Editorial

Treating the whole patient: why the integration of medical and psychological expertise is not optional in fibromyalgia care

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Fibromyalgia (FM) is a complex chronic pain disorder affecting 2–4% of the general population worldwide, predominantly women, and ranking among the most common reasons for rheumatological referral (1, 2). Its pathophysiology involves central sensitisation, neuroendocrine dysregulation, and altered nociceptive processing, features that situate FM within the emerging framework of nociplastic pain and foreground the central role of psychological factors in its onset and maintenance (3). George Engel introduced the biopsychosocial model in 1977, arguing that biological, psychological, and social dimensions are inseparable in understanding illness.

Nearly fifty years later, this model remains more cited than applied, and nowhere is this gap more consequential than in FM. Despite explicit recognition that FM is shaped by emotional dysregulation, traumatic experiences, and maladaptive coping, clinical practice continues to default to a predominantly pharmacological approach. This editorial argues that effective FM management requires structural integration between rheumatologists and clinical psychologists, guided by a genuinely patient-centred framework.

Psychological vulnerability and maintaining factors

Psychological risk factors for FM are well-established and antedate diagnosis. Adverse childhood experiences (ACEs), emotional, physical and sexual abuse, neglect, and household dysfunction, constitute an independent risk factor for FM development, predicting higher pain impact, greater functional impairment, and more severe psychiatric comorbidity in adulthood (4). Post-traumatic stress disorder (PTSD) emerges as a significant independent risk factor, with approximately 40% of FM patients meeting diagnostic criteria, a rate far exceeding that of the general population (5). Shared neurobiological mechanisms (HPA axis dysregulation, autonomic dysfunction, central sensitisation) provide plausible pathogenic bridges between traumatic stress and chronic widespread pain. Importantly, PTSD symptoms antedate FM onset in a substantial proportion of cases, supporting a contributory rather than merely comorbid role. Personality dimensions compound the picture: high neuroticism amplifies FM symptomatology and promotes passive coping (6), while high harm avoidance and low self-directedness are consistently identified as trait features of FM patients. A cluster analysis of psychological variables in women with FM and related nociplastic pain conditions identified three patient profiles ordered by severity, with FM patients showing the most severe burden, high central sensitisation, alexithymia, maladaptive personality traits, and traumatic experiences (7). This heterogeneity has direct clinical implications: no single therapeutic approach will fit all patients.

Once FM is established, psychological processes operate as powerful maintaining and amplifying factors. Depression affects 20–80% of patients and anxiety 13–63%; cluster C personality features are substantially over-represented (8). Pain catastrophising, combining rumination, magnification and helplessness, mediates the relationship between pain intensity and functional impairment (9). These dimensions are not optional complications of FM: they are part of its pathogenic architecture. The FITSS model (Fibromyalgia: Imbalance of Threat and Soothing Systems) formalises this, proposing that an overactive threat system and an underactive soothing system maintain the brain's salience network in continuous alert, amplifying pain and affective distress in a self-reinforcing loop (10). Emotion dysregulation is not a consequence of FM; it is a core pathogenic mechanism.

Assessment as the clinical pivot

The heterogeneity of FM patients, across trauma history, personality structure, psychiatric comorbidity, coping style, and alexithymia, makes comprehensive psychological assessment indispensable, not optional. Assessment is not merely a preliminary step: it is the clinical act that makes individualised care possible. A thorough psychological evaluation should systematically explore trauma history and ACE burden; personality organisation and temperamental features; presence and severity of psychiatric comorbidities; pain cognitions including catastrophising and illness representations; coping strategies; and degree of alexithymia and emotional dysregulation. Recent research has confirmed that these variables cluster into distinct patient profiles that carry different treatment implications (7); assigning all FM patients to the same intervention pathway is therefore not only clinically inadequate but empirically unjustified. A joint first-line evaluation by the rheumatologist and the psychologist enables comprehensive phenotyping, capturing not only pain characteristics and functional disability, but also the psychological profile that should directly determine the therapeutic plan from day one. Deferring psychological involvement to a later stage, or reserving it for patients who have already failed pharmacological treatment, is both clinically inefficient and, for many patients, too late. The diagnostic encounter itself is a therapeutic act: the way the patient's story is heard, framed, and validated at the first meeting shapes the entire subsequent trajectory of care.

Psychotherapy referral: evidence and tailoring

An expanding evidence base supports the efficacy of psychological and mind-body interventions for FM (2). Patients should be systematically referred to psychotherapy, and this referral should be guided by the specific psychological features emerging from assessment. Selecting a therapeutic modality without prior characterisation of the patient's profile risks a mismatch that attenuates efficacy and undermines adherence. Cognitive-behavioural therapy (CBT) remains the most robustly evidenced approach: it consistently improves pain intensity, sleep quality, and quality of life, and is endorsed in international multidisciplinary consensus guidelines (11). Acceptance and Commitment Therapy (ACT) has demonstrated robust and replicable outcomes across pain, mood, and functional disability, with additional advantages in digital delivery and superior adherence (12). These two modalities currently represent the first-line psychological treatment options for FM.

However, no single approach suits all patients. For those with significant PTSD or ACE burden, a clinically prevalent subgroup, standard pain-focused CBT may be insufficient or even contraindicated without prior trauma stabilisation; trauma-informed approaches are more appropriate in this context. Patients with severe alexithymia may require preparatory emotion-focused work before engaging with cognitive techniques. Other non-pharmacological interventions, mindfulness-based stress reduction, mind-body practices (yoga, biofeedback, guided imagery) and emotion-focused therapies, show promising results for specific symptom clusters (13) but currently require larger and more rigorous randomised trials before definitive recommendations can be issued. Expanding the evidence base for these complementary modalities is a clinical necessity, given the psychological diversity of FM presentations encountered in routine practice.

Towards structural integration: a call to action

The case for psychological integration is not grounded in the assumption that FM is a psychogenic condition, such a framing would be both scientifically inaccurate and clinically harmful, risking delegitimisation of the patient's suffering and undermining the therapeutic alliance. The argument is more fundamental: in any chronic, painful and disabling condition, psychological factors are not optional complications but inevitable accompaniments. Persistent pain reshapes identity, disrupts relationships, impairs work and sleep, and challenges the patient's sense of self and future. No patient living with FM is unaffected psychologically, not because FM is 'in the mind', but because living with any severe chronic illness is an inherently psychological experience. We advocate for the systematic integration of clinical psychology within FM-dedicated rheumatology units, not as a referral of last resort, but as a structural component of the very first clinical contact. The rheumatologist and the psychologist should work side by side from the initial assessment onward, sharing a common biopsychosocial language through which to jointly understand and jointly plan care (10, 14). Multidisciplinary treatment combining psychological and rehabilitation components consistently demonstrates superior outcomes compared to single-modality approaches (15). Patient-centred medicine, understood as a paradigm in which care is organised around the individual person rather than the disease, provides both the ethical and practical framework through which this integration is enacted. Fibromyalgia will not be resolved by the next drug trial. It is an invitation to rethink how medicine conceives of the person in pain, and to build a clinical practice worthy of that rethinking.

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