



Primary attributions in women suffering fibromyalgia emphasize the perception of a disruptive onset for a long-lasting pain problem

Christine Cedraschi^{a,b,*}, Elodie Girard^c, Christophe Luthy^a, Michel Kossovsky^a, Jules Desmeules^b, Anne-Françoise Allaz^a

^a Division of General Medical Rehabilitation, Geneva University Hospitals, Geneva, Switzerland

^b Division of Clinical Pharmacology and Toxicology, Multidisciplinary Pain Centre, Geneva University Hospitals, Geneva, Switzerland

^c Division of Emergency and Liaison Psychiatry, Geneva University Hospitals, Geneva, Switzerland

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ABSTRACT

Objective: Fibromyalgia (FM) is a chronic musculoskeletal pain disorder characterized by widespread pain. This study focuses on patients' attributions of illness and of symptom onset.

Methods: Semi-structured interviews were conducted with 56 women to elicit patients' views on what triggered their FM. The transcripts of the interviews were analyzed using a classical indexing technique to identify key themes. Content analysis was performed by two independent coders.

Results: Primary causal attributions fell into five categories: psychological problems (28 respondents); somatic concerns (N = 12); violence/abuse during childhood (N = 7), gynaecological/obstetrical problems (N = 6), and fatigue (N = 3). Patients' attributions were internal and external in the same proportions, more frequently unstable than stable, and more often described uncontrollable than controllable. Participants expressed decrements in self-esteem and feelings such as self-blame or despair; global perceptions of persistent pain and long-lasting problems, evoking chronicity and hopelessness; and low perceived control over their lives as well as beliefs that nothing can be done, thus increasing a feeling of guilt and vulnerability. Patients' narratives emphasized disruptive circumstances surrounding symptom onset.

Conclusion: Attributions often referred to the psychological dimension of the events surrounding FM onset, even though some of them also had a clear somatic dimension. Many narratives mentioned successive disruptive events and suggested an increasing loss of control. Addressing these illness representations may contribute to tailor the treatment and to help patients gain self-coherency by providing means to understand pain onset but also to guide future behaviours, particularly in terms of adjustment and help-seeking.

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Introduction

Fibromyalgia (FM) is a chronic musculoskeletal pain disorder characterized by widespread pain and pain upon palpation at tender points [1,2]. A majority of patients also complain of fatigue and nonrestorative sleep, memory or concentration problems, stiffness, and mood disturbances. A number of studies also point to central sensitization in patients with FM [3,4]. Attempts have been made to elucidate etiological mechanisms underlying FM. This is important as assumptions about the nature and origin of symptoms play an important role in clinical management.

Research on psychological factors, such as the perceptions and cognitions that patients hold about their pain problem, has shown the importance of patients' illness perceptions. These perceptions provide a

coherent and empirically-based framework within a 'common-sense' model [5,6]. Such a model suggests that patients suffering FM develop personal representations about their illness and that these representations may influence what this illness means to them [6].

Causal attribution theory brings understanding into the ways patients reconstruct their illness experience. Causal attributions are the common-sense explanations people give to account for an event and their own interpretations which will guide future behaviours [7–10]. Various studies [11–13] have highlighted how much causal attributions influence cognitions and symptom experience but also contribute to determine the illness response, help-seeking behaviour, illness-associated disability as well as coping behaviour and adaptive resources in various illnesses, including heart infarction [14], somatoform disorders [15,16], somatoform disorders in patients with suspected allergies [17], orthopaedic surgery [18], chronic pain [19], fatigue [20,21] and fibromyalgia [22,23].

Attributional theories were first elaborated with reference to the locus of causality. Further studies showed the importance of two additional dimensions which may influence affective and behavioural

* Corresponding author at: Division of General Medical Rehabilitation (SMIR-BS), Geneva University Hospitals, 1211 Geneva 14, Switzerland. Tel.: +41 22 382 35 40; fax: +41 22 382 35 65.

E-mail address: Christine.Cedraschi@hcuge.ch (C. Cedraschi).

responses to stressful events: stability over time and controllability of the event [9,10,24–26]. Causal attributions can be thus classified into three dimensions: 1) locus of causality, 2) stability, and 3) controllability [26]. The locus refers to the perceived location of a cause as either internal or external to the person and will influence his/her affective experience of the event (e.g. in terms of self-blame and self-esteem); stability refers to the perceived degree of permanence/changeability of the cause over time (stable vs unstable) and is modulating expectancies for recurrence of the event; and finally, controllability refers to the differentiation between causes that are under, versus not subject to, volitional control (controllable vs uncontrollable), and may predict subsequent outcomes. A combination such as internal, unstable and controllable attributions has been described as facilitating positive coping strategies which improve the management of distressing emotions and cognitions. On the contrary, stable and uncontrollable attributions have been associated with avoidant coping strategies and negative psychological adjustment [26,27]. This basic taxonomy is an aid in reconstructing assumptions that individuals have about their illness and is thus of interest in understanding illness in FM patients.

Guidelines for the management of FM stress the importance of a comprehensive assessment of the patient [28,29]. In this context, the investigation of how patients suffering FM describe symptom onset may help tailoring the treatment to the individual's needs. In this study we explored what kind of attributions women suffering FM make regarding their illness. Our purpose was to investigate FM onset using the dimensions of the attribution theory as a framework to analyze the patients' accounts of symptom onset. Drawing on a qualitative interview study, we focused particularly on the women's primary causal attributions, i.e. the cause they presented as the main or primary reason for pain onset.

Methods

Participation in the study was proposed to FM patients involved in a neurophysiological assessment [30]. Patients were recruited from the community and were referred by their physicians to the Multidisciplinary Pain Center of the Geneva University Hospitals, a public hospital which is the major primary care facility for the area. Diagnosis of FM was established by the patients' treating physicians. The inclusion criteria were fulfilling the American College of Rheumatology 1990 criteria for FM [1]. As FM mainly affects women [31], participation was proposed only to female patients. In qualitative studies, the number of participants is usually determined by inductive sampling, i.e. by the need to encompass the range of possible responses and to achieve theoretical 'saturation' [32,33]. In this study, more than three-quarters of the global sample of FM patients ($n = 56$ out of 73) were interested to communicate their experience of FM onset and accepted to participate in a semi-structured interview. Those who refused did so because of time contingencies or difficulties to respond to an interview in French. This sample allowed achieving theoretical saturation of the established analytical categories.

Participants were questioned using face-to-face semi-structured interviews [34]. Interviews [34,35] were conducted to elicit patients' views on what triggered their FM, on the possible causal explanations of their pain problem, and they were also questioned on what they considered as the main or primary reason for pain onset. The topics were not addressed in a fixed order, although the opening question was always 'Tell me about your fibromyalgia, how did it start?' As the interview progressed, issues about the causes of the symptoms were addressed ('According to you, was there any reason for pain onset?'). If the patients mentioned a set of circumstances associated to pain onset and to its early developments, they were then questioned about the main reason for pain onset. If respondents declared that they were no doctors and could not identify the causes of their FM, they were prompted to give their own opinion, and they were told that we were interested in their point of view about pain onset and

that there was no right or wrong answer. Two members of the research team trained in qualitative research procedures, a psychologist and a psychiatrist who were not involved in these patients' care, conducted the interviews. The two researchers were familiar with patients suffering from chronic pain problems and FM in particular. Interviews lasted 45–75 min. The aim was to access the range of attributions about FM triggering events or context. A qualitative methodology using open-ended questions allowed gaining access to the patient's way of thinking about the origin of pain [36–38].

The interviews were tape-recorded and transcribed. The transcripts were then analyzed using a manual data indexing technique to identify key themes [39]. The qualitative analysis was performed by two researchers (a psychologist and a psychiatrist), beginning with close readings and annotations of the interview transcripts. The systematic analysis continued throughout data collection and coding process, using the constant comparative method [40,41], which consists of analyzing the interviews by comparing one response with earlier observed responses. This was followed by a discussion and comparison of the readings of the data, which were subsequently used to establish analytical categories and themes. These categories and themes served as the basis for a final grid, which was then used independently by the two researchers to analyze the transcripts in order to maximize theoretical sensitivity and rigor [42]. Using patient-generated data via the interviews and verification of interpretation using two researchers allowed for an assessment of trustworthiness [37]. In short, as for credibility, confirmability and transferability, research methods were derived from previous comparable projects; familiarity with the culture and adequate understanding of participating groups of patients has been developed before the first data collection; and triangulation was used insofar as two investigators collected and analyzed the raw data so that findings emerged from consensus between investigators. Emergent findings were corroborated with existing theories and examined in comparison with previous research findings to assess the degree to which they were congruent with those of past studies.

Overall agreement between the two raters was assessed by means of the Kappa value. Disagreements were solved by consensus. The results of the separate analyses showed excellent between-raters agreement ($K > .85$). The final grid provided a basis for the identification of the attributions patients made regarding the onset of their pain problem. In this process, primary causal attributions were specifically identified, i.e. the cause presented as the main or primary reason for pain onset. The three dimensions of primary attributions, namely locus of causality, stability, and controllability, were characterized in terms of their internality/externality, stability/unstability, and controllability/uncontrollability.

Patients were interviewed at the site of the neurophysiological assessment and were informed that their responses would not impact on their care. Complete confidentiality was guaranteed and responses were anonymized. The protocol was approved by the local Ethics Committee and written informed consent was obtained from all participants.

Results

The 56 respondents were mainly middle-aged (51.3 years), married (64.2%), and professionally qualified (57.1%) women. The majority were either on sick-leave (23.2%) or on disability (41%). Duration of pain was >5 years in the majority of them (66.1%). Mean present pain intensity was scored high (57.3) on a 100 mm Visual Analogue Scale (Table 1).

Primary causal attributions of illness

All fifty-six respondents expressed causal attributions for FM. Content analysis of patients' responses showed a great diversity; primary causal attributions fell into five mutually exclusive categories: 28 (50%) of the respondents mentioned "psychological problems" including 'relational problems' (e.g. divorce) in 10 patients, 'depression', i.e. feelings of sadness, hopelessness and helplessness (9 respondents), and 'death of a relative' (in 9 respondents); 12 (21%) mentioned "somatic concerns" including an

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