation to symptoms. The strategy here is for the health professional to foster mutual goal-setting and to negotiate the preferred interventions, in light of the variable nature of treatment effectiveness. Treatment options could include exercise therapy, massage therapy, aquatic therapy, counselling, acupuncture and so forth. The process of negotiation also affirms that the patient holds the power for recovery. In the final phase of care, there must be adequate intervention and

follow up to the exercise program or treatment. The practitioner must provide proper instruction and identify barriers to patient's adherence. The patient must also be honest in their participation of a programme and report and explore reasons for lack of participation (Barr and Threlkeld 2002). An exercise contract is an effective way for both the patient and practitioner to agree to the required therapy. Follow up appointments should address the concerns of both parties including reducing the barriers to treatment or exercise adherence.

FMS is a complex illness in which patients often struggle to establish legitimacy and credibility of their symptoms. Due to the varying nature of the symptoms, health professionals can easily misinterpret the patient's mood reaction to the presenting symptoms. Many general practitioners still fail to recognise that it is a chronic pain syndrome to which no one single treatment will reliably control the symptoms. Patients without a multi-component treatment regime will be frustrated by continual failure of one off treatments. Acceptance of the condition, by the patient's health care professional, and the belief that the patient can control the symptoms are positive steps toward rehabilitation.

References

- Barr, J., & Threlkeld, J.A. (2002). Patient-practitioner collaboration in clinical decision-making. *Physiotherapy Research International*, 5, 254-260.
- Bowman, G. S. (2001). Emotions and illness. *Journal of Advanced Nursing*, 34(2), 256-263.
- Buffum, M.D., Hutt, E., Chang, V.T., Craine, M.H., & Snow, L.A. (2007). Cognitive impairment and pain management: Review of issues and challenges. *Journal of Rehabilitation Research and Development*, 44, 315-330
- Henningsen P, Zimmermann T, Sattel H. (2003) Medically unexplained physical symptoms, anxiety, and depression: a meta-analytic review. *Psychosomatic Medicine*, 65,528–33.
- Henriksson CM, Liedberg GM, Gerdle B. (2005) Women with fibromyalgia: work and rehabilitation. *Disability Rehabilitation*; 27, 685–94.
- Hughes (2006) Physical and psychological Variables that Influence Pain in Patients With Fibromyalgia, *Orthopaedic Nursing*, 25, 2 112-119.
- Huynh C.N, Yanni L.,Morgan L.A. (2008) *Journal of Women's Health*, Volume 17, Number 8.
- Jensen GM, Lorish C,Shepard KF (1997). Understanding patient receptivity to change: teaching for treatment adherence. In: KF Shepard, GM Jensen (eds). *Handbook of Teaching for Physical Therapists*. Boston, MA: Butterworth Heinemann, 241–269.
- Netter P, Hennig J. (1998) The fibromyalgia syndrome as a manifestation of neuroticism? *Z Rheumatol*, 57 (suppl 2), 105-8.
- Schliefer S.J, Macari-Hinson M.M, Coyle D.A, Slater W.R, Khan M, Gorlin R., & Zucker H.D. (1989) The nature and course of depression following myocardial infarction. *Archives of Internal Medicine* 149, 1785-1789.
- Shapiro B. (2003) Building Bridges between body and mind: the analysis of an adolescent with paralysing chronic pain. *International Journal Psychoanalytic*, 84, 547-61.
- Stewart M, Brown J, Weston W. (1995) *Patient-centred Medicine: Transforming the Clinical Method*. Thousand Oaks, CA: Sage.
- Thieme K, Turk DC, Flor H. (2004) Comorbid depression and anxiety in fibromyalgia syndrome: relationship to somatic and psychosocial variables. *Psychosomatic Medicine*, 66, 837-844.
- Turk D.C, Flor H. (1989) Primary Fibromyalgia > Tender Points: towards a multiaxial taxonomy. *Journal of Rheumatology*, 16, 80-86.

Wolfe, F., Ross, K., Anderson, J., Russell, I., & Hebert, L. (1995). The prevalence and characteristics of fibromyalgia in the general population. *Arthritis and Rheumatism, 1*, 19–28.

Wolfe, F., Smythe, H., Yunas, M., Bennett, R., Bombardier, C., Goldenberg, D., et al. (1990). The American College of Rheumatology 1990 criteria for the classification of fibromyalgia. *Arthritis and Rheumatism, 33*, 160–172.