The Impact of Pain on Persons who have Fibromyalgia

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Abstract

This literary review focuses on the ability to discern how psychotherapy directly affects the quality of life for those who live with the chronic pain of fibromyalgia syndrome (FMS). It will serve to outline various methods of educating persons with fibromyalgia by teaching coping skills and encouraging group support. Through the use of psycho-education clients learn methods that allow each person to differentiate general pain signals the body is emitting from the more serious physical, emotional, and psychological issues of the syndrome that have become the norm due to long term exposure. The loss of independence and traditional coping skills is also a concern that will be addressed as new problem solving skills are explored that directly relate to the changes in lifestyle due to chronic pain. The person with fibromyalgia is encouraged to seek qualified medical and mental health professionals specifically trained and willing to work collaboratively as part of a multi-disciplinary team.
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Defining Fibromyalgia

Fibromyalgia syndrome is defined by Shuster, McCormick, Ridell, and Toplak (2009) as “a disease with a complex etiology that is characterized by symptoms of widespread pain and fatigue. Diagnosis is currently based on criteria proposed by the American College of Rheumatology and includes a history of chronic pain for three months and pain sensitivity of 4kg of pressure at more than 11 of 18 tender points” (p.239).

The tender points are located throughout the body starting with the upper body across the shoulder area and near the collar bone, running down the arms and legs. Medical professionals assess the symptoms, and monitor the intensity and duration of time experienced.

The typical treatment plan includes ruling out diseases and syndromes that mimic fibromyalgia. The differential diagnoses methodology conducts a variety of tests typically within the arthritis and lupus areas. As each test is conducted, the differentials are narrowed down until the diagnosis of fibromyalgia is clearly the cause of the fatigue and chronic pain.

A syndrome that displays similar symptoms is Chronic Fatigue Syndrome (CFS) which is also considered to be chronic. The diagnosis for this syndrome constitutes a much longer duration of 6 months of a fatigue episode which is twice the timeline of fibromyalgia. Due to the mimicking symptoms, it is difficult to differentiate between the syndromes. Both chronic fatigue and fibromyalgia syndromes are categorized as auto immune deficiencies (Walker, Lindner, & Noonan, 2009). CFS like FMS both affect the cognitive and behavioral functioning of a person. Another difference between the two syndromes is that FMS has specific tender points that are part of the formal criteria for diagnosis by the American Rheumatological Society.

According to Moran (2009) the fibromyalgia syndrome affects women more often than
men. The presenting age is typically found between the range of 20 and 55, but it is noted that this syndrome can diagnosed at any age. A diagnosis is made most often by the primary physician referring the patient to a rheumatologist who reviews not only the physical tender points, but also other important aspects of the physical environment. The physician may take the family history as well as conduct a complete physical examination along with laboratory tests to rule out other syndromes and diseases which mimic the chronic pain of fibromyalgia.

The person with fibromyalgia may display symptoms that differ from day to day with no discernible explanation. The challenge vocalized is that the pain and fatigue are not restricted to one part of the body, but rather moves throughout the body. It is a difficult syndrome to treat, and one which requires the expertise of a multi-disciplinary team due to the constant change in intensity, duration, and tender point location.

According to Anderson and Winkler (2007) numerous studies have been conducted which conclude that the fibromyalgia syndrome is characterized as part of the rheumatological family of diseases. It is also being studied as a psychological disorder or caused by traumatic stressors. The comorbid conditions may include, but are not limited to depression, anxiety, post-traumatic stress disorder, fears, phobias, and somatic episodes. Addressing the psychological needs as well as the physical and social needs leads to greater efficacy.

By some authors FM is considered a stress-related disorder due to its frequent onset and exacerbation of symptoms in the context of stressful life events. However, the specific pathophysiology responsible for FM remains unknown, and it is a still matter of debate whether pain in FM patients is predominantly caused by peripheral or central mechanisms (Luerding et al., 2008, p. 3223).

The discussion surrounding the onset of the fibromyalgia syndrome is much like the
nature versus nurture debate. Does the pain cause the lack of restful sleep, thus creating fatigue? Or does the fatigue cause the pain due to the chronicity of symptoms? How are some individuals resilient to the life stressors and physical ailments, while others succumb to the syndrome and are unable to rebound?

Persons with fibromyalgia also deal with cognitive issues such as fibro fog, inability to retrieve appropriate words to converse, distortions, and memory loss. The brain has been examined and studied both from a cognitive perspective as well as the physical implications of the actual organ itself. Again the debate ensues as to which happens first to persons with fibromyalgia – do the physical changes of the brain cause the cognitive changes or over time do the cognitive changes cause the physical metamorphosis? Research surrounding the activity and connection of the central nervous system has focused on the person with fibromyalgia’s response to pain. The study focus was not specific to one particular body area, but covered numerous regions (Okifuji & Turk, 2002). Not only was the attention focused on the response to pain, but also to the rate of recovery from that stimulus.

The syndrome has been studied from a neuropsychological approach examining the effects on the brain. Researchers are trying to discern if the brain matter affects the individual and cognition or if the onset of the physical symptoms interferes with the brain’s processing therefore causing changes to the matter. Cognition is affected and it is called fibro fog, which means that processing and recognition displays a slowed response.

Studies surrounding brain and its activity were conducted by Luerding et al., (2008) regarding how the brain morphology is observed as it relates to the changes in the person with fibromyalgia. It was determined that performance on non-verbal working memory was positively correlated with grey matter values in the left dorsolateral prefrontal cortex, whereas performance
on verbal working memory (digit backward) was positively correlated with grey matter values in the supplementary motor cortex. On the other hand, pain scores were negatively correlated with grey matter values in the medial frontal gyrus. White matter analysis revealed comparable correlations for verbal working memory and pain scores in the medial frontal and prefrontal cortex and in the anterior cingulate cortex (Luerding et al., 2008, p. 3222).

Changes that affect the person with chronic pain are: the level of physical mobility, lowered self-esteem, and coping skills related to mental health. Variables such as new approaches to problem solving skills, availability of resources, and determination of the patient, as well as the support system influence the quality of life, and the level of acceptance and independence achieved. According to Luerding et al. (2008) economics also plays a role in the resilience and forward movement. The lack of funds and ability to locate the resources can create road blocks and hardships. There are also issues related to oral communication. Stumbling over words, stuttering or the inability to find the correct word (similar to stroke patients) makes this syndrome a challenge to live with due to the unpredictable nature of symptoms.

According to Kirsch and Bernardy (2007), persons who have fibromyalgia simultaneously deal with fatigue, sleep issues, irritable bowel syndrome, and morning stiffness. Other issues that affect the person with fibromyalgia may include balance when walking, pain while exercising, vision impairment, but not limited to muscle fatigue. At times the chronic pain is not visible to the general public. Empathy for this disabled population goes unchecked due to the internalized pain. External challenges visible to the general public give a clear message that the person with the disability may need additional time to accomplish tasks due to new coping strategies in place. Persons with disabilities that have no outward manifestation often are
expected to do things for themselves because without that visual cue appear “normal.”

Fibromyalgia for some may become a disability due to the inability to work a forty hour work week. Impairments may also take the form of affecting cognition, physical, and intelligence according to Annemans et al. (2009). The laws and judicial system have strict definitions as to what constitutes a disability, and places the burden of proof on the person with fibromyalgia and lawyer. There must be adequate documentation of missed work, and medical visits. The issue for persons who have fibromyalgia is that if too much work is missed, they risk being fired. Proving a disability exists with the diagnosis of a syndrome with no organic cause is difficult.

Comorbidity

Findings reported in research by Hasset, Radvanski, Vaschillo, Vaschillo, Sigal, Karavidas, Buyske and Lehrer (2007) show evidence suggesting that the dysfunction of FMS is categorized as autonomic. The results outline a delay to dealing with stress in the sympathetic nervous system when the system is heightened and the parasympathetic is decreased. The researchers conclude that the relationship between the two nervous systems may lead to a diagnosis of fibromyalgia.

A comorbid diagnosis that is often found to be associated with fibromyalgia is depression which is due to the chronicity of pain, and duration. There are numerous tests that can be administered to rule depression in or out, such as the Beck Depression Inventory or Minnesota Multiphasic Personality Inventory. The tests are given by a trained individual and reviewed by the appropriate licensed practitioner. Hamilton et al., (2005) also found that irritable bowel and chronic fatigue were comorbid to FMS. Geisser, Strader Donnell, Petzke, Gracely et al, (2008) reported that infections, diverticulitis, and allergies may also be present.
Are the strategies currently in place to deal with a condition such as irritable bowel syndrome adequate to deal with the physical functioning of the body or should new avenues of educated problem solving be explored? And does the fact that the syndrome is comorbid with FMS complicate the solution? Discussion surrounding the feeling, emotions, and stigmas attached to the diagnoses is important. Finding out how they are impacting choices to withdraw or reach out are important to discern when actively setting goals to improve functioning. Focusing on abilities is helpful to reframe the concerns in a positive manner.

Understanding that comorbidity exists creates an awareness which leads to cooperative dialogue between the patient and clinicians. In order to better understand the symptoms of the patient, it is important that the person with fibromyalgia is able to articulate the experience. Also a willingness to undergo testing that will help to collaboratively determine a unique treatment plan.

**Catastrophizing**

Sohl and Friedberg (2008) conducted research which looked for a link between cognition, catastrophizing beliefs, and how it relates to fatigue. Could interventions in cognition help alleviate the need to catastrophize, thereby reducing the effects of fatigue? “Furthermore, ongoing negative emotional states (eg, anxiety, depression) may increase the likelihood of catastrophic misinterpretations of symptoms and symptom-focused attention” (Sohl and Friedberg, 2008, p. 29).

The role of the therapist is to help the client become aware of self-talk, paying attention to the positive and negative thoughts and words, analyzing how it impacts behavior and self-fulfilled prophecy. If the majority of thoughts and words are negative affect, then a psychotherapy goal may be to redirect those into a positive statement. The mind is powerful, and
by setting up small goals working toward a greater goal, change can be achieved.

Discussion of the types of themes and the reasons particular pain, duration, and intensity bring about specific responses can allow insight into what catastrophizing behavior looks like. Catastrophizing, according to Gracely, Geisser, Giesecke, Grant, Petzke, Williams & Clauw (2004) has a profound effect on pain and the attitudinal focus of the intensity. How are shifts made to divert the attention from catastrophizing observations and conclusion to reality based with realistic outcomes that are not located on the extremes of a bell curve, but rather in the median range? What is the benefit of the catastrophizing behavior? How can a positive, reality grounded response solicit a desired behavioral outcome? Reframing may be used within the sessions, both as modeling the behavior and teaching it to move toward less catastrophizing conclusions.

The Fatigue Related Cognitions Scale contains a catastrophizing subscale which measures how fatigue interacts with magnification, rumination, and a sense of helplessness. People with fibromyalgia who feel isolated may score higher on this scale due to the limited interaction with others who share their chronic pain and have an understanding of the issues faced daily. Fatigue is a symptom of FMS that is not necessarily due to overexertion as most would believe. It is a symptom that cannot be seen by others, but is very real and debilitating at times to the persons who have fibromyalgia. When a sound support system is not in place, the person with chronic pain may begin to catastrophize allowing the pain to be the focal point of existence rather than approaching each day with a positive, problem solving approach to meet challenges with new outcomes.
Psychotherapy Goals of Fibromyalgic Clients

According to VanHoudenhove and Luyten (2008) there needs to be three segments considered when working in the clinical sessions directed toward psychotherapy goals. Discussion of the syndrome and how it affects daily living should be considered. Are there any other comorbid diagnoses that need to be addressed? As an effective treatment plan is formed, a conversation regarding what is a solid measureable goal versus one that is not tangible.

Shuster et al. (2009) encourage sessions to include how the pain is affecting not only the physical body of the person with fibromyalgia, but how it relates to other psychosocial components. Does the constant pain within individuals create more negative self-talk and thoughts? How can that negativity be used in a constructive manner to deal with pain and symptoms in a more positive approach? What life lessons can be taken from each experience to allow forward movement?

Educating the client on reframing techniques would serve useful to train the client how to turn the negative thoughts into positive ones by creating challenges to accomplish, rather than succumbing to complacency and stagnation. Forward movement comes with challenging the mind to revisit beliefs and lifestyle choices. Were those beliefs and choices passed down through the family structure or are they a result of the individual’s discernment?

An Adlerian therapist may take this goal a step further and explore the family of origin and the impact the belief system has on the client. Of the beliefs passed down through the family constellation, which beliefs are kept and disregarded by the children is a matter of interpretation on the part of each individual child. According to Watts and Maniacci (2006) Adler encouraged therapists to aid the client in disseminating mistaken beliefs, and helping them become aware in order to address and choose to change.
As individuals mature, develop, and explore the stages of life; the truths about how men, women, and the world are evolve and change as well. What is triggered in an individual’s mind that allows some to mature while others are faced with incidences that lead to trauma which inhibits the process? An Adlerian concept of striving for perfection is to yearn and work toward learning how to better accomplish lifestyle tasks and to become an autonomous adult. Another important concept is that of social interest. It is used by therapist to teach clients to take an interest in the lives of those who are part of their lives, and could benefit from the compassion of another human being, exploring how the client can add to the person’s quality of life (Carlson et al., 2006).

Goals set to encourage the forward movement may include acceptance of the syndrome, changes to the quality of life and independent status of the client, pain monitoring and medications, along with conventional and alternative therapies. Goals are discussed between the client and therapist to determine the best course of a treatment plan tailored to individual needs. The plan needs to be both qualitative and quantitative in measurement. Realistic goals are set, one building upon the other to gain self-confidence, self-assurance, and motivation to live a quality life.

Another goal within the treatment plan may be to create a safe place where self-expression is valued. The therapist’s office space may be considered a place of safety. What type of environment is it projecting? Is it a place of acceptance, an atmosphere that allows for brainstorming, and open dialogue?

The difficulty with setting physical goals that define the pain level and intensity of the persons who have fibromyalgia is that the pain moves from area to area throughout the body and has no discernible path. It differs among individuals as well.
The construction of pain-related goals may be particularly important for those managing a severe and poorly understood chronic illness, such as fibromyalgia syndrome (FMS). Persons with FMS present an enigmatic clinical picture characterized by diffuse pain the absence of systemic disorder (Aronoff, 1988). FMS pain seems to emanate from muscle and soft tissue (Wolfe et al., 1990), and although chronic pain is a central diagnostic symptom” (Hamilton, Karoly, & Zautra, 2005, p.455).

Pain is subjective to each person with fibromyalgia. The threshold and tolerance of pain is unique to the person. Exercise may be a goal that is beneficial to the person with fibromyalgia or chronic pain. According to Kelly and Loy (2008) a graduated scale similar to the Likert Scale could be implemented which has agreed upon definitions of pain intensity at each gradation. As the person begins the exercise plan a daily log would be kept with the activity, duration, corresponding number from the scale, and a brief summary of the emotions and feeling attached to that entry. Included in this goal are a pre-determined number of days to achieve small goals. The exercise goal is evaluated by the therapist and client to determine if new goals should be constructed to build upon the achieved goals, and if this form of therapy should be incorporated into daily life. Does this goal stand alone or would the client benefit from adding a pharmacological element?

The relation between pain perception and adjustment is believed to be influenced by the type(s) of life goals a person elects to pursue, the ways in which persons are cognitively appraised and organized, the ways in which the process of goal pursuit is represented schematically, the structural relationships among the goals in a person’s hierarchy of aspirations, and the availability of goal-related environmental resources (cf., Affleck et al., 2001; Emmons

Setting goals that are realistic and measurable is important. The person with fibromyalgia needs to begin with small physical goals. It is important to keep in mind that the body may hurt at the onset of any new physical activity, and it is vital to remember not to rush the launch of any new program. Slow and steady progress, allows the client to become familiar with what his or her body is capable of completing, and to learn what it feels like to experience relief due to increased activity.

Many think that rest equals relief. The body does need rest in the form of down time and sleep to rejuvenate. The person who has fibromyalgia also needs to keep the body in motion with varying intensities in order to decrease stiffness. Self myofacial release and stretching are valuable goals to consider. Goal setting encourages the client to go out into the community, advocating for his or her own well-being by finding trained professionals to teach the various exercises. Searching for answers by asking direct questions is a powerful morale booster. This task helps to engage the mind, body, and soul which have a connection to one another.

It is important to make goals that focus on the medical health of the client. Appointments and follow-up visits are vital pieces of information needed when working on the psychotherapy goals. A factor to consider that is difficult for most people to attain is proper rest. Holshoe (2009) focused on the importance of sleep. It directly affects cognition, immune systems, mood, and endocrine systems. Lack of sleep has been linked to diseases such as depression, diabetes, obesity, pain, and heart. A sleep study can be a test performed to assess the level of sleep achieved, and to explore ways to set goals to improve.

The four basic goals of Adlerian Counseling according to Carlson et al., (2006) are to: build and maintain a relationship based on mutual respect and trust, create a climate where
clients may experience and articulate beliefs through self-discovery, teach clients the difference between beliefs and mistaken beliefs, and finally to explore new skills and strategies to move forward in the healing process. Adlerian therapists would take this initiative a bit further, and create a goal in which the client was actually completing a task for another individual. Adler called this tool Social Interest. He taught that when a person takes the time to plan a meeting or activity for another individual, the task becomes the focal point. The focus is taken off of the giver and placed on the receiver.

**Common Tests**

One of the discussions surrounding the organic cause is that it is stress induced by either a serious physical ailment or severe emotional crisis. Medical tests are conducted to rule out that the pain experienced is not caused by a biological condition that may be treatable by drug therapy, surgery or rehabilitation. Testing includes, but is not limited to blood work testing for diseases such as lupus, arthritis, muscular dystrophy, multiple sclerosis, and other musculoskeletal related illness.

According to Hamilton et al., (2005) studies show that persons who have fibromyalgia may have trouble voicing their level of pain, and find the appropriate medical professionals. The goals set by this population need to be clear and measurable. Allowing the client to be part of the planning is an important part of the healing process. By giving a reference point to the pain, fatigue, and muscle stiffness is important in terms of communication with the primary physician. If the physician is a family practice doctor, he or she most often will refer the persons who have fibromyalgia to a specialist, such as a rheumatologist. A physical therapist or mental health therapist may also be part of the treatment plan, and part of a multi-disciplinary team. The client needs to be honest and forthright with his or her provider, and candidly discuss what works, what
has failed, and define the quality of life he or she is seeking.

The Cognitive Bias Questionnaire, as listed in the study presented by Shuster et al., (2009) measures cognitive biases as it relates to depression and bias. Distortion may come from the bodies overwhelming inability to deal with the pain level and duration. Levels for an extended duration skew what has been called “normal” and the client finds that chronicity becomes the new “normal.” Persons with chronic pain may be unable to recall what life was like prior to the pain, and has made compensations either physically or mentally to deal with the roadblocks and barriers which affect daily choices. Distortion may also be a coping mechanism that helps to defray the loss associated with this change of lifestyle.

According to Shuster et al. (2009) many tests are used with fibromyalgia, which include, but are not limited to: The Adult Nowicki-Strickland Internal-External Control Scale used to examine locus of control; The Multidimentional Health Locus of Control measuring beliefs of control based on internal, other, and chance; The Center for Epidemiologic Studies Depression Scale gauges depression frequency; The Penn State Worry Questionnaire rating tendencies to worry; Perceived Social Support and Friend/Family Scale rating how well an individual feels support from others; and the Cognitive Bias Questionnaire examines negative thinking. These tests have been used to study the effects of the syndrome, and served as point of measure.

Understanding what triggers the increase in pain, duration, and intensity levels is due in part by the client’s frame of mind, physical health, active or inactive lifestyle, exercise, and nutrition choices. To some patients test are viewed as an opportunity to seek a greater understanding to what is happening within the mind and body. Others may view it from a negative perspective, and look to seek what is wrong, feeling sorry for him or her rather than searching for solutions.

The Brief Pain Inventory is used to assess pain as a whole rather than in specific body
parts. Most often these patients have pain throughout the musculoskeleton (Eggermont, Bean, Guralnik, & Levelle, 2009). Observing a client’s movement helps to discern that chronic pain exists. The gait and balance are often affected, as well as the flexibility and ease of movement of not only the limbs, but also of the core. Seeking the expertise of physical therapist may be an option to help with exercises to build strength, flexibility, and balance into a routine. A personal trainer or a swimming coach trained in working with this population may also be a valuable resource. Tests specifically used when studying fibromyalgia may include, but are not limited to: McGill Pain Questionnaire, Beck Depression Inventory, Wechsler Adult Intelligence Scale, California Verbal leaning Test, and Trail Making Tests according to Luerding et al. (2008).

Walker et al. (2009) discuss using tests such as The Cardiac Depression Scale, Ways of Coping Questionnaire, and Illness Perceptions Questionnaire which are used to observe the five dimensions related to the patient’s diagnosis. They include name of syndrome or disease, organic cause, duration and length of symptoms, the lifestyle changes, and what type of new coping strategies can be taught that are effective. Another model presented is called self-regulatory. The focus is on both the cognitive functioning and the relationship to a patient showing signs and being tested for emotional illnesses. Are persons with fibromyalgia and those who live with chronic pain more susceptible or prone to developing emotional responses in an effort to persevere?

Understanding not only the chronicity of the syndrome, the waxing and waning of symptoms, but also helping the client to understand that it is a life-long malady for which there is no cure is vital. Educating each individual with the knowledge and new skill sets of what can be done to live a quality life full of positive experiences and encouragement, but also with the realistic expectation that there will be difficult days as part of the framework.
The source of frustration to the person who has fibromyalgia comes with the inability to know for certain what each day will bring in regard to feeling strong enough to accomplish the events scheduled on calendars. The loss of the ability to say yes to invitations with confidence is difficult to express. Acceptance of activities becomes contingent upon the way he or she physically feels that day.

According to Sohl and Friedberg (2008), research was done by measuring the response of participants to a question describing a worst-case situation that surpassed their abilities. Sohl and Friedberg’s work was to find out if there was any type of relationship between recall, and the variable of anxiety. Could the excess stress cause fatigue, and therefore create delayed recall time? The Rand Vitality Index was used as a means to measure fatigue. An exercise that may be helpful to show how clients gravitate toward the negative side is to have them complete sentences about how they feel. Repeat the exercise numerous times during different cycles of pain. After enough samples are collected, compare the answers, analyzing them for themes.

The pain does have some link to organs within the body as discussed by Van Houdenhove and Luyten (2008) as it relates to the hypo or hyper activity of the hypothalamic-pituitary-adrenal (HPA) axis. The HPA may inhibit stress and create increased inflammation, which may affect the neurotransmitters. Do those who live with chronic pain, but specifically FMS have a higher tolerance of pain, or is it an issue with the transmission of too many pain signals launched into the system? Pain is something that cannot be seen, only described and experienced by the client. It can be rated on a scale defining parameters to give it a base foundation. Body language and facial expressions may signal someone is in pain, but the measure of how much is subjective to each person’s idea of what pain is, what pain is not, and what it should be.
Society as a whole deals with pain in various ways. Chronic fatigue and physical complaints are common among persons who live with daily pain according to Geisser, Strader Donnell, Petzke, Gracely et al, (2008). Is it something that can be treated with pharmacological remedies? Is this solution helping the patient to cope and tolerate the pain, or is it masking the pain giving a false sense of what the body is actually experiencing. Is the prescription medication habit forming? Will that addictive type of prescription drug create a new set of issues and problems to resolve? Side effects must be considered and the risks weighed. Will the medication cause new diagnoses that require additional medical professional intervention?

Excess amounts of pain result in the persons who have fibromyalgia becoming hyper-vigilant. Prior to the diagnosis of fibromyalgia syndrome, many went undiagnosed or were labeled hypochondriacs. The medical professionals were unable to diagnose, and the mental health professionals often times labeled it as a form of somatic abnormality. Gulec (2008) reminds us that all persons experience physical manifestations of the body even when healthy. The Multidimensional Pain Inventory (MPI) is used to measure both psychosocial and behavioral traits. According to Verra, Angst, Brioschi, Lehman et al. (2009) the MPI can also be used with persons who experience musculoskeletal pain.

**Chronic Pain**

Variables to consider when working with chronic pain clients according to Tunks, Crook, and Weir (2008) are: pain, concurrent demographics, psychological, psychosocial, and employment. How are quality of life and the changes to lifestyle viewed by the person who has fibromyalgia? Is he or she at the point of acceptance and moving forward, or stuck in denial choosing a more isolated existence?

Exploring the coping mechanisms in place from the family of origin which taught the
member how to deal with pain is important to understand. Most individuals throughout their lifetime experience pain, but the duration is typically acute once the cause is identified. People with chronic pain learn to deal with a pain that is more intense, has no identifiable origin, and lasts for a lifetime. How are those skills taught?

Tunks et al., (2008) offer the definition of pain given by the International Association for the Study of Pain as “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. Chronic pain is a highly prevalent condition” (p. 225). This definition not only talks of the physical implications of pain, but ties it to an emotional experience. As a therapist it is important to understand the themes associated with episodes of pain of a client. Is the pain association with a sense that the family will be a support system, there to care, nurture, and promote wellness? Or is pain associated with a traumatic and frightening time when no one came to comfort, and a sense of isolation or stigma became attached to the individual?

LaChapelle, Lavoie, and Boudreau (2008) detail the four relevant elements of The Chronic Pain Acceptance Questionnaire which are activity engagement, pain willingness, thought control, and chronicity. A positive attitude toward the acceptance of pain helps to understand its impact on a person’s life. Use of this questionnaire allows the persons who have fibromyalgia to self-report, empowering individuals to discern how the syndrome is affecting daily life as it relates to a chronic illness. This allows the clients to have a voice in each unique treatment plan.

The client needs to be met where he or she is at on the journey of well-being. Chronic pain is a disability that cannot always be objectively observed and therefore tends to be dismissed or ignored. It is difficult for individuals dealing with the constant pain to express their
level of discomfort when there is no outward physical expression. VanHoudenhove and Luyten, (2008) point out that it is difficult to get better when a person is constantly trying to find medical help. Pain tolerance is an individual register within each of us. For example, there are women who give birth naturally with no aid of pharmacological products; while others describe childbirth as extremely painful and need to the aid of an epidural.

Pain is a subjective measure by each of us. Understanding the complexity of pain, acknowledging that it is real and exists to varying levels of intensity is therapeutic to the education of both the physical and mental health of individuals. An introvert and an extrovert will also have a different framework from which they describe and outwardly express pain.

The Visual Analogue Scale is a tool that allows persons who have fibromyalgia to plot out the level and intensity of pain. It is a scale that gives each individual the ability to mark and measure daily how the pain is today compared to other days. It records pain, fatigue, sleep patterns, and feelings of depression/anxiety (Anderson & Winkler, 2007). This assessment is similar to a daily journal, allowing the author to have a diary of days. In making notations associated with the pain level, a few brief sentences could also accompany it to record what actions were taken to deal with the change, and what activities were postponed. Examining the logs will help the persons who have fibromyalgia put into perspective how much a part of his or her life pain is, and encourage strategies to deal and cope with the evolving lifestyle?

Small goal oriented steps and planning help create positive initiatives toward doing something about the lifestyle changes. One may also questions how the chronic pain over an extended period of time affects the person’s quality of life. Does the pain define the person by limiting activities that were once done independently? How has the constant pain, and loss of independence affected the mind-set and framework of the person who has fibromyalgia? Has the
client accepted the nuances of the pain and learned strategies to work around it or has it taken over and consumed the old lifestyle, requiring one to redefine life and abilities rather than disabilities?

Sohl and Friedberg (2008) discovered that using electronic diaries gave persons with chronic pain the opportunity to report the level, duration, and intensity of the pain as it happened, as well as the physical and emotional responses. The reporting tool gave the person with chronic pain the opportunity to review various segments of time searching for patterns and typical responses. The information gained would be a useful observation to bring into a session to review the problem solving skill set that was used, and the value of a modified set.

Persons who have fibromyalgia live with a syndrome that has no organic cause, but physical and cognitive symptoms. Associated with the syndrome are comorbid diagnoses such as irritable bowel, fatigue, and depression which also need to be addressed. It is common to run tests that rule in and rule out various diseases and syndromes that closely mimic fibromyalgia. The patient needs to work closely with the physician through the journey of diagnosis and treatment.

Model Theories

Cognitive Behavior Therapy Model and the SET Model

According to Anderson and Winkler (2007) Cognitive Behavior Therapy (CBT) sessions examine stress, distortions, reframing, skills, and coping techniques. A treatment plan built around these five concepts is beneficial. Defining the quality of life and changes that result in a lifestyle filled with positive and purposeful living is an appropriate topic to address as well. Life changes for the person who has fibromyalgia; it may be gradual or a sudden onset of symptoms. Problem solving and a variety of coping skills are important components to teach and practice.
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The therapist as the moderator of the group is obligated to set up the format of the group sessions, and foundational expectations. It is important that the expectations be discussed so all members are aware, and actively participate. Understanding that persons deal with the same struggles and emotions helps to break down the wall of isolation is necessary to present, which so many with chronic pain and syndromes have built around themselves due to their limitations? Focus can be aimed at coping; problem solving, new strategies, and dealing with acceptance are all part of the process.

The theory is based on the assumption that physical symptoms experienced by the client translate into inappropriate responses both verbally and non-verbally (Anderson & Winkler, 2007). Individuals react to stress with various coping and defense mechanisms. CBT is an educational tool that teaches an awareness of the results of stress from living with a chronic illness. Walker et al. (2009) explored the use of the therapy with depression as well as various types of arthritis and immune deficiency viruses.

Fibromyalgia is classified as an auto immune syndrome. CBT gives the participants an inclusive experience to group therapy in which to gain a sense of belonging, and offers empathy for others who experience similar levels of symptoms. It also is a place to hear testimonials regarding coping strategies. There is a comfort knowing that the changes in the mind and body are not single episodes, but a common theme among those with the same syndromes. According to Anderson and Walker (2007) group therapy also helped to alleviate sleep problems, often a major concern for persons with fibromyalgia. Understanding that there is a community to support and encourage individuals may set some at ease, which in turn elicits forward movement and acceptance.

VanHoudenhove and Luyten (2008) conducted a study which used Cognitive Behavior
Therapy (CBT) and coupled it with Graded-Exercise Therapy (GET). Their findings suggest that incorporating exercises designed for those with arthritis-like symptoms would benefit. The exercise plan starts off with a few exercises, and as the client continues on the program more exercises are added being cognizant of the effects of pain or lack thereof to the physical body. Including physical exercise with CBT allows the body to be worked at a pace that promotes healing. The mind and the body simultaneously are being stimulated working in harmony with each other.

The GET is an approach that is used when teaching new skills in an exercise program. If the exercises are taught within a class setting, the instructor will often demonstrate the exercise and show several modifications so that clients attending can modify the pose to their ability and comfort level. This type of instruction allows the client to choose the impact exercise level each class.

Another type of therapy within the psychotherapy grouping is the Supportive Expressive Therapy (SET). This type of therapy according to Anderson and Winkler (2007) encourages socialization and group membership building a bond of uniting and creating friendships. The attempt is to diminish isolation and pity for oneself. This type of group therapy environment allows the client to understand that the chronic pain, cognitive, and behavior symptoms are manageable and shared with those who can relate.

The Supportive Expressive Therapy promotes community whether it is at the family, group or societal level. It is much like Adlerian Individual Psychology where encouragement to engage with one another is the norm. The psychological placement of an individual within the family constellation is important to review and understand. Problem solving skills and family dynamics factor into the success of therapy and the approach.
Independent adults have difficulty accepting that they may need the services of a particular organization to provide opportunities that can no longer be realized. Dependency on others in society is seen as a weakness and with it comes a loss of importance to the family unit, work group, or social network. Society focuses on staying young, and promotes an independent and useful persona through the advertising and marketing of products that promise the resiliency and façade of the fountain of youth. Clients who are limited in support systems may benefit from the group environment of SET.

**Adlerian Theory**

The Individual Psychology Theory is credited to Alfred Adler. He was born near the turn of the twentieth century. He practiced medicine in Austria before moving to the United States of America. He found that there was value in educating his patients not only of their physical bodies, but also that there is a connection between the mind and body. In 1907 Adler joined Sigmund Freud as a member of the Wednesday Psychological Society, which later was called the Viennese Analytic Society. Adler participated until 1912, when he formed The Society for Individual Psychology. The original group had nine members who focused more on solutions to the symptoms rather than the cause (Carlson, Watt, & Maniaci, 2006).

Psychoeducation is an important component to psychotherapy according to Adler. He held open forums where the public was free to come and watch an actual session unfold. Avid students of Alfred Adler were his son Kurt Adler, and Rudolph Dreikurs. They carried on the traditions of theories and concepts of Individual Psychology. There are many tools that Adler designed within the framework of his psychotherapy approach. One of the fundamental concepts is to use encouragement as a way to motivate clients to move forward. His goal was to find out what was the cause of the behavior of symptom, focusing more on how to positively approach
the client’s situation rather than hone in on the illness (Carlson et al., 2006).

Adler wanted to understand the client’s definition of who men are, women are, and the world is. Lifestyle choices and the formation is a personal choice. Throughout life individuals are observers of events. As a result of the observation conclusions are made which mold and shape the problem solving skills and perceptions or mistaken beliefs as we grow and mature (Carlson et al., 2006).

It is important as an Adlerian therapist to meet the clients where each person is at on the life journey. The role of the therapist is to work collaboratively with the client toward goals of a treatment plan. Goals need to address the individual steps to take that are measurable and attainable. Each step should bring the client closer to an understanding of the issues surrounding chronic pain that are interfering with normal functioning. How can the chronicity be defined, embraced, and coping strategies be set in place? How do the weekly sessions address the concerns of the present and fears of the unknown future?

Education regarding the physical and emotional ramifications of the labeled syndrome is difficult to process and accept. The client is asked to understand that the diagnosis of FMS typically does not stand alone rather it is coupled with other autoimmune deficiencies or mental health concerns. The comorbid concerns add to the overwhelming emotions expressed, but may also help to explain the underlying concern of the presenting problem.

Alfred Adler often spoke about social interest and how important people are to one another. “To gain the benefits of group wisdom (the cognitive motive), protection (the security motive), and survival training (the competence motive), individuals needed to belong to the group (attachment motive), and had to contribute to whatever extent they could. People still need to contribute. Humans are interconnected” (Carlson et al., 2006, p.26). Adler stressed that
taking the steps to take the time to spend or care for another person changes the client’s issues from being at the forefront and focuses energy and resources for good.

**Stress Reduction Interventions**

VanHoudenhove and Engle (2004) found that the onset of symptoms displayed by a person with fibromyalgia appear after the individual has been exposed to a painful injury, excessive stress or a traumatic experience.

This would suggest that the illness onset might be facilitated by a shift within the stress system from chronic hyper function to hypo function, implying an inability to adequately respond to the new stressors and, eventually, giving rise to long-term disturbances in stress-regulating, pain-processing and immune mechanisms (Van Houdenhove & Engle, 2004, p.271).

Stress can be either a positive or negative event. It is important to have processing and coping skills in place that produce a reaction that is consistent with the exposure. Learning to deal with stress is taught first from the family of origin. Is stress embraced and are solutions explored? Or is the reaction extreme and amplified in comparison to the stimuli? What problem solving skills are employed as a way to minimize the negative effects of the stressful situation?

The family constellation and the role of the parent are essential to the development of the children from both a behavioral and neurobiological stance. Children exposed to constant inconsistencies in the form of physical or psychological demands may have a greater risk to developing syndromes such as fibromyalgia or those that are the result of hippocampal damage according to Van Houdenhove and Engle (2004). Could the prolonged stress be a strong argument showing that prolonged episodes may lead to delayed or non-responsive biological function? The flight or freeze mechanism is not intended to serve the need of a chronic
condition of stress. Constant overuse will cause the body to compensate for the abuse endured.

The level of stress during the formative, early years of a child’s life set the reaction and response times. As more stressful situations are incorporated, the body and mind learn what is an acceptable way to function? The more a person is exposed to these situations, the more likely research shows that a stress related mental or physical health illness will surface (VanHoudenhove & Engle, 2004). The limbic system bears a strong connection to childhood early memories.

Pediatrician offices and children’s hospital facilities also leave impressions and are given teachable moments to discuss healthy coping mechanisms. Is the child exposed to other children dealing with chronic pain? Are those children able to function at some level independently? Is there a sense of hope instilled in daily living accomplishments? The family constellation also plays a role in how pain is both perceived and appropriate response as dictated by the metarules.

Childhood memories are powerful, and help the child to observe the environment. The mind retains a vast amount of memories, those that are given when asked reflect on the present life and ways to cope as well as serving as memory. For those who have difficult memories that emerge, a method called the Willhite Method named after Robert Willhite may be employed to empower the client to understand the actions of the people and events presented in the memory (Willhite, 1991). The client is able to take the memories and transition them into a more positive memory by changing a personal feature that helps to resolve the difficulty presented in the memory. Empowering and encouraging a client to explore strengths rather than weaknesses is the goal.

An Adlerian tool for helping client process memories by the use of tool called Early Recollections. It is a procedure that asks the client to narrate the earliest memories that come to
mind without edit. The therapist records the narrative, repeats it to the client asking for the most vivid memory. Several memories are collected in order to give insight to the both the client and therapist a theme that is emerging (Carlson et al., 2006).

Multi-Disciplinary Approach

Current research according to Shuster et al. (2009) recommends that an integrated model of treatment for persons with fibromyalgia. The model could include, but is not limited to: education, exercise, medication to aid in sleep and pain management, as well as non-pharmacological approaches of alternative methods such as chiropractic care, nutrition, and therapies such as cognitive behavioral. Incorporating various treatment methodologies gives a wider scope of determining treatment that is useful.

Other studies completed by Joshi, Joshi, & Jain (2009) recommend a multi-disciplinary approach that prescribes to the use of prescription antidepressants and analgesics. The United States Food and Drug Administration approved the use of the following drugs for use with persons who have fibromyalgia: pregabalin, duloxetine, and milnaciprin. Patients also benefit from cardiovascular and strength training exercises as well as aerobic and flexibility programs.

Fibromyalgia is a syndrome that affects both men and women, but disproportionately linked to the female population. There are numerous treatment options that include, but are not limited to the use of exercise, prescription drugs, therapies such as Cognitive Behavioral, Supportive Expressive, Graded Exercise, and Adlerian. The positive goals met daily surpass the negative implications of the chronic pain and exhaustion. Clients who are able to feel a sense of accomplishment focus on what can be done and the abilities to move forward according to Hamilton et al. (2005).

A multi-disciplinary approach with the numerous options is preferred as there is a strong
connection between the mind, body, and soul. Treatment focuses on the whole person not only the illness. The first approach would be from a medical stance. Tests need to be run that rule out various diseases that mimic fibromyalgia. The list of test may include, but are not limited to chronic fatigue syndrome, rheumatoid arthritis, and lupus. It is necessary to rule physical ailments out, and endure the test of time as well as the tender point examination.

The medical profession exhausts the list of possible treatable maladies before diagnosing fibromyalgia. There is no one regiment that is standard for all persons who have fibromyalgia because the root cause has not yet been discovered. Agreement among scientists and medical doctors conclude that the nerves and nervous system are involved. The argument is about whether the person is more sensitive to pain or is more pain signals emitted?

A chiropractic approach may be taken as part of the multi-disciplinary attempt. This type of treatment helps align the spine, thus allowing the spinal cord and nerves connected to it the ability to communicate more effectively creating efficiency. This relief is temporary and must be repeated in order to keep the vertebrae aligned. Chiropractic care may cause the person who has fibromyalgia discomfort due to the manual manipulation of the body. Depending on the type of adjustment as well as the pain location and sensitivity of the client the adjustment may do more harm than good. It is imperative that there is open communication between doctor and patient. And that the patient is persistent in the search to find the best care giver to meet his or her needs. It may take multiple visits to numerous chiropractors to find the one that alleviates the pain, even if only temporarily (Hamilton et al., 2005).

Another approach to treatment may be exercise and nutrition. It is difficult to think of movement, especially exercise related moves when one is in pain. The person who has fibromyalgia must understand that movement is as necessary for him or her as it is for anyone
In fact, it is more important because the longer one is inactive, the more recovery time is necessary to achieve the basics of a quality life. So a personal trainer who understands the needs and limitations may be an important member of the team (Kelly & Loy, 2008).

Nutrition is also a growing concern. It is thought that toxins pool within the body of the person with fibromyalgia which are made up of artificial additives and food consumed. The filtration system of the persons who have fibromyalgia does not work as well as those who are not afflicted. Rather the toxins pool and create discomfort within the body near and around the tender points. There are many books written that discuss the importance of nutrition, what to include to reduce the inflammation. Avoiding processed food, selections high in sugar and fructose corn syrup, consuming adequate amounts of water, eating fruits and vegetables are good talking points for all of us to heed. It is especially important to maintain a healthy diet. Without it other serious comorbid diseases like obesity and diabetes may develop.

Still other approaches to dealing with this syndrome include acupuncture, massage therapy, yoga, meditation, breathing, and exercises both on land and in the water. These approaches are helpful to the soul as well as the body and mind. Allowing the person to focus on quieting oneself and reach toward a higher power. Persons who have fibromyalgia must be cognizant of the choice to use alternative approaches, listening to their body’s reaction. It may take the body several attempts of these treatment methods, as with exercising it will take the body time to reply to the actions that have not been done for years. A study conducted by Kelley and Loy (2008) discuss the measurement of the response of cortisol in women who are exercising. Both land and aquatic exercise programs proved to have positive effects on the decreasing the intensity of pain perceived by persons who have fibromyalgia.

The approach taken to aid the mind is therapy is Cognitive Behavioral Therapy an
approach that allows teaches new strategies and behavior to the mind to help cope with the syndrome. Fibromyalgia is a frustrating diagnosis due to the lack of a root cause, symptoms and remedies vary from person to person, and the fibromyalgic does not know from one day to another how he or she will feel and respond to everyday life around him or her.

Therapy teaches and builds coping strategies that one can go to when faced with the challenges of a difficult day. It is a place where one can find the support and education needed to develop a quality of life that is doable. Understanding the mind and body, its reaction to working harmoniously and in a state of chaos where days can be extremely painful day. Guiding the client through the journey of what can be expected when diagnosed with fibromyalgia and how to effectively deal with the symptoms aids in developing a new skill set.

Prescription drugs that have been found useful are those within the anti-seizure family and anti-depressant. All medications should be closely monitored by a physician to ensure that proper dosing is given, and measurements of the patient’s response to the medication is within range of normal side effects. Amitriptyline was also approved by the Food and Drug Administration as efficacious in alleviating the symptoms of fibromyalgia according to Cios and Kim (2009).

There are many types of therapies that are effective as part of a treatment plan for persons who have fibromyalgia syndrome. Choices for formal therapy include, but are not limited to Cognitive Behavior Therapy, Supportive Expressive Therapy, or an Adlerian approach. A treatment plan is built around the unique needs of the client. The plan may focus on ways to reduce stress, as well as nutrition, exercise, and alternative therapies. A multi-disciplinary team approach is preferred as it allows the client to experience the expertise and counseling of a variety of professionals.
The Impact of Pain on Persons Who Have Fibromyalgia

Skill Sets

Control, Boundaries, and Pacing

A study conducted by Walker et al., (2009) found that patients who were unable to find medical professionals willing to work with the diagnosis of fibromyalgia tended to have more psychological difficulty. Control, boundaries, and pacing are key components to incorporate into the lifestyle of persons who have chronic pain or fibromyalgia. There are two types of control – internal and external. According to Shuster et al., (2009) persons who are driven by an internal locus of control have a cause and effect mentality as it relates to actions and the resulting pain. Persons internalize the pain and are less likely to report an accurate frequency and duration, minimizing the chronicity. The opposite is true for persons with an external locus of control they do not view the outcome of pain as a result of action or lack thereof.

Anxiety over loss of control can be measured by administering the Beck Anxiety Inventory. This is a tool that measures 21 items by means of self-reporting. The inventory is used to determine how much interference anxiety is causing based on the symptomology of the syndrome. Discussion regarding the results can benefit both the persons who have fibromyalgia as well as the therapist to set goals within a treatment plan.

According to Reich (2000) the onset of an illness creates chaos and disorder to daily life and routine. A confirmation of the illness allows for processing to begin, and the opportunity to develop a skill set that addresses the changes to daily living. Habits create routines which become familiar and accepted as the norm. Knowing what to expect as the outcome helps to squelch the issues associated with anxiety. Struggling with the loss of control may cause undue stress for some individuals.

A lack of boundaries may cause undue stress. Kelly and Loy (2008) review the physical
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results due to stress. The manifestations include, but are not limited to: headaches, poor circulation to limbs, ulcers, irritable bowel leading to diarrhea, an increase in blood pressure, and a decrease to the immune system. Symptoms can be observed and measured. The goal setting and steps toward creating healthy boundaries may decrease the stress-induced symptomology. The autonomic nervous and endocrine systems are the first responders to stress. They signal the body to choose between the ‘fight or freeze’ coping strategy. Van Houdenhove and Engle (2004) define stress a menace to the delicate balance of the organism. The body’s response to stress is to rid itself of the cause, and resume the balance within once again. The types of stress may be: physical, neurological, emotional or hormonal.

The struggle within the body to achieve homeostasis was examined by Kelly and Loy (2008) as they studied the relationship between the sympathetic and parasympathetic nervous systems. The research revealed that persons who have fibromyalgia have an over-stimulated sympathetic nervous system which seems to be the cause of the chronic pain. The system sends a signal to release hormones as cortisol into the body. The surge of hormone perpetuates they chronic cycle.

It is important to set boundaries. They allow for each individual to understand what is acceptable and what is not. Good boundaries are healthy and teach valuable lessons. All need boundaries whether diagnosed with fibromyalgia or any other illness. Boundaries create an atmosphere of acceptance. Defining individual limits helps to set up realistic expectations.

The Fibromyalgic Impact Questionnaire is a helpful tool used to determine how the syndrome affects work attendance, evaluates job match, and overall well-being. The test is 20 questions in length, and also helps to gauge levels of pain, sleep patterns, depression and anxiety. It is essential to understand the importance of pacing. The persons who have fibromyalgia may
be able to continue working and participate in social activities, but at a different pace than before the diagnosis. As the syndrome progresses over time, the clients learn to set goals to achieve a reasonable pace that allows for the new lifestyle.

Although one cannot predict the pain on a Likert Scale in advance, the Adlerian therapist can work with the client to create an individualized scale that encompasses the definition of a good day through the gradation of a more challenging day. A steady pace is tested by trial and error. Sleep is necessary for all, but to the persons who have fibromyalgia it is difficult for most to obtain sound sleep for an extended period of time. Learning to understand the basics of sleep is imperative, setting an environment, and adhering to a schedule that promotes that end is essential.

Walker et al. (2009) found that coping mechanisms fall into two categories. The first identifies and is problem focused in resolution. The other mechanism is emotionally focused and helps with adaptation to the situation. Emotions can be powerful and overshadow the problem solving skill set of an individual. Learning to use the coping mechanisms effectively allow for the integration of strategies.

Support Systems

Shuster et al., (2009) studied women and the value of a support system. They found that an increase of stress within the framework of the family correlated to an increase in the health concerns women presented. As a woman cares for her family, and those needs increase, the time available for self-care diminishes. Discussion regarding the importance of a healthy support system related to a more positive response when dealing with the health issues from a psychological approach. A solid support system may not always come in the form of an immediate family or significant other.
Education is vital, and necessary to teach those around the client so that each may be a positive force rather than be illiterate and viewed as a source of contention. The support may be the multi-disciplinary team or a support group of those dealing with fibromyalgia. There are times when it is perceived that this syndrome rules peoples’ lives, and creates a self-imposed isolation or depressive behavior may result.

The support group of persons who have fibromyalgia helps to teach each member that he or she is not alone and also offers ideas, fellowship, and educational tips that may help with the coping or pacing portion of everyday life. Shuster et al. (2009) go on to discuss that a strong support system is linked to decreased episodes of depression, helplessness, and the pain associated with fibromyalgia.

**Independence**

The dictionary defines independence as a competency that frees us from the controls that impede our lives. To achieve independence, persons need to take an active role in the choices and actions of their lifestyle. The loss of independence regardless of the reason why is difficult to discern and assimilate. Part of the lifespan development focuses on children learning and understanding the important role and responsibilities that are independence. Taking away those freedoms such as driving a car, caring for oneself, or a loved one is a tremendous loss that takes on the structure and attributes of grief. Client involvement is important to define the goal of independence versus dependency on care givers or support system.

The goal of seeking assistance via alternative medicine might well yield positive consequences to the degree that it reflects patient self-determination or negative consequences to the extent that seekers of alternative medical help are often alienated and
disaffected and have, for varied reasons, derived little benefit from traditional sources.

(Hamilton et al., 2005, p.457).

**Family Roles**

**Communication**

Morin (2009) discussed the importance of giving patients and care providers realistic data about fibromyalgia as it relates to symptoms, and treatment. By setting an honest foundation goals can be set and measured working toward an improved quality of life. The study showed that pain diminished when sound sleep was experienced for longer durations. The body was able to complete the restorative, healing process.

Communication is necessary to the family unit. It comes naturally and easily to some, while others struggle to express themselves or may not be allowed to do such. Keeping the family involved, educating them not only on the syndrome, but what role each member plays in one’s daily life and how those behaviors and physical acts can improve the quality of life. The Adlerian term for this type of interaction is social interest. Defined by Griffith and Powers (2007) social interest is an Adlerian tool that is used by therapist to set a goal with the client to help another person. Caring for the needs of another tends to lessen the focus on the care giver.

Working together as one family system aids the growth and development of all members. It is important that the family understand that the persons who have fibromyalgia deal with issues that may include “lonliness, fears, vulnerability, losses, family problems, sense of worthlessness, suicidal ideation, and dependency” (Anderson & Winkler, 2007, p.456). Prior to the onset of fibromyalgia was the family able to engage in conversation surrounding issues and concerns of the members? Is the family an open system that encourages, supports, and
welcomes dialogue? Or is it a more closed system that does not encourage self-expression?

Measuring self-worth on tangible contributions negating other attributes and characteristics?

Existing research has indicated that the uncertainties that accompany FMS may be one explanation for these patients’ low level of well-being (Akkasilpa, Minor, Goldman, Magder, & Petri, 2000; Kaplan, Schmidt, & Cronan, 2000) compared to healthy controls or other pain patients (Boissevain & McCain, 1991). Their higher level of bodily pain is related to their perception of greater negativity and stressfulness of their social relationships (Davis, Zautra, & Reich, 2001). In addition to these challenges, they report poorer effectiveness of their coping strategies (Martin et al., 1996; Wolfe & Hawley, 1999). The difficulties they experience are increased under higher levels of illness uncertainty (Johnson, Zautra, & Davis, 2006). These results suggest that their coping efforts are not leading to increased certainty and more positive outlook about their current state and their future (Reich & Olmsted, 2007, p. 628).

The support of the family whether it is made up of the family of origin, extended family, community or social family is a crucial component to the support system of each person. Clients who do not feel close to a biological family may reach out to a support group or an educational group. The group dynamics allows for interaction among the members of the group and creates the cohesive experience of a family with expectations, encouragement, and metarules to follow.

Grief is typically thought of as an emotion related to the death. Understanding and negotiating through the losses of a syndrome that is chronic or has elements of chronic pain, it is difficult to deal with the changes both physically and emotionally. The body is unable to navigate and complete various tasks due to the pain’s interference with the cognition that helps drive the body to accomplish them effectively and efficiently. As each of us ages we must come
to grips with the changes over time, the same is true with chronic pain and or conditions. Over time the loss of mobility or cognitive abilities may diminish.

Some may choose to become angry and lash out verbally or by causing harm to themselves through self-doubt, over-medication, or isolation. None of those choices are healthy or promote sound mental and physical health. Adler describes the natural consequences of actions as a result of decision and problem solving skills. The choices made can benefit the lifestyle changes and enhance the quality of life. Or one can choose to destroy the options and opportunities, thus creating more problems and issues to resolve. It is up to each individual to choose for him or herself which journey to take while dealing with a chronic condition.

**Physical Limitation Implications**

Physical limitations for some fibromyalgics can be severe and debilitating. There are those who must use a cane or wheelchair, while others lessen their activity commitments. It varies widely from person to person, and also from attitude to attitude. The mind is very powerful and can aid the body into understanding that movement, activity, and exercise are important segments and need to occur daily. The client typically hurts and is in some degree of pain whether being stagnant or choosing to participate.

Participation in exercise helps the mind and body by the release of endorphins. This promotes a feeling of well-being, allowing the activity to be enjoyable rather than a chore. The absence of movement creates a more likelihood that extreme limitations will set in, and become the norm. A study conducted by Reich (2000) analyzed the relationship between physical mobility, mental health, and the goal of coping strategies.

Dealing with the loss imposed by the physical limitations can be compared to the stages defined by Elizabeth Kübler-Ross (1969) by five stages. The first stage is denial and isolation
focuses on the patient unable to grasp and process the diagnosis. Realization that it is true and accurate is too painful to internalize. Second opinions are often sought. It may take the person who has fibromyalgia numerous visits to medical professionals with a variety of specialist performing tests to diagnose so that when the actual diagnosis is given, disbelief is expressed because of the exhausting journey to this point.

The second stage is anger as the patient wonders how it is possible that he or she is singled out to have this malady. Anger may be shown through outbursts that may be deemed inappropriate or inexcusable. It is way to express an emotion which is part of the process toward the final step of acceptance.

Bargaining is the third step. It is seen as a time which moves the patient on throughout the process to a more accepting place, but still one that has not fully embraced the diagnosis or the course of treatment. It is often an internal dialogue that the patient experiences with a higher power in exchange for a cure from the chronicity of symptoms.

The fourth stage is depression. Some of those who suffer with fibromyalgia get stuck in this stage and the depression becomes a comorbid diagnosis that must be treated professionally. Dealing with the loss of cognitive ability, work, social networks, and physical limitations may manifest in the form of depressive episodes or chronic depression.

The final stage of acceptance allows the chronic sufferer to come to a place where a new lifestyle that incorporates the realities of the present day is what matters. Patients understand that chronic pain changes the way a person accomplishes tasks and communicates with others. It is a place of change similar to the changes that accompany the developmental changes from birth to death. Individuals adapt to their environments and situational circumstances in families by the roles he or she chooses to adapt. Work and social genres expect adaptation and change. So the
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final stage of acceptance requires the sufferer to understand what has happened to him or her, and new ways to experience the quality of life that each of us deserves.

Final Summary

Effects of Cognitive Behavior Therapy

Anderson and Winkler (2007) concluded that Cognitive Behavioral Therapy helps to promote the use of the mind as it incorporates new skills and strategies. CBT works better when paired with other forms of therapy such as SET and GET. This is due in part to the comorbid nature of the fibromyalgia syndrome. Therapies which work in unison focusing on the various diagnoses help the patient see results that deal with issues as a whole. According to Anderson and Winkler (2007) Cognitive Behavioral Therapy coupled simultaneously with Supportive Expressive Therapy work well together.

LaChapelle et al., (2008) discovered that pain management models have moved from the more traditional cognitive behavioral therapy modality to a model of acceptance, which creates a balance between the mind and body. It is vital to have that connection working toward sound health practices. The mind and the body relay messages to one another continuously.

Future Research to Consider

The difficulty with studying fibromyalgia is that it is typically comorbid. Women were the subjects most often due to disproportionate amount of the female gender that are afflicted. In 2001, a study done by Kaschak revealed that the number of women diagnosed with autoimmune disorders, more specifically fibromyalgia showed a steady increase yearly. He questioned why women were diagnosed with the syndrome more often than men and how many persons with autoimmune syndromes are under or misdiagnosed. Future studies could include just men or a combination of the genders. Does one gender respond to certain methods of treatment the same,
better or worse than the opposite gender?

Studies conducted were not longitudinal in nature. Tracking and checking in with patients over a five and ten year time frame could analyze the effects of fibromyalgia through its chronicity, and discuss if age plays a part in the severity, duration, and intensity of symptoms. The question of how demographics play a role should be challenged?

Another area to consider for future research could include the study of brains of persons who have fibromyalgia compared to a control group during autopsies. Compare the size, weight, and density to the brains of persons who had fibromyalgia to persons who do not have the diagnosis. Does the morphology change with the onset of the syndrome? Does the brain deteriorate or change after decades of living with the syndrome? What types of compensation or over compensation occur?

According to Shuster et al., (2009) future research includes accurately measuring the duration, intensity, physical ability, and level of psychological impact would be valuable information to gather during the assessment. The data could be extrapolated into tables giving valuable feedback regarding how the physical variables affect the emotional and internal processing of persons with fibromyalgia. Is there a difference between the pain and fatigue of a woman in pre-menopausal compared to peri-menopausal or post-menopausal? Do the processes associated with child bearing make women more susceptible to the over active pain. What happens to the group of men? Does the level of testosterone vary or remain stable?

Longitudinal studies are important to undertake to observe and record the changes experienced by this population as they become a geriatric population. Would the syndrome still be attached to women or will men develop it as they age, and are exposed to more life stress events? Determining the comorbidity of FMS is necessary. Will it be linked to diseases such as
Parkinson’s disease, Muscular Dystrophy or Lupus?

LaChapelle, Lavoie, and Boudreau (2008) posed the question of determining how a person reaches a point of acceptance needs to be addressed before research on the physical symptomology can begin. Dealing with the psychological aspects of the syndrome may promote the willingness to try the various physical and pharmacological remedies. The exploration of the importance between the mind and body as well as the interactions and influences of each on the other.

Future research suggestions given by Kelly and Loy (2008) include, but are not limited to studies which discuss the effects of exercise as it relates to cortisol levels, long-term exercise efficacy, larger/broader group of participants, the effects and efficacy of group exercises in relation to a support system for promoting improved health, and exploring other intervention methods that may also bring relief with an overall increased quality of life. Van Houdenhove and Engle (2004), suggest that focus should be placed more of a biological level with a high risk group that has been in traumatic accidents or are diagnosed with chronic pain.

Conclusion

The loss of independence and traditional coping skills is a frustration to clients with fibromyalgia along with the ability to find qualified medical and mental health professionals able and willing to work collaboratively in a treatment plan. Coupled by the loss of control over daily life tasks has created challenges to the current lifestyle, with obstacles and barriers to overcome. The medical profession has defined fibromyalgia syndrome to an extent, but because there is no verifiable organic cause agreed upon with certainty at this point in the research which makes it difficult to treat. A multidisciplinary approach seems to be the most effective treatment plan. The team deals with the emotional, psychological, biological, and physical ramifications as a
result of the syndrome.

Fibromyalgia is difficult to diagnose, and therefore persons who have fibromyalgia go for many years without resolution. Giving a name to the symptoms validates the pain, fatigue, and loss of defined cognitive abilities. Understanding and awareness are the first steps toward recognizing that the quality of life changes, which can be a positive change once the stages of grief and loss are reconciled, and acceptance is found.
THE IMPACT OF PAIN ON PERSONS WHO HAVE FIBROMYALGIA

References


