A Psychotherapeutic Exploration of the Meaning of Fibromyalgia

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Abstract

A psychotherapeutic exploration of the meaning of fibromyalgia; the syndrome which does not have a specific aetiology it is a diagnosis given when all other possibilities are ruled out. Medically it is an unsatisfactory diagnosis. Difficult to treat and its management is multifaceted. Doctors, psychiatrists, psychotherapists, psychoanalysts, physiotherapists and social resources are used in the treatment of this syndrome.

Because of the nature of this research the emphasis is on its meaning. Why does the body cry out with chronic pain? What has been ruptured that emanates such pain? What caused this invisible wound that is relentless in its expression?

Firstly the exploration will focus on the literature that expresses the meaning of pain both emotional and physical, on how as human beings we experience emotional pain finding the earliest experience in object relations theory. The research will explore the meaning of pain and loss of the object, how the object is incorporated and what that means. Researching hysteria will give rise to whether fibromyalgia is a hysterical symptom or not. Investigating the manifestation of physical pain and gaining insight into trauma in the psyche will broaden the research to find links to a sense of meaning in this chronic pain.

To broaden the sense of meaning in the research and for the research to be non-bias, a combination of professionals were used in the interviewing process. One GP, one Psychiatrist and three psychotherapists were interviewed, reflecting the fact that fibromyalgia is managed using a combination of care. Pseudonyms were used to protect the identities of the participants. A qualitative approach was used to allow for an in depth exploration of the participants’ sense of the meaning of these symptoms. Semi-structured interview style was used using questions that were aimed to explore their personal sense of the meaning of
fibromyalgia (See Appendix 1). The interviews were transcribed and thematic analysis was used to report the findings.

The findings will report the answers to the questions and will also contain additional information which came up in interviews, which was then elaborated on and investigated further in subsequent interviews. Largely the emotional influence on the symptom was prevalent in all interviews.

The discussion will focus on areas that had not yet been thought of. And will include areas for further research.
Chapter 1 Introduction

_A Psychotherapeutic Exploration of the Meaning of Fibromyalgia_

"Her body was the perfect incarnation of the emptied ego of a person in pain, an ego that has collapsed, caught in the vivid memory of the lost child . . . Physical pain is indeed the ultimate affect, the last contraction of a desperate ego that congeals so as not to sink in nothingness."

(Nasio, 2004 p.1)

1.1 Outline

In this current, a psychotherapeutic exploration of the meaning of fibromyalgia, the researcher intends to investigate pain as is a phenomena, indeed an enigma that is difficult to define and often invisible. Fibromyalgia is chronic widespread pain and a litany of symptoms most prevalent are sleep disturbance, fatigue and depression. Endless doctors’ appointments and clear test results leave the sufferer with more questions than answers.

The description in Arthritis Ireland of Fibromyalgia is that it is an illness of unknown aetiology. This information booklet for patients makes a link between mind and body that emotion affects the severity of physical pain and that many people can link their onset of this syndrome to a physical injury pertaining to an accident or emotional trauma for example; bereavement. Nine pages of this twenty-two page booklet containing information on what drugs best manage the pain and symptoms of fibromyalgia. The complimentary therapy section consists of two paragraphs which makes no mention of psychotherapy and includes aromatherapy, acupuncture and reflexology and states that these therapies aim to treat the person not the condition.
With the initial mind-body connection and then the statement that other therapies aim to treat the person not the condition there is a connotation that they are separate. That psyche and soma are not one, assuming the dis-ease is foreign that the pain is external.

Fibromyalgia is treated with a combination of care and psychotherapy is not often incorporated into the treatment plan. There is a sense that the emotional pain can be treated with drugs and the physical pain can be treated with drugs, exercise and relaxation and sleep can be drug induced to control sleep disturbance.

How in psychotherapy do we work with pain? In psychotherapy the treatment of pain emotional or physical is not separated. They are both one of the same. Unbearable states are contained within the psyche via the defences. They are managed by their inability to come into awareness because of the rigidity of the defences surrounding the feelings and experiences. The defences contain the window into the experience they act as if a gate keeper to avoid the feeling of the contained unbearable states. Only in the transferential dynamic of the therapeutic relationship is there an opportunity within the co-created space for the thawing out of such early trauma for it to be experienced when there is enough in place and the ego is strengthened for integration of the experience. The transference allows what is unconscious to be expressed via the other.

The counter transference allows an opening up of the tolerance and understanding within the therapist to accommodate the space and range of the unbearable feelings finding expression in the transference. The compulsion to repeat to remember is played out in this constantly.
Without constant self-reflection, internal awareness of oneself and supervision this is impossible. When Nasio (2004) describes a client’s pain as being foreign it highlights how far from consciousness the trauma can be and the danger in not being attuned to oneself and the client to feel and comprehend its presence, "to attribute a symbolic value to a pain that is in itself pure real, brutal emotion, hostile and foreign" (Nasio, 2004 p.2).

1.2 Aims and Objectives

The aim of this study is to explore a psychotherapeutic meaning of fibromyalgia. To do so drawing on the experience of professionals who treat persons with this widespread chronic pain is necessary in a hope to find some link to a possible aetiology. Exploring the psychoanalytic theory around object relations, pain, loss, hysteria and trauma will lend to an understanding of the phenomena of pain.

The information available on fibromyalgia is largely from a medical model. Studies are of quantitative research concluding; relief of symptoms with a specific drug or physiotherapy intervention. Most of the research is scientific and mostly measurable. There is a gap of integrated research on fibromyalgia. It is as though there is a void of meaning of this pain and myriad of symptoms and also a loss of the person suffering.

“To give a meaning to an unfathomable pain is, in the end, to provide a place for it within the transference, where it can be shouted, cried, and used up by the sheer accumulation of tears and words.” (Nasio, 2004 p.13)
Chapter 2 Literature Review

2.1 Introduction

A psychotherapeutic exploration of the meaning of fibromyalgia, pain is a phenomena an enigma difficult to define and often invisible. When the psyche is wounded or ruptured the ego becomes impoverished and in its last efforts to sustain the upheaval of its drives, physical pain is its last defence. The aetiology of fibromyalgia is unknown and its symptoms are that of widespread chronic pain; in gaining insight to psychical pain and its’ assault on the body there is a hope one can find a window into the threads of meaning in the physical manifestations of this syndrome toward a sense of its aetiology.

2.2 Object Relations

Melanie Klein (1946) in her paper on Notes on Some Schizoid Mechanisms describes the object relations theory from the beginning of life. Object relations are the dyadic relationship of mother and infant and exist from the beginning of life. For the infant the first object is the mother’s breast. When the infant experiences the breast as gratifying it is internalized as good and when it is experienced as frustrating the breast is internalized as bad. The ego hasn’t the capacity to see the whole object as bad as this is overwhelming so it is split in the ego into love toward the good object and hate toward the bad object. The beginnings of object relations are patterned by the process of introjection and projection. If these projections are managed by the mother whereby she makes it manageable for the infant, integration can take place. These processes are essential in the building of the ego and super-ego and object relations which enable the infant move through normal development and prepare the child for the onset of the Oedipus complex.
Klein (1946) illustrates the necessity for these defense mechanisms, the early infancy anxieties characteristic of psychosis which drives the ego to develop particular defense mechanisms. These defenses of the ego are mechanisms of splitting the object and impulses, idealization, denial these defenses enable the infant to avoid emotions of inner and outer reality. Becoming fixated at this point is the etiology for psychotic disorders. In the oral-sadistic stage destructive impulses are phantasies of attacks on the mother’s breast; these develop into assaults on her body by all sadistic means. The oral sadistic stage is rife with persecutory fears with impulses to steal the mother’s body of its good. The anal-sadistic impulses to put excrement into the mother’s body and the desire to enter into her body and control her from within, these are defenses against primary fears of being poisoned or devoured. This is the paranoid schizoid position.

The threat of loss or abandonment of the good object - if experienced too early and too often - inhibits the infant’s ability to move into the depressive position. If the infant has experienced more bad than good from the mother there is not enough good object in place to withstand the despair and loss experienced in the depressive position. For the infant experiencing mother as frightening, withholding or non-responsive triggers destructive impulses and phantasies, these become stronger and more primitive, the defences to these are a flight to repair and laden with guilt of having destroyed the whole object. The infant projects these impulses and phantasies into the object, if not made manageable via the mother she in turn will project these back into the infant along with her own projections and will reinforce the bad object.

At approximately six months old during the weaning process the infant moves into the depressive position. Idealisation is the essential element of the manic position and is bound up with denial. Without partial and temporary denial of psychic reality the ego cannot bare the imminent disaster, it feels threatened when the depressive position is at its height.
Omnipotence, denial and idealization, bound up with ambivalence, enable the early ego to assert itself to a certain degree against its internal persecutors and against an unquestioning and death-defying dependence on its loved objects, to make further advances in development.

In the depressive position for the first time the infant experiences the object as separate. Until this point infant and object were one. It is a normal developmental phase the working through of the depressive position is necessary developmentally. This working through strengthens the ego and brings cohesion. With this cohesion integration is possible and along with it the ability to see the other.

Klein (1946) confirms it can have lasting effects if there is an inability to work through the infantile depressive position it results in depressive illness, mania or paranoia later in life. The inability of saving and securely reinstating their loved objects internally, they must turn away from them in an effort to deny their love for them. To face this love, the grief and loss would have to be faced. Escaping into these states is the ego’s defence to the suffering connected with the depressive position.

This can be seen in as failure to experience mourning. Emotions become inhibited and love is denied and turned into intense hate. At the same time, the ego uses different ways of dealing with paranoid fears which reinforces the hatred. The internal 'bad' objects are manically subjugated, immobilized and at the same time denied, also projected into the external world. Failure to experience mourning may escape from an outbreak of manic-depressive illness or paranoia only by a severe restriction of their emotional life which depletes their personality. The mania offers a relief from the intense guilt felt in the depressive state. The loss is too great to work through later in life the pathological morning is one that dates back to the depressive position.
2.3 Mourning the loss of the object

Freud (1917) in his paper Mourning and Melancholia his view is that there are three preconditions to melancholia the first being the loss of the love object, ambivalence also regression of the libido into the ego. Ambivalence in the case of melancholia is shrouded in what is repressed connected to the traumatic experience with the object, other repressed material is liable to be activated. Melancholia is often evoked by the perceived loss of the love object. In instances of melancholia being triggered by an actual death or loss it can be a case that although the sufferer will be aware of whom he has lost there is an absence of what was lost to him. What was lost in the internalised object and the perception of it within the ego.

Freud (1917) connected melancholia to the threat of a loss or abandonment. For the melancholic the sleeplessness affirms the rigidity of the condition, there is an inability of drawing in the necessary “cathexes” for sleep (Freud.1917. p.253). In this paper there is a connection between melancholia and somatic symptoms where he links the mania to the economic nature first of physical pain and its parallel to mental pain.

2.4 The incorporation of the object

Nasio (2004) explains that the object is incorporated in fantasy that is fuelled by desire for the other which structures the order of the unconscious. It is as though in incorporating the other like an amoeba enveloping its food this process is similar in the taking-in of the other. The fantasy in internalising the other clouds the reality the image distorted by a veil and bound in the unconscious marked by symbolic representations that restrict how the bond of love is seen. It is from this unconscious place ruled by fantasy that we see the other.
In the symbolic, the bond’s function is to mitigate desire. The object governs the limit of desire, its protective function is against turmoil “jouissance” is limited. This process facilitates repression.

It is the life in the other a force in the unconscious that causes the person to be who they are without this the self no longer has any consistency. The real is the life; energy that emanates from the body and unconscious of the other excites the person as long as the other is living. It is quite difficult to distinguish clearly this force that emanates from the body and from the real force of desire mutual between the person and incorporated object is what binds them. In this process the loved one lives within as a fantasised object which re-centres desire complete satisfaction becomes unattainable. This process increases the love for the object. Lost with the love object is the internal framework of desire, the very rhythm.

According to Nasio (2004) the imaginary consists of a duplicate image of the actual other internalised in image in the unconscious. Internal images are imposed on this image along with projections, reflecting self-images, affected by the force of desire. The images are fragmented and are of self and other. When recalled have an instant effect on emotion provoking feeling. These images reinforce narcissistic love. The reliance on the actual life in the body of the other in the external sense is needed to keep the image of the object live; the vividness is directly linked to this rhythmic force of desire, charging the images with energy creating feeling.
2.5 The pain in losing the love object

“Without the censorship of repression, we would know the ultimate pain of an unlimited jouissance.” (Nasio, 2004 p.126)

This fantasy relies on the living body of the other. When the loved one is lost the fantasy collapses and in its place pain emanates. In the loss of the other the source that has nourished desire is quashed. The force lingers within the psyche indestructible and inexhaustible. The mirror that reflects the internal image is lost along with it the rhythm to which the force of desire vibrates. In losing the rhythm, the symbolic other is lost so is limit which has held consistency in the unconscious. The actual other lends to cohesion, without the other something tangible is lost, the fragments unattainable with the loss and so vital to the structure. The ego collapses and body and psyche become imbued with pain, from this overwhelming pain comes limits in sense and meaning Nasio (2004).

Nasio (2004) affirms there is no difference between psychical pain and corporeal pain they are one of the same and both follow a process whereby three moments exist: “the rupture, the trauma, and the defensive reaction of the ego”(Nasio, 2004, p.16). Psychical pain experienced in the body is the sudden loss of body armour. The physical sensation is one of disintegration. The primitive release of this soul wrenching pain is dissipated in the scream. The mind tries hard to find words to comprehend what was lost and find a sense of reality in the unknown that lies ahead. This is an attempt to lessen the pain in the body and disperse the pain into the psyche (Nasio, 2004). The death of the loved one represents the death of the limit to which satisfaction can be reached or the limit of dissatisfaction. The work of mourning is to reconstruct a new limit. This enables the drives to be tolerable.
2.6 Hysterical Symptoms

“The uncanny substitution that takes place: at the centre of the seduction theory is a young girl seduced by the father; at the centre of the Oedipus complex, there is a young boy constructing erotic fantasies about his mother. In the new, substitute theoretical formulation, then, the little boy takes the place of the victimized girl.” (Evans, 1989, p.80)

Hysteria is not exclusively a female structure; the structure has been seen in men in the course of history. Charcot (1889) viewed this nervous illness in men as being triggered by a physical trauma which was brought into light with man’s interaction with industry. He highlights the error of the stereotype of a the effeminate man being hysterical and through his words “the vigorous artisan, well built, not enervated by high culture, the stoker of an engine for example, not previously emotional, at least to all appearance, should after an accident on the train, by a collision, become hysterical for the same reason as a woman.” (Charcot. 1889 p.222) He makes the link between trauma and hysteria although he illustrates it via an external trauma to the physical causing the onset of hysterical symptoms.

For Janet (1901) a key psychological factor in hysterical patients is their state of “absent-mindedness” stating it is an actual natural and perpetual state which limits the person from having the ability to appreciate any other sensation than the immediate one occupying the mind.

Freud (1957) Studies on Hysteria make a link between the loss of the object and highlight it in the case of Elisabeth Von R, he describes how the “hyperalgesia” that mainly affected her muscles which as a disorder is mostly responsible for the diffuse and local sensitivity to pressure when applied to the muscles he describes as “rheumatic infiltration” of the muscles, the hard fibres in the muscles causing sensitivity.
Freud (1957) describes how the organic change in the muscles, indicated that as the symptom persisted and pain became of exaggerated importance, the reason being was that the neurosis attached itself to the symptom in an effort to find somatic expression. His explanation of this is that the pain was not created by the neurosis but used and maintained by it. The hysterical pain that Freud described as always being genuine and organic but the difference is their unconscious meaning in the neurosis attaching itself to the particular symptoms to be made conscious. In beyond the pleasure principle Freud (1922) relates the meaning of feelings of pleasure and pain that have such a profound effect on the psyche. The unconscious drives look for expression. When repressed sexual impulses arise in the Id, they fight their way into consciousness recognised by the ego and are translated and experienced as pain.

Isaccs (1952) illustrates the evidence of phantasy that exists without words that is prevalent in hysterical conversion-symptoms. These neurotic symptoms highlight how ill people display a primitive, preverbal language whereby use is made of sensation, postures, gestures and visceral processes to process and express emotion and unconscious wishes. There is a psychogenic character in these bodily symptoms. Interpretation of such symptoms reveals specific meaning in each detail of the symptom. When specific phantasy is expressed there is a direct link to the form and intensity of the body part affected, this reflects changes in phantasy. The symptom therefore has an unconscious meaning to a specific phantasy. The symptom is the id's only form of expression translated by the ego into conscious pain.

Cardinal (1983) in her harrowing and frank account of her analysis describes her symptoms, her sickness and her madness as being all that was repressed and all that she had lost. Her symptom was something real that could be measured, analysed, one she could find words to describe and which gave her something tangible to investigate. The relentless flow of blood she recalls as having loved making it the centre of her illness. She makes a link between the enjoyment in holding onto her symptom and the idea that such a symptom could be the
aetiology of her madness. She writes “What woman would not have been driven insane to see her own sap run?” (Cardinal, 1983 p.4) When her analyst wouldn’t let her speak of the symptom it stopped, no longer consuming her every thought. Nasio (2004) writes that pain is the last defence of the ego against madness. It reflects the brokenness of the ego. The defences are worn out, no longer able to withstand the internal suffering.

2.7 Physical Pain

“I do not possess pain it possess me: I am pain” (Nasio, 2004 p.49)

Nasio (2004) describes pain as being impossible without an ego it is the ego that recognises the loss of the loved one, sees the upheaval of drives in the Id and translates it into conscious feeling. Naming the Id as “the true source of pain” (Nasio, 2004 p.42).

Freud (1929) in Civilisation and its discontents describes how living in the world causes the human race to suffer because humans are ruled by unconscious drives and the necessity for repression to be a part of society. This repression which is necessary ruins the imagined pleasure causing people to succumb to suffering.

Physical pain is in affect an emotion, a bodily sensation that can only be experienced via an actual symptom. In all physical pain there is unconscious meaning to be found. The experience is its expression.

Nasio (2004) describes pain as an object of drive. “Pain is one of the forms in which sexuality appears in transference” (Nasio, 2004 p.77). When the ego identifies with the masochistic and sadistic other and assumes both roles, the character of the sadomasochistic fantasy becomes imprinted in the psyche creating a sadistic superego and a masochistic ego. For pain to prevail ego, other and pain become one in the same fantasy. For pain to be sexual
jouissance, the pain emerges the moment the ego deserts external reality to live through the objects of fantasy alone. He recognises that the ego identifies with pain as an object whereby the libidinal circuit is organised and the libidinal circuit turns.

2.8 Trauma in the Psyche

“A dangerous situation is different from a traumatic situation. While danger awakens anxiety, trauma provokes pain.” (Nasio, 2004, p.127)

Ogden and Minton (2000) view trauma as somatic, held in the sensorimotor processing of the individual. Symptoms of trauma are bodily based. They state that the majority of traumatized clients when the trauma has not been worked through and integrated become fixated on the trauma. Traumatic states such as dissociation, intrusive images, sounds, smells, body sensations, physical pain, constriction, numbing and the inability to modulate arousal is symptomatic. The sensations are felt in the body and are rarely linked to emotional and cognitive functioning. Kolk (1987) describes that in developmental trauma bodily sensation, disassociation and a lack of motivation are psychosomatic reactions to the trauma. Its memory is held in the body. It is as if the person is stuck in the freeze response, helpless and these symptoms are suggestive of passive defences whereby the person cannot actively defend against danger. The danger is in the experience which has been disavowed, the trauma being outside awareness. It is felt by the individual who is experiencing such trauma that they are at the mercy of their sensations much like an infant would without the ability to regulate the bodily sensations. In somatic therapy there is a belief that the trauma can be safely accessed through the bodily sensation and psychosomatic reactions.
Nasio (2004) explains that trauma lies dormant in the psyche, imprints itself to be recalled. When there is a trigger the actual trauma is forgotten but when triggered the memory of the pain in the psyche is experienced as a rush of violent energy by the ego. When this energetic rhythm is in turmoil it finds expression in the physical tensions and translates into physical pain.

The literature represents the pain in relation to the other, pain of repression, love and hate. It highlights the necessity of the other in limiting pleasure. The energetic rhythm in the dyadic relationship of mutual desire when the other is lost, the rupture in the psyche scrambles to find cohesion. Displacement from what was lost onto a new object - *Pain* - is identified in the ego and is invested in the libido. Physical pain becomes an expression of the unconscious wound of all that is lost.
Chapter 3 Methodology

3.1 Aims and Objectives

Most of the studies published on fibromyalgia are that of quantitative research they are based on symptom relief from a specific intervention. The quantitative research does not focus on the meaning of the symptom or allow for an exploration of its meaning. For the purpose of this research a qualitative approach will be more appropriate. Dallos and Vetere, (2005) suggest that qualitative research method permits the participants’ voices to be heard and for the individuals experience to be seen in its entirety. They also say that this method allows for the emphasis of subjectivity, as each person’s experience is unique. In a thesis of this size it is not possible to review all materials relevant to the subject matter.

The purpose of this research is to explore the meaning of fibromyalgia from those who treat the people that suffer with this chronic pain. To explore a broad view of what the general sense of this syndrome is. It will be an inquiry into the meaning of this through the experience of small number of therapists, five of whom are treating people who suffer from fibromyalgia syndrome. The process of these interviews will involve relating the stories of participants to existing theories of fibromyalgia and the meaning of the syndrome. The following list outlines the specific objectives of the research:
1. To gain insight into what their sense is of fibromyalgia
2. To explore how their approach helps the person suffering from fibromyalgia
3. As fibromyalgia is of unknown aetiology to explore their understanding of what is causing this pain, exploring a possible common link
4. To explore if there are commonalities in their experience to gain further insight on this syndrome
5. To contribute to existing theory

3.2 Methodology Approach

This qualitative research will aim to explore the meaning of fibromyalgia to build on the theory by turning to the individuals who have personal experience with the phenomenon under study, and will allow them a voice to express their own experiences and sense of meaning (McLeod, 2001). Using the qualitative approach will allow for focus on the individual meaning and experience and it will place emphasis on context, emergent design, open-ended data, and inductive interpretation, this will allow for free flowing interview. This current research is therefore, an exploration of an individual’s meaning and experience.

3.3 Research Strategy: Thematic Analysis

Thematic analysis will be used as a method for identifying, analysing and using themes within the data. Themes and patterns within the data will be identified in an inductive way which means the themes which are identified will be evident in the data (Braun & Clarke, 2006). The data in each transcript will be given equal attention. The data will be split into potential themes to complete a thematic map of the analysis. These potential themes will then be refined to specify each theme, naming each theme that illustrates the core concepts of the responses associated with the theme. Excerpts of data will be then used to illustrate the themes that have arisen from the analysis procedure (Braun & Clarke 2006).
3.4 Research Design

The research design is qualitative to draw on how those in the sample group have experienced fibromyalgia and to seek their differing sense of its meaning. During the interview process this will allow for the research to be open to the experience of the interviewee. The qualitative research will be conducted by five interviews and will be approximately 30 minutes long. The structure of the interview will be semi-structured with a short set of appropriate questions on the topic in exploring the interviewees meaning of the symptoms or condition in their experience of clients or patients with fibromyalgia. The data collected will be transcribed and there will be a process of thematic analysis. In this process relevant themes or themes which have not been considered in the research will be examined. This process will create an opportunity to find if there are commonalities in their experiences or not. The qualitative approach will be used in order to explore in depth, the real life experience of the participants in their treatment of fibromyalgia. The objective of using this approach is to gather information-rich data with a subjective and experiential content. This data was then analysed in order to extract themes that conveyed the participant’s subjective meaning of the subject under examination.

The research questions pose a number of objectives in order to gather a broad range of data for analysis and thematic extraction. Objectives of the research are to establish whether or not the participants have a sense of the aetiology of fibromyalgia. In their experience has there been a link between trauma and fibromyalgia? It will explore the link to hysteria and in their experience their sense of meaning of the symptom.
3.5 Sampling

For a psychotherapeutic exploration of the meaning of fibromyalgia, three psychotherapists will be chosen who are accredited and have experience working with clients who suffer from fibromyalgia syndrome. A general practitioner who treats patients with fibromyalgia and a psychiatrist will also be chosen. The research will be broader and allow for identifying areas of consistency amongst treatment and highlight where they differ. Having a variety of different perspectives will give rise to the different meaning attached to the individual and or the symptoms or condition. Fibromyalgia is treated with a combination of care it will give an inclusive sense of the meaning of this syndrome to include all of those involved in the care. Qualitative research requires a small sample group that is purposively selected because of compatibility of their experiences to the research topic (McLeod, 2001). In selecting the sample phone calls will be made, to those relevant to the sample group requesting they take part in the study. Once agreed a letter will be sent detailing the planned research and interview style.

3.6 Materials

The materials required to carry out this research project include a list of questions, Dictaphone and pens and paper. Consent forms to be signed.

3.7 Data Collection: Semi-Structured Interviewing

These will be one to one interviews in person to gain insight of their experience and meaning of fibromyalgia and its treatment. The questions will be designed to allow openness to the experience of the interview and will be conducted in a manner that is organic. The semi-structured interview questions will allow for a depth of content which will come from the individual’s experience which is required for thematic analysis. Each interview will be taped and transcribed verbatim. The benefits of the semi structured interviewing technique are
highlighted by Wildemuth (2009), who emphasises that the interviewer has a certain amount of room to manoeuvre with the way the questions are structured. This affords the interviewer the opportunity to explore areas that they deem to be significant, to maintain the natural flow of the conversational tone, and to avoid rigidity and the possible loss of relevant material.

3.8 Ethical Considerations

The sample group will be provided with information regarding the research topic and the structures of its design. This will include their rights as research participants outlining the voluntary nature of the study, their right to choose what to disclose as well as the right to withdraw from the study. The right to withdraw from the study will be noted in the informed consent form that any participant choosing to withdraw from the study can do so on a specific date three weeks prior to the hand in date. This information will be given to the participants prior to the interview in the form of a letter. There will be an opportunity for participants to raise any queries regarding the research or the letter received. In line with Kvale’s (2007) guidelines, participants will be briefed in greater detail about the nature of the study and to the nature and procedure of the interview prior to the interview. At this point participants will be asked to give written consent to their participation in the study they will be asked to read and sign a consent form.

The participant’s identities will be protected using pseudonyms on all documents and will be used on the transcripts also. Confidentiality will be ensured. None of the meaning or content will be changed only identities will be protected. Only the researcher will have access to the interview transcripts and these will be stored on the researcher’s personal computer which only the researcher will have the password for and access to.
Chapter 4 Data Analysis

4.1 Introduction

This chapter focuses on the findings from the interviews that were carried out on a psychotherapeutic exploration of the meaning of fibromyalgia. Five professionals working with patients with fibromyalgia were chosen. As fibromyalgia is managed using a combination of care, one GP, one Consultant Psychiatrist and three Psychotherapists were interviewed. The interviews explored the meaning of this chronic pain and focused on trying to find a link to a thread of meaning or new insight into its dynamic symptoms. The results of the interviews were examined and using thematic analysis, themes and sub-themes which were extracted in order to report the findings. Pseudonyms have been used to protect the identity of the participants and will take the form of, P1, P2, P3, P4, & P5.

The analysis was not ridged to the questions posed in the semi-structured interview if there was a sense that something was of interest in deepening the meaning questions were added spontaneously to deepen meaning. When interviewing P1, psychotherapist who works with people with fibromyalgia and runs support groups, a theme of loss was emerging during the interview. Although it was a loss of the future that was being expressed, based on the literature review, a question burned about earlier loss.

4.2 Loss of the object

During the thematic analysis it was apparent that loss was a factor; a different type of loss for different clients but loss came up as a trigger in most cases. Actual loss was minimal and there was a common theme of a lost childhood.
G. “I noticed that you mentioned loss loads of times and I am wondering about that in relation to early loss or a perceived loss in childhood?”

P1 “Completely absolutely well “I know everybody is not the same” being diagnosed with fibro due to an early loss... It’s funny you should ask that I would be inclined to say no, but I’d say I’ve dealt with loss of some kind or another.”

G. “A rupture in the bond?”

P1. “Ah, no but you know what every one of the clients I’ve dealt with to date even if it’s a loss of a childhood from their up brining. And your handing that back to them. I think through counseling your allowing them be themselves again finding their identity and I think that’s very important and I think I do an awful lot of that through my counseling is allow the person find themselves trying because they were lost in the person they were meant to be, em yeah.”

G. “In your experience would you see it as an inability to move into the depressive position?”

P5. “The inability to move into the depressive because it’s too painful, so many people have said to me I’d rather the physical pain than the emotional pain. They have said, I’d rather have cancer.”

P2. “Well my view of that would be it’s a spectrum, how many human beings lose control and surrender completely. The child has to do it the adult doesn’t.”
During the interviews there was a strong sense that the physical symptoms were a defense to the emotional pain. There also seemed to be a catharsis in experiencing the physical pain in that in many ways it expressed the emotional wound contained within the psyche.

P5. “The last man I saw was a carpenter; lost his business in the recession, young kids and couldn’t manage. Developed pain went to rheumatology, and was told it was fibromyalgia…”

The onset in this case was triggered by a loss. Also this was the only man that was mentioned in all of the interviews. None of the other participants had experience with working with a man with this diagnosis and when asked why they thought the ratio of sufferers were a higher amount of women than men, they didn’t know why.

When P2 was asked about early loss in the dyadic relationship between mother and baby he was asked was there a rupture in the bond, his answer was: P2. “Well it’s not the rupture, the bond was never there it’s not the rupture it would be different and in eh, instead of the bond there was hostility, the mothers rejection, it wasn’t even emptiness it was lack of safety.” A child cannot bond in nothingness, bonding is impossible with a possessive or indifferent mother. If bonding is not present the necessary process of separation from the mother is missing. This would be the schizoid stage. In this piece there is an aspect of nothingness that would bring up a question of structure.

In this answer there is a difference to the other interviews his view is that there is no bond. Interestingly only P5 answered this question on the economic factor in the symptom. The other participants were surprised by the question and couldn’t link it to fibromyalgia. In answering if there was an economic factor for example, a gain in the symptom in the example he gave, also contained the fear of loss. P5. “In a sense it’s the economic factor in the pain even as it is a defense it represents this…I remember very clear had facial pain, she had a
deeply unhappy marriage, her husband was a violent alcoholic and she developed severe facial pain that she could no longer look after their children. She had a pain in her face so he stopped drinking and started bringing the children to school and he did a cordon blue course in cooking and started to prepare meals for her. So I asked myself how quickly is she going to get better. The risk is if she gets better he says well have no need to remain off the drink, I don’t need to take the children to school and no need to spend half my day in the kitchen. So is she going to get better? This is the complexity, because she was so hurt by him that I didn’t see her getting better anyway and certainly she had so much to lose in getting better you would say it was almost in her interest to remain sick.” Instead the physical pain was endured at the expense of feeling the grief and loss of the ending of a relationship that isn’t working. If the inability to move into the depressive is correct at what cost would one hold on to an unhealthy relationship to avoid feeling the morning in the depressive position?

4.3 Pain

P3. “What I see is it’s a physical manifestation of people experiencing particular symptoms out of psychosomatic origin that is how I would see it em, so that could be related to trauma, stress, loss.” From the medical model perspective the interviews reviled there is no doubt that this pain is of emotional origin. There was no doubt that the pain is real. Even though the aetiology is unknown its physical manifestation is a result of psychological pain. P3. “I don’t think is in a physical complaint within the physical body I think their symptom is in fundamentally of psychological origin and that doesn’t make it any less real because pain irrespective of what is causing it is pain, pain is pain.” P5. “….but it’s not due to a disease it behaves more like an emotion and the problem is almost like in the control center and the problem may have arisen in the control center because of very traumatic things a person has experienced and very painful, emotional painful things someone has experienced.”
Interestingly P1 and P4 mentioned that it is difficult for fibromyalgia sufferers to sit. When asked why, it was contributed to the pain. It was inferred that most stand for their sessions. The pain being in the pelvis and hip area, some attributed it to whip lash or earlier injury.

P4. “And I have some people most people with fibromyalgia are much better standing than they are sitting actually work on things here they can lay down they usually can’t stay in the same position so it’s a combination of sitting or not the client I’ve seen the longest just doesn’t sit she has learned it. If she sits it makes things worse so we either do it laying down or standing up.” Learned it seemed like an odd way to describe it, why did she learn to stand it seemed the action was loaded with fear. When P4, was asked; could it be fear that made it preferable to stand? He said; P4. “I don’t think there is a fear in doing it it’s the pain of actually doing it and it’s not like they are sensitive they are actually enduring more pain than most people could take.” Also, P1 said that her clients with fibromyalgia preferred to stand because sitting was too painful. P1. “If they want to stand that’s okay too and walk around because they are in pain. I have had clients that have had to walk around the room while there talking to you because they are in too much pain.”

P2 used a description he client used to describe the pain. P2. “…symptoms such as, a lot of physical pain and a lot of joint pain, the body screaming in some sense, as how my client would have described it.”
4.4 Identification with the Symptom

During the interview process when asked about their experience of clients with fibromyalgia. Had they noticed an identification with their symptom? P1 said no, the other two avoided the question and answered something different, both P2 and P5 answered the question.

When P2 answered the question he stated that until his client went to a talk on childhood trauma and read a book associated with the topic she had previously attributed all of her symptoms to fibromyalgia. The question posed in the book was as follows; P2. “What would she loose if she didn’t have fibromyalgia? And, she found that very relevant that she hadn’t thought about it in that way before, you know. What is the upside to her having fibromyalgia? And she feels that there is something in that and she is not sure exactly what it is.” P5. “When you look at identification certainly with some over time it is what defines them so you take individuals, who you know, you can meet someone and they would say hello, I’m a nurse, and some might say there identity is tied up with their career. Some people with a lot of chronic disorders become like, I’m a pain sufferer. It’s all encompassing.

Lucas (2009) in psychotic depression he emphasises, the patient is “.totally identified with an idealised ego-destructive superego, which remains tyrannically in control.. There is a pull to remain in identification with the absolute in order to avoid all the confusing mixed feelings towards the ideal that result from starting to experience separateness.” (Lucas, 2009, p.278)
4.5 Sleep Disturbance

Although this wasn’t one of the questions on the interview list it was something that came up repeatedly in the interviews. When asked about what they thought of the sleep disturbance in fibromyalgia there were very different interpretations of it. All were asked was it a fear of sleeping due to a fear of unconscious processing.

Although P2 was open to the possibility he felt it was more to do with a lack of control in sleep. P2. “One of the characteristics would be a tendency towards control that and that need for control would link with your lack of control in sleep that their life and how they have led their lives control would be a significant factor. In who they would relate to and how they would perform attachments and if their control was challenged in a significant way they would leave the relationship.”

P4 was describing trauma disrupting sleep and mentioned that the body when it cannot sleep for a long time has to sleep or it will die so the dreaming stops. P4. “Because when it first happens the body tries to process it through the dreaming at night one of the things that might happen when you’re trying to dream about a traumatic reaction you get it so strong that when you dream it you can’t contain it and it keeps you awake.”

When P5 was asked he attributed the disturbance to stressful times form all three modes of origin. P5. “In the bio/psycho/social model and sleep cycles and all of that, what can help is an old fashioned antidepressant amitriptyline. It’s non-addictive and the person gets a better quality of sleep and more restful sleep. And be more resourced.”
P1 contributed the disturbance to the symptom. P1. “Depression can kick in and also the bladder infections and IBS and restless legs it interferes with sleep.”

The findings in this area were varied and there was little commonality.

4.6 Fibromyalgia and Sexuality

All were asked; what is your sense of fibromyalgia and sexuality? The findings were split between organic and emotional links.

P1. “Yeah, okay a lot of them could have problems around it because of their pain and lack of sleep, and at the end of the day sex is the last thing on their mind and their lack of libido due to the antidepressants.”

P2. “In terms of sexuality exactly would probably always have to be in relationship the man would be seen as safe and some ways also punishing and intimidating but relatively less toxic than the mother…..Well in the case that I would relate to there would be a lot of drama in relationship from extreme infatuation to extreme rejection, a lot of sadomasochism played out within the relationship. And again if you take it back to attachment your back to that.”

There is evidence here that the sadomasochistic drive is active and formed in the attachment relationship.

P4. “It’s probable just because, I say all of my clients that have it have been sexually abused and that’s em, on the order of ten or twelve.” It important to note that it is P4’s experience but not all participants attributed fibromyalgia to sexual abuse.
P3. “I imagine and here, I am speculating the nature of the problem for men or women, I suspect they are not very sexually active. Their fatigued, pain, a lot of pressure points around the body and I think this could be, ah but they are not very sexually active because of their condition”.

P5. “Em, sometimes it works two ways if you look at people with relationship difficulties and psychosexual difficulties it can lead on to symptoms of fibromyalgia; it can lead on from pressure. em, interacting with the vulnerability of the individual.” It was implicit but there seemed to be a split in some responses between the sexual act and sexuality of the person.

4.7 The Link between Fibromyalgia and Trauma

The data analysis, about the link between fibromyalgia and trauma, was that there is definitely a link but the type of trauma differed in the thematic analysis no one specific trauma was linked. The participants were divided between; childhood trauma and abuse, emotional trauma, stress and physical trauma to the body.

P5. “Oh yeah there certainly be a link in terms of trauma but I’d use the word stress. Trauma may have specific connotations but much more it’s sort of like pressure, stress and also when you think of frequently the type of personality of the individuals who frequently get fibromyalgia are usually nice people who usually have difficulty saying no, often very conscientious and often have a tendency to worry. There often a bit sensitive and they would look at adversity in their lives and pressure in their lives whatever, and it would present itself physically.”
P4. “I have never really resolved this for any fibromyalgia parent, I mean patient. And I don’t think it’s the fibromyalgia itself. I think it’s the long term abuse in childhood, it seems to be related to the length of time the person is in the abuse it seems the tension and so fourth when you’re younger there are ways you can deal with it.” This unconscious slip of resolving this for the fibromyalgia parent could not go ignored as there is possibly something very important in relation to the internalised object.

P1. “There is an absolute link to it. I would say maybe more than fifty percent. The fibromyalgia is due to trauma, as I’ve said, in accidents injury to the top of the neck. You’ll find when you talk to them. Have they been in a crash, have they had a fall? And eventually have they had, and eventually, you will see.”

P3. “There might not be a major, major, trauma just a series of things, yes sometimes they have some form of loss or trauma and then something else happens when there just getting over the first episode. There may not be a single event that was a cataclysmic event that was the defining point, succession of events and maybe after one event they haven’t adapted well. So there’s maladaptive response.”

P2. “I would see it as relating to childhood trauma eh, difficulties, and an expression of psychic pain in some way, manner or form, expressing emotional pain in a physical way.”

Trauma in the body, the contraction of the body because of a traumatic event or that has not been worked through came up twice and when asked was it like an armor? P4. “It is body armor and when you’ve been traumatized you need armor, if you’ve been beaten up in a battle you want armor.”
P2. “Yeah, I would definitely see the physical rigidity as armor.” When asked, if the body was in contraction to brace oneself or as a defense to keep something in. P2. Replied; “it could be both.”

When asked; was it a hysterical symptom? P2 and P5 both said that it could be but not in all cases. P1,3 and 4 either didn’t believe in the existence of hysteria or did not see any link.

4.8 Conclusion

The findings, although very informative brought up more questions than answers. The interviews opened up other avenues for discussion. In hindsight, IPA would have brought out more organic and unconscious material. Regarding treatment, four of the five participants were more focused on the symptom than on the meaning. P1, P3, P4, P5 contributed their approach to managing the symptom. Some contributed pain to trauma, stress, pain in the psyche that was a physical manifestation. Only P2 seemed interested in finding what the actual pain was expressing, wondering why the symptoms of fibromyalgia. P2 didn’t mention managing the symptom and instead he described his approach as follows:

P2. “I do it in a very non directive, humanistic, not knowing collaborative kind of way. And I suppose going back in to try and form a healthy attachment really. I see it as trying it for them having the first experience of a secure attachment and allowing them to feel more safe in their bodies and working with it somatically, and also so they know and are aware of their sensations and awareness and also creating safety and also so they are more resourced to move into that depressive state.” He added it is important to always check his counter-transference and to make sure his heart is open.
Although all agreed, people with fibromyalgia improve and that symptoms lesson, four out of five mentioned there was no cure and it was about management. In the discussion other avenues of interest in relation to fibromyalgia will be discussed, areas that have not been previously mentioned and are a direct result of the interview process. Also it will be an opportunity to elaborate on the findings.
Chapter 5 Discussion

5.1 Introduction

During the interviews, two in particular, there was a thread of similarity with the description of autism and fibromyalgia in a physical sense. If there is no object would that mean no structure and ultimately mean psychosis. Armouring of the body also came up and spurred an interest in relation to pelvic armouring. There was a common thread in three of the interviews about feeding, in relation to nutrition, diet and good food and there seemed to be a desire to feed. These were themes that came from the findings and inspired further discussion.

5.2 A link to Autism

“The psychotic part cannot think (lacks the capacity for symbolic though); it can only fragment and expel. If the expelled parts come back, individuals experience this as an assault by actual objects. The more they aggressively fragment the particles coming back at them, the more they experience them as increasingly hostile.” (Lucas, 2009, p91)

P1 spoke of the symptoms in fibromyalgia as a hypersensitivity to heat, cold, light, sound and smell and added people with fibromyalgia have very acute senses. When she spoke about the importance of exercise, P1 “if you don’t use it, you lose it” in relation to muscle tone. When P2 spoke about fibromyalgia he referred to it as a spectrum which again seemed like a connection. Autistic disorders often incorporate sensory issues and low muscle tone. Like fibromyalgia there is also sleep disturbance and some autistic people suffer slow bowel, similar to suffering from IBS in fibromyalgia. In relation to libido in autism the libido is turned inward toward the self as in auto-eroticism. It is fascinating how on researching autism it sounds like a psychological armouring against intrusion of the other. In
fibromyalgia if the libido is invested in the lost object, if linked to an inability to move into the depressive it is plausible and there was evidence to suggest this in the analysis. Yet, if there is no object does the object become pain? Nasio, (2004) suggests that pain can be an object of drive. In relation to the mother baby bond if there is none is the object incorporated as pain? To lose the pain, the object would be lost. The question would be is it dangerous to remove the symptom if it is the object, if it is there would be no structure in place. In this case would this mean psychosis? If meaning cannot be found there is no signifier, no way of rooting it in the symbolic, foreclosure in the symbolic results in psychosis.

5.3 Pelvic Armouring

Pelvic armouring seemed relevant in connection to the symptom of pain in the pelvic area in two of the interviews it was expressed that this pain caused clients with fibromyalgia to have to stand for their sessions. What does pelvic armouring mean? According to Reich’s Map of Body Armour in relation to the pelvic segment, it is made up of the muscles of the pelvis and lower limbs. When armoured, the pelvis does not move with ease. Resulting in painful muscles such as; the thighs, lower back, anal sphincter, pelvic floor and gluteal muscles contract. This can cause sciatic nerve pain down the legs, and numbness and cold sensations and also varicose veins. Because of the rigidity of the armouring it can cause symptoms of misalignment which can impact the entire skeletal structure.

The restriction on energy flow can create a lack of sensation and sensitivity in the genitals and interfere with sexual function. If there is a constant build-up of energy without release it can result in mental and physical symptoms. Symptoms connected to the pelvic segment consist of constipation, IBS, haemorrhoids, cysts, vaginal pain and anaesthesia, bladder inflammation, penis anaesthesia, erectile dysfunction and sexual intimacy issues.
Feelings of anger, rage and fear are held here. These feelings are connected to the sexual act and sexuality and hold the vulnerability of intimacy. In many ways the pelvic armouring seems linked to symptoms of fibromyalgia and its link to sexuality. In the literature review Nasio (2004) describes the physical manifestation of pain is the sudden loss of body armour it would seem the pain is its contraction.

5.4 The Feed
In many ways this seems related to the deprivation in the dyadic relationship in childhood. Melancholia’s roots are to be found in the oral stage. P2 denoted this to the envious, critical rejecting mother to be significant to fibromyalgia. The feed is so important in development the quality of the mother’s holding from a physiological sense and her energetic presence while feeding is what lays the foundation, the feed needs to be one of undisturbed enjoyment for the most part. The infant takes in the mothers love along with the feed and possesses it. If this does not happen the infant experiences dissatisfaction, which is dissipated through the body felt as discomfort in both psyche and soma. The ever striving need to achieve to seek approval, seems related to this the huge insecurity created in this void in relating. This need for love, relatedness it would seem could attribute to the insatiable appetite and the counter-transference of the urge to feed and focus on diet and nourishment. There is a saying; “I want it so bad it hurts” the yearnings manifestation could relate to this physical pain, in relation to the other. The devastation and under that rage in not being met is inevitable.

5.5 Conclusion
The findings were interesting. There was a commonality among those who worked with people who suffer from fibromyalgia, that it is a physical manifestation of psychic pain. But
the cause of the pain had participants divided. There is a connection to loss of the object the emotional dysregulation is evidence of this. In most interviews sexuality and its connection to fibromyalgia hadn’t been considered. The symptom took centre stage in most interviews. Meaning didn’t seem as important. There was a sense that the meaning of the pain was too painful to approach and that the symptom was easier to focus on.
Chapter 6

6.1 Research Conclusion

Fibromyalgia is fascinating in its complexity and dynamic behavior. Its effects are so debilitating. There is a closer understanding and respect for the physical manifestation of psychic pain on completion of the research. The participants who shared their sense of meaning enriched this experience. As therapists it can be a mucky place to be when one knows more than is known. To stay in the symptom seems as debilitating as the symptom itself. The etiology of fibromyalgia is still unknown and more avenues are open for research. In the approach to its treatment this quote seemed to fit eloquently, “Stay with the questioning, not rush the answer. Not knowing is held to be primary requirement of being able to “get to know” that impedes exploration and learning because it is saturated knowledge without space for discovery and an active relationship. To the as yet unknown and a process of cognitive and imaginative relating to experience that is a transitional and provisional one and leaves room for changing emotions and for uncertainty.” (Rustin & Bradley 2008, P12)

6.2 Strengths and Limitations

Strengths were in the fact that the participants experience enriched the research and made other areas open to be researched. The diversity was good as it gave a broader sense of fibromyalgia.

Limitations were that there are so many splits across the interviews it mirrored the schizoid position, fragmented and enmeshed with the symptom or object. A lot of the interviews stopped short of the symptom and focused on management. Only P2 mentioned the aggression and control. No other interviewee mentioned the client’s fear of their
destructiveness which stunted the research somewhat. It limited the personal responsibility for one’s own feelings. In a sense it was felt that was voided from the approaches.

6.3 Recommendations for Further Research

Further research is needed on fibromyalgia from a psychotherapeutic perspective. From a perspective of meaning to gain understanding of its etiology, to date an organic etiology has not been found. Also notably in all of the interviews there was very little said about the fear of one’s own feelings. This was striking considering the description of people with fibromyalgia is one who has had to be much defended. More research in the connection between ones defense to feeling and physical symptoms could prove beneficial. Cardinal (1983) her experience was that her symptoms kept her away from how she felt. When she no longer feared herself she was free. If further research is done viewing the symptoms from a borderline or psychotic frame of reference it would broaden the research.

6.4 Recommendations for Training Institutes

A module on pain would be something that would bring more understanding to symptom formation. Also it would be beneficial to include psychosomatic illness into the training so that some understanding is had before entering the field

6.5 Overall Conclusion

The research could not find something specific that directly could only link to fibromyalgia. To conclude; if desire is always desire of the other – for one to be in constant physical pain the question left would be is the desire of the other to inflict pain? In cases where no actual death of the other has occurred is it the inevitable dip into the depressive triggered by something else that awakens the wound of loss and separateness from the other. In the
phantasy the infantile destruction of the other is a result of the infantile rage. In the unconscious this rage has destroyed the other in turn this would trigger fear of physic annihilation of the self. The symptom can act as a defense to such rage keeping the phantasy unconscious keeping the fear of one’s one destruction at bay. Cardinal (1983) it was the “thing” that rattled her very being that kept her connected to her mother that kept her focus on the symptom. Her escape from the “thing” was her psychosis. In the end it was her rage that freed her of all of her symptoms and ultimate separation from her mother. It sounds so close to fibromyalgia for her a cure was possible. There is still hope that this can be the same for fibromyalgia because to only manage the symptom seems like such a dim prognosis.
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Appendix 1

Interview Questions:

1. What would you consider the aetiology of fibromyalgia to be?

2. What is your sense of the meaning of the symptoms in fibromyalgia?

3. In your experience of clients with fibromyalgia how have you experienced identification with their symptoms if any?

4. Is there any commonality in this syndrome between clients?

5. In relation to trauma is there a link to the expression of the symptoms?

6. Often, with fibromyalgia sufferers, there is a connotation that the symptoms are “in their head” or psychosomatic, because of its somewhat unknown aetiology, what is your experience and/or opinion of this?

7. What is your sense of fibromyalgia and sexuality?

8. Is there a sense of an economic factor in their pain meaning a gain in their symptom?

9. How do you approach the treatment of such symptoms in patients with fibromyalgia?

10. Fibromyalgia was predominantly a female syndrome up until the last few years what has been your experience in relation to this? Research has shown in statistics from Arthritis Ireland the ratio of men to women diagnosed is 1:10.