

Self-help and compliance

In this issue *JBMT* is initiating a series which will feature a page, free of copyright, so that therapists and practitioners can copy this for distribution to patients, free of charge. The presence of this page, on a regular basis, represents the fruition of an idea which was first proposed before *JBMT* existed, at the first meeting of its editorial team, in 1996. Craig Liebenson DC has prepared the material for this, and a number of future issues, and has provided a paper to accompany the launch of the self-help page, which discusses issues of compliance in chronic pain settings.

Each 'self-help' page will have on its reverse a 'clinicians' page which will briefly explain the clinical usefulness of the method being outlined and illustrated.

Self-help, and its accompanying problem of compliance (or adherence or concordance, as it is variously known), is an emotive issue, with strong positions being taken as to the value, or otherwise,

of measures which make (sometimes major) demands on people's willingness to devote time and effort towards recovery and rehabilitation.

The issue is not whether many of the self-help methods relating to musculoskeletal dysfunction are, or are not, potentially useful – they patently often are. It is more a question as to whether people will perform exercises, or other measures, regularly, and for any length of time, even if benefits are noted.

Take for example the undoubted rewards experienced by many people suffering with fibromyalgia syndrome (FMS) if they introduce regular aerobic exercise. A Swedish study compared groups of FMS patients who, over a 6-week period, were given (six 1-hour) educational lectures about their condition and how to manage it, with a group who attended these same lectures, but who also received (six 1-hour) sessions of physical training (Burckhardt et al. 1994). A further group (used to compare the effect of doing something with doing nothing in similar patients) were untreated during this entire study, but received treatment after it was over. The

results (86 patients completed the study) showed that both the lecture, and the lecture plus exercise groups, showed a positive impact on their quality of life as well as their pain levels. However, it was those who performed the active exercises that were shown to maintain the benefits long-term more effectively. Eighty-seven per cent reported that they were exercising at least three times weekly for 20 min or more. Perhaps significantly only 46% reported that they had increased their exercise level as a result of the programme. Around 70% were practicing relaxation techniques. A number had been able to return to work as a result of the programme.

A similar study in Norway (Wigers et al. 1996) compared aerobic exercise with stress management and 'treatment as usual' in treatment of FMS. In this randomized study, involving 60 patients over a 14-week period, with a 4-year follow-up, both treatment groups showed short-term positive results, with aerobic exercise being the most beneficial. However, at follow-up there was no obvious group difference in severity of symptoms, which for aerobic

exercise seemed to be due to considerable compliance problems.

There can be few more comprehensibly distressing conditions than FMS, in terms of its range of symptoms, including more or less constant severe pain. And yet, despite achieving symptom reduction and a better quality of life, as a result of exercise, the majority of patients in this study failed to continue doing something which empowered them, and which made them feel better!

Does this invalidate the use of self-help measures? Clearly not, since many people do benefit, and many do comply (or adhere). What can we do to encourage compliance in those who stop doing what is patently good for them?

For a start, we can try not to be judgmental, because there are few amongst us who, hand on heart, can say that they do all the things that they should to enhance health, and who do not do at least some things

they would not advise, in the pursuit of good health – whether this relates to overwork, dietary habits or lack of exercise.

The truth is that most people are sluggish when it comes to changing habits and performing routinely some prescribed exercise, or other self-applied treatment, unless and until it becomes routine and habitual. How can we encourage this? By explaining and demonstrating whatever we are suggesting, in ways which make sense to the individual, including describing fully the mechanisms involved, and by making this process simple as possible. All explanations should be related, as far as is possible, to the cultural, ethnic, educational background of the individual being asked to perform the task.

A New Zealand study offers yet another way. Compliance to home-based exercises can be encouraged by provision of written and

illustrated reinforcement (Schneiders et al. 1998).

Leon Chaitow
Editor

Readers are asked to send the Editor suggestions for the self-help page (either as ideas or as offers to produce one) and to offer constructive criticism about the way it is being presented.

REFERENCES

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