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**An Exploration of the Role of Psychotherapy for Fibromyalgia Syndrome, in the  
Context of Underlying Trauma and Insecure Attachment.**

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Counselling and Psychotherapy.**

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## **Abstract**

Fibromyalgia Syndrome (FMS) is the most common cause of chronic, widespread pain in Europe and North America (Ungureanu, 2011). FMS is becoming more widely recognised in the medical community; however, the diagnosis remains vague and non-specific. The organic causes of this condition remain unclear. There appears to be a complex interplay between the different psychological and physical features of FMS but there is evidence of a high prevalence of psychiatric comorbidities in FMS, including post-traumatic stress disorder (PTSD) (Ehlert, 2001).

Trauma and dissociation tend to be interrelated, and many pathological FMS features resemble PTSD (Peres et al, 2009). Individuals with PTSD symptoms often present with concurrent pain, and vice versa (Roy-Byrne et al., 2004). Over the past decade, PTSD treatment has become more sophisticated, resulting in improvement in symptomatology and patient quality of life (Peres, 2009). This study aims to explore the commonality between trauma and FMS and the common pathology of each, in order to identify overlapping therapeutic options which may be beneficial for FMS sufferers.

An insecure attachment model may contribute to the dysfunctional regulation of stress and emotion and may be a risk factor for the development of chronic pain syndromes like FMS (Kowal et al., 2015; Griffin & Bartholomew, 2005). The mechanisms by which these maladaptive processes are interconnected are not well understood. This paper attempts to draw these links and proffer some clarity on these associations. The co-occurrence of trauma and FMS, and the overlap between trauma and insecure attachment, is the focus of this study (Cohen et al, 2002; Pall,2001) The article presents an overview of these overlapping relationships with the aim to increase the understanding of this complex disorder.

The final part of this dissertation considers the role of psychotherapy as a viable treatment option for FMS. The connections drawn between FMS and trauma, as well as insecure attachment, may help us to conceptualise the painful core of FMS and approach a therapeutic technique which will provide greater relief from the burden of illness. Ultimately, we must treat this complex condition by respecting that no simplistic approach exists to its management and treatment.

## **Chapter One**

### **1.1 Introduction**

Fibromyalgia syndrome (FMS) is a chronic pain disorder, associated with widespread musculoskeletal pain with no clear pathological causation. Currently, the treatment for FMS remains suboptimal (Hauser et al., 2009; Okifuji & Turk, 1999). This paper focuses on the relationship between FMS and trauma, as well as maladaptive attachment styles, and the potential role for psychotherapy in FMS management (Jacobson, 2015; Recla, 2010; Nielson, 1997). The role for psychotherapy has been widely established in the treatment of Post-Traumatic Stress disorder (PTSD) through rigorous research and investigations (Bisson et al., 2013; Schnyder et al., 2015; Watts et al., 2013). The prevalence of PTSD amongst FMS patients and the overlapping symptomatology underpins the hypothesis that psychotherapy may be beneficial in relieving the burden of symptoms.

Psychotherapy may allow for the exploration into maladaptive attachment styles ascribed to FMS sufferers in recent studies (Ungureanu, 2011). Presently, the existence of effective treatment options for this patient cohort is limited, with pharmacological and non-pharmacological interventions offering a marginal reduction in the burden of symptoms for only a minority of patients (Okifuji et al., 2016; Fajardo et al, 2020). The purpose of this study is to explore the potential role for psychotherapy in understanding and relieving patients' symptoms.

### **1.2 Background to Fibromyalgia Syndrome**

FMS is a chronic and complex disorder associated with widespread musculoskeletal pain, accompanied by tenderness at specific, predictable anatomic sites known as tender points (Jones et al, 2016). There is no identifiable medical injury or disease to account for symptoms

which includes fatigue, sleep dysregulation, stiffness and disruption in cognition. Patients often report concurrent symptoms of anxiety and depression (Duque et al, 2019).

FMS is a surprisingly common disorder estimated to affect 2– 3% of the general population and is predominant in middle aged women (Fietta et al., 2007; Carmona et al., 2001; Goldenberg, 2003). The American College of Rheumatology's (ACR) current criteria for FMS includes the subjective report of chronic, widespread pain for at least three months, and the presence of extensive mechanical tenderness (Wolfe et al, 1990). Sufferers must have pain in all four body quadrants and at least eleven out of eighteen tender points positive for pain.

FMS is an ill-specified diagnosis, lacking robust criteria for diagnosis. There is tremendous variation in how individual practitioners diagnose FMS in the clinical setting. The ACR criteria does reveal a significant overlap with the PTSD diagnosis in the DSM V (Hauser et al., 2015). The ACR conducted an elaborate analysis of FMS patients (1972-1990) in order to establish concrete, objective criteria. However, the subjective nature of the tender points test and inclusion of many symptoms including headaches, irritable bladder, dysmenorrhea etc.- creates a flexible and non-specific view of FMS. The diagnosis is based on criteria that were developed by expert consensus but is limited by the lack of definitive histological or radiological findings (Arnold et al., 2004). The lack of strict, specific criteria for diagnosis leads to an extremely heterogenous patient population and a non-specific approach to treatment.

The creation of a criteria for FMS diagnosis, albeit wide-ranging, has led to increasing interest and research in the area. Giving this elusive disorder a real title and meaning has piqued the interest of the research community. FMS has become a recognised clinical construct, endowed with the investment of medical researchers who wish to gain a detailed and accurate understanding of this mysterious disorder (Cordero et al., 2016; Wallace & Clauw, 2005;

Greenhalgh, 2001). This greater understanding has triggered rapid advancements in the treatment of FMS by both pharmacological and non-pharmacological interventions.

There is a growing body of data, some of which seeks to pinpoint a central, organic, pathological explanation (Wassung, 2015; Yunus, 2008; Ethod,1988). Other research claims a more purely-psychogenic or behavioural causation (Duque & Fricchione,2019; Sharpe,1997; Schuessler & Konermann,1993). This paper focuses on psychological core components of FMS. The symptoms of FMS are looked at in relation to trauma as well as attachment style.

### **1.3 Understanding Pain in Fibromyalgia Syndrome**

The relationship between psychological distress and physical pain is not widely understood but is gradually emerging as a focus of research (Buskila & Cohen,2007; Severeijns et al., 2001). A link between FMS and certain affective disorders, including anxiety, major depressive disorder, and PTSD has been reported (Buskila & Cohen, 2007). The link between FMS and PTSD is multifaceted, with both conditions showing similar symptomatology and pathogenic components. This study aims to elucidate an understanding of these complex disorders and identify the direct overlaps between them, exploring how psychological trauma manifests as somatic pain.

Recent research has been aimed at understanding the significance and impact of stress in the treatment of FMS (Sluka, 2016; Reich et al., 2006). Several investigations across multiple disciplines postulated that individual differences in stress responses may be a determinant of FMS development (Goldenberg, 1996; Crofford, 1996).

### **1.4 Fibromyalgia and Post-Traumatic Stress Disorder- Two Complex Conditions**

Exposure to trauma is not sufficient for subsequent development of PTSD and only a percentage of people exposed to trauma will develop the clinical disorder (Yehuda, 2002; Brewin et al., 2000). Exploring both the psychological and physiological pathology

underpinning these conditions may help to understand those who may be more at risk, as well as helping clinicians to determine the most appropriate treatments. Some studies suggest an obvious association between PTSD and FMS, although whether this is one of causality or consequence remains unclear (Staud,2004; Clauw & Chrousos, 1997),

Difficulty in treating FMS lies in its complexity. As well as pain and tenderness, patients often report psychiatric comorbidities including borderline personality disorder, anxiety, obsessive compulsive disorder, depression and PTSD (Busikila &Cohen, 2007). This research suggests that a meaningful relationship between FMS and the psychological symptoms of PTSD does exist. An increasing number of studies are now addressing the link between FMS and physical, sexual and emotional abuse (Taylor et al., 1995; Walker et al., 1997). The prevalence of PTSD amongst FMS patients has been shown to be significantly higher than in the general population (Peres et al, 2009). Roy-Byrne et al. (2004) reported a 20% lifetime prevalence of PTSD among individuals with FMS. PTSD is characterised by a specific set of symptoms, including avoidance and numbing, re-experiencing of the event, and hyperarousal. The overlap between PTSD and FMS symptomatology including - chronic and widespread pain, fatigue, headaches and sleep irregularities and has been investigated in modern research One study describes 60% of FMS participants had “clinically significant levels of PTSD symptoms” (Cohen et al, 2002 pg.38). The high rate of PTSD among FMS sufferers strengthens the belief that FMS has a psychological underpinning, rather than a purely biological one.

## **1.5 Conclusion**

By no longer dismissing FMS as an unexplainable condition, we must try to ascertain if emotional distress, trauma and relational difficulties could potentially underpin an FMS diagnosis and its symptomatology. Psychotherapeutic interventions for addressing trauma and insecure attachment are widely discussed and given importance in explorative literature.

Therefore, if these connections can be made, the potential for insights and improvement into more effective FMS treatment could be real and profound. Further exploration of the associations between trauma and insecure attachment with FMS may show even stronger links exist between the psychological cores of these conditions.

## **Chapter Two**

### **2.1 Introduction**

This study explores the hypothesis that trauma is linked to FMS with insecure attachment style as a mediating variable in this relationship. The aim of this study is to better understand the link between these variables. Childhood trauma can take the form of maltreatment, abuse and neglect by the caregiver which disrupts one's ability to form strong relational bonds and may lead to varying degrees of insecure attachment in the child and subsequent adult (Mikulincer & Shaver, 2007; Roisman et al., 2007; Dozier & Kobak, 1992). The co-occurrence of PTSD and FMS, and the overlap between PTSD and insecure attachment, implores the need for rigorous investigation (Cohen et al, 2002; Pall, 2001). If a significant relationship exists between FMS and adult attachment style, this could create new avenues for treatment and potentially relieve the burden of symptomatology for patients.

### **2.2 Pathophysiological Mechanisms in Fibromyalgia Syndrome**

There are conflicting medical opinions regarding whether FMS is a psychosomatic illness or functional somatic syndrome due to its relatively subjective clinical tableau (Hauser, 2014; Ungureanu, 2011). Recently, more empirical data has emerged, and a number of theories are gaining recognition amongst the medical community. One theory of interest connects FMS to a dysfunction of the hypothalamic-pituitary-adrenal (HPA) axis (Ciccione et al., 2005; Raphael, 2006). The HPA axis serves as a link between a stressor, such as pain, and the individual's endocrine, autonomic, and behavioural response (Ciccione et al, 2005). Stress-processing may be a crucial factor in the development of FMS symptoms, rather than a cause-effect relationship (Ungureanu, 2011). It is argued that FMS patients do not have the expected, appropriate response to acute physical or psychological stress. This is based on observed abnormalities in the neuro-hormones expressed by those with FMS (Crofford, 2002; Goldenberg, 1999). The

findings of research on the HPA axis in FMS patients reveals an abnormal reactivity to stressors when compared to healthy individuals (Crofford et al., 1996). This altered physiological experience of FMS may be comparable with that of PTSD. Both FMS and PTSD share some complex physiological components and similar functioning of the central pain pathways. They also exhibit similar reactivity of the HPA axis when exposed to stress (Crofford, 1996).

HPA dysregulation is now seen as a characteristic abnormality seen in FMS, as well as depression, anxiety and PTSD (Hudson & Pope, 1996). The enduring stress experienced by those with PTSD and FMS is reflected in the dysregulation of the HPA axis (Hart et al., 2003; Ehlert et al., 2001; Crofford, 1998). The term dysregulation refers to both hyper and hypo reactivity in these studies. This chronic abnormal functioning of the neuroendocrine system is linked to FMS and PTSD symptoms and may be caused by exposure to trauma. Psychological trauma can impact HPA functioning and strengthens the argument that PTSD and FMS are strongly bound (Abeles, 1998). A study of the frequency of PTSD in FMS patients showed that 57% of the FMS sample had clinically significant levels of PTSD symptoms (Cohen et al, 2002; Pall, 2001). These findings indicate a significant overlap exists between PTSD and FMS, according to the DSMV's currently accepted diagnostic criteria. Many participants met the criteria for FMS and PTSD, and each disorder appears to be commonly triggered by a relatively short-term stress response followed by chronic pathology, indicating that stress may induce a self-perpetuating vicious cycle (Cohen et al, 2002; Pall, 2001).

The association between early-life trauma, such as neglect or abuse, and alterations in pain processing later in life, has been widely documented (Sherman et al., 2015; Davis et al., 2005). These maladaptive changes in the HPA axis may be mediated by the impact of early life stress (Sancassiani et al., 2017; Smith et al., 2011). Dysfunction of the HPA axis has also been suggested as the potential biological mechanism mediating the association between attachment

and the development of FMS (Jain et al., 2003; Crofford, 1996). Observations from animal and human studies have indicated that early life stresses and insecure attachment experiences, are linked to greater vulnerability to stress disorders, including FMS and PTSD, both mediated by HPA axis dysfunction (Kempke et al., 2011; Heim et al., 2009; Davies, 2009; Van Houdenhove & Luyten, 2008). Furthermore, it has been reported that dysregulation of the HPA axis predicts the onset of new episodes of chronic widespread pain independent of the effects of psychological distress (Davies, 2009).

When attachment figures have been abusing, neglectful, nonresponsive, and/or insufficiently available to the infant, attachment deactivating or hyperactivating strategies may be typically observed later on in adulthood. This attachment style may be a formative factor in the individual's habitual and normal response to stress (Mikulincer & Shaver, 2007; Roisman et al., 2007; Dozier & Kobak, 1992). Studies in this context have found not only high levels of early adversity in patients with FMS, particularly high levels of emotional abuse and neglect (Kempke et al., 2011; Van Houdenhove et al., 2009), but also a prevalence of insecure attachment histories (Luyten et al., 2006; Maunder & Hunter, 2008; Waller & Scheidt, 2006).

### **2.3 Insecure Attachment and Fibromyalgia- The Painful Connection**

Adult attachment style is a psychological representation of self and others, defined by the earliest childhood experiences of relationships with primary caregivers (Bowlby, 1978). Attachment style is considered to be a stable trait throughout adult life, determining how individuals relate to each other, and is linked to our reactions to threatening circumstances (Bowlby, 1978). Attachment styles are believed to be particularly apparent in stressful events (Bartholomew, 1990; Bowlby, 1969) and influence affect regulation and expression (Kobak & Sceery, 1988). Mikulincer and Florian (1998) reviewed studies on populations facing a variety

of stressors and concluded that adult attachment style is one predictor of the way in which individuals cope with stressful events.

Research has classified four sub-types of infant attachment, with some variation existing between different theorists and researchers (Bartholomew & Horowitz, 1991). This study looks at the following groupings: secure attachment and insecure attachment which includes - avoidant attachment, ambivalent attachment and disorganized/disoriented attachment (Brisch, 2002).

The provision of a secure, reliable base from which the infant is free to explore typically leads to the development of a secure attachment style in later years (Bowlby, 1978). Insecure attachment is potentially dysfunctional insofar as it tends to perpetuate distress and may increase vulnerability to a broad range of illnesses (Kotler et al., 1994). This forms the basis of the hypothesis that an insecure attachment style may predispose the individual to the development of unexplained illness such as FMS.

Writing about survivors of trauma, Bessel van der Kolk wrote:

“Their failure to translate somatic states into words and symbols causes them to experience emotions simply as physical problems. . . . [They] experience distress in terms of physical organs, rather than as psychological states”

(van der Kolk et al., 1996, p. 423).

The body of patients who dissociate from traumatic experience can thus become a battleground on which psychological issues are fought out. Such patients often have many physical problems as a result of this embattled experience (Wallin, 2007). Attachment processes and the link with various health issues, have been an important area for recent study (Ungureanu, 2011).

Ulcerative colitis (Maunder et al., 2000), outcomes in diabetes (Turan et al., 2003) and the likelihood of developing breast cancer in women (Tacon, 2003) have all been included in this research.

A comparison study between FMS and osteoarthritis found that FMS patients were more likely to use avoidance coping strategies (Davie, 2001). These strategies include passivity, resignation and social withdrawal. These are related to more negative and less positive affect and more bodily pain. Another study found that for the FMS patient, but not for patients with rheumatoid arthritis, there was a significant correlation between dissociative symptoms and traumatisation (Amital, 2006). FMS patients reported significantly greater levels of traumatisation and dissociation than patients with other types of pain across these studies. This avoidant style of coping with pain may be a key feature of FMS that has important implications for long term adaptation to pain (Sheon et al., 1996).

There has been increasing recognition of the importance of adult attachment style and the experience of pain (Meridith et al., 2008; Porter et al., 2007). Social engagement and bonding are essential human needs. Secure attachment has a strong evolutionary selection bias as it increases the likelihood of survival. Lack of attachment is detrimental to survival and can be extraordinarily painful. Social rejection and lack of belonging is a most painful emotional experience (Eisenberger & Lieberman, 2004). Those with FMS often feel isolated as they struggle to maintain social relationships under the burden of their illness (Eliklit et al., 2016). Some of the literature suggests that physical and social pain overlap in their underlying neural pathways and computational processes (Eisenberger & Liberman, 2004). These systems are intertwined to enable the individual to respond to attachment threats in the same way as physical danger, in order to increase likelihood of survival. From a neurobiological standpoint, part of the price of early relationships that necessitate dissociation is that the child, for whom

attachment figures are frightening, may fail to fully develop integrative neural structures (such as the hippocampus, orbitofrontal cortex, and corpus callosum) that help modulate the brain's emergency response system, the amygdala (Wallin, 2007). Without such integration and modulation, the over-reactivity of the amygdala makes it likely that relatively innocuous triggers will provoke extremely intense autonomic responses in many unresolved patients (Wallin, 2007).

Attachment mechanisms are triggered when faced with stressors or a perceived threat (Bowlby, 1977). Chronic pain is experienced as stressful and subsequently activates the attachment system (Ungureanu, 2011). Studies propose attachment theory as a basis for understanding the development and adaptation to chronic pain and emphasise the increased susceptibility to stress of insecurely attached individuals (Mikail et al., 1994; Mikail, 2003). Insecurely attached people have been shown, to experience more pain than people with secure attachment (Davies, 2009). These studies suggest that securely attached individuals would be less likely to develop chronic pain and would cope more effectively if diagnosed. Attachment style may therefore mediate the way in which a person deals with chronic pain, insecurely attached individuals appraising their condition in more negative and threatening terms (Mikulincer & Florian, 1998).

Many studies suggest that there is a high prevalence of insecure attachment among patients with chronic pain (Schroeter et al., 2015; Davies, 2009; Waller et al., 2004; Ciechanowski et al., 2002). Ciechanowski et al (2002) demonstrated a link between insecure attachment and a number of reported somatic symptoms. Waller et al (2004) reported insecure attachment to be significantly more common in somatoform disorders, than in nonclinical controls. Chronic pain sufferers reported an insecure attachment style, more often than pain free controls, and this was found to be highly associated with medically unexplained musculoskeletal pain (Schroeter et al., 2015). The reference to chronic pain in the aforementioned studies is not specific to FMS,

however this research does support the link between somatoform pain and an insecure attachment relational model.

Abnormal attachment styles may lead to the development of chronic pain and have been explored in the research literature investigating links between childhood trauma (such as physical and sexual abuse) and the development of subsequent medically unexplained symptoms, including FMS (Sansone, 2001). Penacoba et al. (2017) looked at the interrelationship between attachment and pain intensity in a cohort of FMS patients. FMS patients had a lower percentage of secure attachment and higher avoidant and anxious-ambivalent attachment, when compared with the healthy control cohort. Mechanisms that may explain the observed relationships include persistent tendency to dissociate when stressed (Saxe, 1994), a tendency to communicate in terms of physical symptoms instead of emotional feelings (De Gucht, 2003) and abnormalities in the way affected individuals perceive/respond to threats and engage support from others (Ciechanowski, 2002; Spertus, 2003).

## **2.4 Conclusion**

This chapter establishes a connection between trauma, stress and FMS. This helps to frame FMS as a disorder compounded by psychological factors with a very real organic pathology. An insecure attachment model may contribute to the dysfunctional regulation of stress and emotion, as seen in the dysregulation of the HPA axis, which may be a risk factor for the development of chronic pain. The next chapter looks at the therapeutic options for FMS and explore the potential role for psychotherapy in this context.

## **Chapter Three**

### **3.1 Introduction**

The focus of this study is on the close relationship between FMS and PTSD, and establishing the link between FMS and Attachment theory. By drawing these connections, this study aims to inspire further discussion regarding the potential role for psychotherapy in the treatment of FMS. Psychological treatments are presently considered one of the first-line interventions for PTSD patients suffering from traumatic experiences (Cusack et al., 2016; Peres et al., 2009; Foa et al., 2000). However, psychotherapy remains to be included in the standard recommendations for FMS treatment.

Patients with FMS are often considered as ‘difficult to treat’ (Fischhoff & Wessely, 2003). There remains a high clinical burden of symptomatology which takes its toll on the emotional well-being of sufferers, affecting them both personally and interpersonally (Ungureanu, 2011). FMS patients must cope with this pervasive and devastating condition with little effective treatment options available. The need for effective treatment is paramount to improving quality of life for those suffering with this debilitating disorder.

### **3.2 The Failings of Pharmacotherapy for Fibromyalgia**

The FDA has approved several drugs to offer relief of symptoms for FMS patients (White, 2018; Staud, 2010; García-Campayo et al., 2009). Selective serotonin reuptake inhibitors (SSRIs) and Tricyclics, in low doses, relieve pain, fatigue and improve sleep. However, recent evidence showed SSRIs were also associated with increased suicidal tendencies (Gerardi et al., 2016). Antidepressants and anti-seizure medications have more negative side effects including drowsiness, weight gain, blurred vision, dry mouth, nausea and constipation (Üçeyler et al., 2008). Non-steroidal anti-inflammatories may be recommended but can increase the risk of heart attack and stroke (Üçeyler et al., 2008). Opioid painkillers are not recommended as they

do not work and may increase pain (Goldenberg et al., 2004). Tramadol may be prescribed but is highly addictive so is contraindicated over an extended period.

A meta-analysis of 18 randomised controlled clinical trials (RCTs) recommended that alternate treatments such as psychotherapy should be discussed prior to commencing medication due to the many associated adverse side effects (Goldenberg et al., 2004).

The need to find an alternative treatment option becomes obvious and confronting when we see that each of these drugs has its own side effects, ranging from mild to serious. FMS patients must often experiment with various drug combinations with only limited efficacy and a potentially catastrophic impact on patient quality of life.

### **3.3 The Role of Therapy**

Psychotherapy aims to calm the dysregulated physiological state caused by trauma and FMS and hopefully dissipate the negative symptomatology experienced by clients. Therapy can restore balance to the autonomic nervous system and reduce the disruption of the HPA axis (Häuser et al, 2015). The client must feel safe in the therapeutic relationship as this will determine whether or not they can relax and successfully manage to calm their neural and psychological experiences and ultimately discharge trauma from the body.

Research shows that psychodynamic trauma therapy supports the stabilisation of patients with childhood experiences of chronic threat and trauma (Lampe et al., 2008; Diseth, 2005; Cusack et al., 2003). A systematic review of studies involving 1019 references, looking at PTSD and dissociation in children and adolescents published over a 10-year period, various aspects of assessment and/or treatment were studied in detail (Van der Hart et al., 1990). A combination of individual psychotherapy, pharmacotherapy, and family therapy were often required as treatment. Hypnotherapy, eye movement desensitisation and reprocessing (EMDR),

psychodynamic therapy, and an integrated approach were the main psychotherapeutic techniques described.

### **3.4 Attachment and Therapy**

FMS sufferers may be influenced by preverbal attachment experiences that are imprinted and stored as implicit procedural memories—building blocks that shape and mould the patients' original patterns of relating, feeling, and thinking. This model operates at an unconscious level in adult life, orientating the appraisal and assimilation of emotions and experiences (Di Tella & Castelli, 2013). Recognising the significant impact of the early mother-infant relationship is especially pertinent to psychodynamic therapy and may be a valuable area for exploration in FMS treatment (Jacobs, 2012). There is mounting evidence, supported by RCTs, showing the efficacy of psychodynamic therapy in FMS and related conditions (Scheidt, 2013). As discussed in Chapter Two, attachment processes and the link with FMS may implore the therapist to promote in the client a secure attachment style, as parallels exist between the therapeutic relationship and mother-infant relationship (Bowlby, 1969).

Chapter Two has identified the increased risk of illness associated with insecure attachment (Kotler et al., 1994). Studies attest to the connection between generalised chronic pain and insecure attachment (Davies et al., 2009; Oliveira & Costa, 2009; Meredith et al., 2008; Mikail, 2003;). Hazan & Shaver (1994) found that, compared with secure adults, individuals who described themselves as either anxious or avoidant in love relationships tended to also report higher depression, anxiety and psycho-somatic illnesses, such as FMS, as well as purely physical illnesses. Therefore, this paper posits that by utilising therapeutic interventions which address the client's dysfunctional attachment style, a reciprocal reduction in somatic pain and pathology for FMS clients may be achieved.

### **3.5 Challenges to Therapy**

The goal of therapy is to provide insecurely attached clients with a different experience and adjusted working model for relationships. Interventions aim to foster a secure attachment relational model which may be beneficial for those with a maladaptive one (Elklit et al., 2016). The therapeutic relationship can generate a new attachment relationship that is safe, reliable, and inclusive and in which disruptions can be repaired (Wallin, 2007). This relationship should promote the development of the patient's own internal resources, including those necessary to resolve past trauma (Wallin, 2007).

The therapeutic challenge, then, is to respond to this evocation of the past in a firm but empathic fashion. This creates safety and consolidates the widening gap between the old attachments that may anger and terrify the client, and the new attachment relationship whose optimistic and hopeful possibilities the client can tentatively begin to imagine. The problem for the client may be that they are unaware that a deep-rooted wish remains, which continues to evoke the old, familiar and cyclical patterns of insecure and unsafe relationship modelling. This unconscious desire may continue to stoke and rekindle the harmful flames of relational modelling which burned them in the past. The internalised working models of self and others become increasingly concrete over time and impervious to change (Sroufe, 1988) and in the context of a therapeutic relationship that is felt to be unsafe, resolving the client's trauma becomes an almost impossible challenge.

PTSD is associated with a tendency to withdraw and isolate oneself. Life becomes more restricted as the individual tries to avoid the situations and activities in their environment which might trigger a response similar to the traumatic state. This may be a state of helplessness, with associated numbing, visceral feelings, body sensations (including pain) and thoughts (Scaer,

2012). The more the individual avoids triggers, the less likely they are to become desensitised to them.

Although not all FMS sufferers have insecure attachment styles, those who do, tend to avoid close relationships. The negative impact on mood and energy levels may force sufferers to cut social ties and isolate themselves (Scaer, 2012; Arnold et al., 2008). Hallberg and Carlson (1998) reported that there are differences in the amount of significant relationships held by the general population when compared to the population with FMS. Therefore, the unresolved client may have trouble tolerating a secure relationship with an empathically attuned therapist (Wallin, 2007). It is important to consider this tendency to avoid closeness, when considering a client's willingness to become involved in treatment whereby intimacy and closeness in the therapeutic relationship is considered imperative.

### **3.6 Therapeutic Options**

There is significant evidence to suggest that psychological and behavioural therapy, especially cognitive behavioural therapy (CBT), is effective in FMS (Goldenberg et al., 2004). RCTs of CBT with longitudinal data over 6 to 30 months found improved functioning and lowered pain severity in FMS sufferers (Goldenberg et al., 2004). Systematic reviews have confirmed that CBT improved pain, fatigue, mood, and function when meditation, relaxation and stress management skills were utilised (Goldenberg et al., 2004)

CBT has been seen to show improvements in FMS symptoms, which are sustained for months after the ending of these sessions (Goldberg, 2004). CBT is commonly seen as the therapy of choice for FMS sufferers and focuses on teaching skills such as relaxation, cognitive restructuring and goal setting to improve illness symptoms (Bernardy, 2018; Williams, 2003). CBT aims to teach skills necessary to control and manage pain, and promotes the belief that clients can successfully utilise these skills which are effective in reducing pain, improving

mood and function (William, 2003; Rossy et al., 1999). A review and meta-analysis on the effectiveness of CBT for FMS showed the tolerability and efficacy of CBT helped to reduce the prevalent symptoms of FMS when compared to the control (Bernardy et al., 2018).

This review explores the nature and treatment of FMS, which may be best rooted in attachment and psychodynamic approaches. If the link between FMS and insecure attachment is to be considered, the role of CBT as the sole therapeutic option could be inadequate as it does not address the underlying attachment issues. An abundance of research exists supporting the use of CBT, however it cannot be deemed the most effective if research into the other schools of therapy is lacking. CBT was shown to be ineffective in improving symptoms for FMS patients with interpersonal problems, suggesting that CBT is ineffective at addressing interpersonal issues which may be an essential aspect of treatment for this client cohort (Okifuji & Turck, 1999). These findings, that CBT does not address interpersonal problems and has limited therapeutic effects, has fuelled a resurgence of interest in the psychodynamic approach (Luyten & Van Houdenhove, 2013; Lumley, 2011). Therefore, the therapeutic strategy should be selected according to the client's individual needs.

FMS does not represent a single clinical entity. It is possible to distinguish subgroups within the FMS population as some may or may not share various characteristics of the disorder (Stratz, 2007). This research strongly suggests that FMS is highly correlated with past trauma and insecure attachment. However, it is important to stress that this does not apply to all FMS sufferers. Some may suffer from high pain sensitivity and no associated psychiatric or interpersonal issues. For the group who do have serious previous or existing psychological problems, the role of therapy should be investigated and defined.

It is imperative that all psychotherapeutic programs are tailored to clients on an individual basis. The cause and symptoms for FMS are broad and multifaceted, therefore a case by case

approach with multidisciplinary involvement could be critical in its management (Wallin, 2007). Not everyone with FMS needs, or would benefit from psychotherapeutic work. For some, a psychoeducational approach may be the most helpful and appropriate psychological intervention (Goldenberg, 2004).

It is challenging but essential that the therapist can create a safe holding environment for the client. It is especially important when working with those clients who may be unable to recognise and describe their own feelings. Improving social cognition abilities might help some individuals better express their feelings and subsequently reduce their psychological distress, and FMS symptoms (Wallin, 2007). Shared decision-making on treatment options can be based on patient preferences and comorbidities (Wallin, 2007). It should be both the ultimate goal and a precondition of therapy for beginning to resolve the patient's trauma (Wallin, 2007). However, more studies are needed to explore what treatment type and focus would be most beneficial in such circumstances.

Creating an attuned, inclusive and collaborative relationship requires a concentrated focus on the emotionally based, nonverbal subtext of the therapeutic dialogue. The patient's preverbal attachment experience, trauma from which they have dissociated, may be made accessible through the therapeutic relationship, bodily and emotional experiences awoken, evoked and enacted in the safety of the therapy sessions (Wallin, 2007).

### **3.7 Conclusion**

Psychotherapy may be a useful and valid tool for the management of FMS symptoms, offering support to those suffering the isolation and pain which accompanies this disorder. Psychotherapy can help FMS clients to recognise healthier management processes, such as new thought patterns, which might help alleviate the arrival of pain. Throughout the course of therapy, the goal is to rework, update or otherwise change the narrative of experiences. In this

way, it may be possible to revise and change the negative symptomatology somatically experienced by FMS sufferers. The client may then move towards increased resilience and a reduction in pain with a resolution of their trauma.

Therapy provides a secure base which facilitates a client's development of a more robust sense of self. Through the therapeutic relationship, the client may move towards a more secure attachment style.

Crucially there remains a need to continue investigating the clinically significant benefits of therapy and the need for an individually tailored approach to treatment. The various types of therapy, as well as the frequency and intensity, must be rigorously explored, in order to ascertain the best therapeutic direction for FMS patients.

The connections drawn between FMS and trauma, as well as insecure attachment, may help us to conceptualise the complexity of this disorder. By doing this, future research might recognise the failures of a generalised summation of the clients' experience of pain and begin to approach a more individualised and complete management of this complex condition.

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