Psychological Factors Related to Fibromyalgia Syndrome Phenomenon

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Abstract

Fibromyalgia is a chronic rheumatic syndrome characterized mainly by diffuse musculoskeletal pain. Its diagnosis is clinical and the presence of 15 to 18 tender specific painful body sites (tender points), with no specific laboratory alterations. It is often associated with other symptoms such as constant fatigue, swelling, morning stiffness, difficulty in memorizing and concentrating, mood swings, anxiety, and depression, among others. This condition mainly affects women, bringing a considerable negative impact on carriers. Pain perception is the result of multiple factors: biological, social, and psychological. This study sought through qualitative research to recognize the psychosocial factors related to fibromyalgia, as well as identify the possible meanings to suffering, seeking to contribute to elucidate the psychogenic phenomena related to the pain of Fibromyalgia Syndrome. Finally, to analyze if patients who are undergoing psychotherapy follow-up benefit from the symptoms caused by chronic pain of fibromyalgia. The result is divided into three categories: Implications of the diagnosis in social relations, repercussions of the diagnosis on the interviewees' quality of life, and psycho-affective symptoms experienced by the interviewed fibromyalgia patients. According to the research, it was observed physical limitation, adding severe pain, memory impairment, concentration, excessive fatigue, resulting in psychic suffering characterized as guilt, frustration, depression, anxiety, and self-image affected. In this study, ten female patients with a mean age of 40.2 years were interviewed, of which 30% are undergoing psychological follow-up, which resulted in greater acceptance of their comorbidity and coping with it.

Keywords: Fibromyalgia-FM, Biopsychosocial Factors, Women

INTRODUCTION

Fibromyalgia is a rheumatic syndrome mostly diagnosed by clinical examination. The symptoms

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of this clinical condition are painful and have implications for the quality of life of the individual with this syndrome. The Fibromyalgia Syndrome - FM is usually polymorphous, that is, subject to change of form. The symptom presented by patients with this syndrome is chronic pain, and patients have difficulty locating the pain and specifying whether the origin is muscle, bone, or joint. The amount of pain varies among patients and may be characterized by burning, stinging, weight (tiredness), or as a bruise. Also, according to this, the aggravation of symptoms may be related to cold, humidity, climate change, emotional tension, or physical exertion. (RUSSEL, apud PROVENZA, J.R. et. Al, 2004)

According to Martinez (cited in PROVENZA, JR et al, 2004), fibromyalgia significantly affects patients' quality of life due to the deterioration in functional capacity, sleep, sexuality, and professional life. Fibromyalgia patients should be given a global approach and not only regarding physical complaints. According to Junior (2012), fibromyalgia syndrome can affect patients of any age and mainly diagnosed in women. A study was conducted at the American College of Rheumatology that found a prevalence of 3.4% in women and 0.5% in men, especially in the 35-60 age group. Due to this significant information, we chose gender as a research factor and the age group, which is among the most afflicted by the disease. The individuals with fibromyalgia syndrome find their body as a source of suffering, frustration, and impotence in the face of pain. Knowing the origin and accepting body limitations can lead to better adaptation and possible improvement of pain.

Through informal conversations with physicians and patients in the community, there was an interest to investigate more about this pathology, as well as the possible causes and treatments to alleviate chronic pain caused by FM.

METHOD

A qualitative, descriptive/exploratory research, this research proposes to analyze the interaction through individual interviews through questions related to the biopsychosocial context involving patients with the syndrome and analysis of qualitative data. According to Bardin (2006), content analysis is a set of communication analysis techniques, which seeks to interpret the information contained in the interviews, which can be about the meanings or significant, is highlighted in this field, the importance of semantics for method development.

The research aimed to analyze a group of 10 women. The interviewees were indicated by a local hospital in Manaus, Amazon - Brazil. Inclusion Criteria: Women residing in Manaus, aged between 30 and 50 years, who have a final diagnosis, with at least one year of diagnosis. Exclusion Criterion: It is perceived as indicative of exclusion - being fit to the inclusion criteria and: being women with severe mental disorders (a definition that associates the duration of the problems, the degree of emotional distress, the level of disability that interferes interpersonal relationships and social skills and diagnosis). Women who have only suspected fibromyalgia syndrome; have another nationality that makes it impossible to speak or understand the Portuguese language.

We used the individual interviews as methodology; through these, we worked the theme, divided into two moments. In the first moment, we presented the Informed Consent form, informing the participants that the interviews and the collected information would be used exclusively for the research and that the identity of the participants were going to be preserved. Later, in the second moment, we proceeded with the interview, addressing the themes of the biopsychosocial aspects of fibromyalgia, possible meanings to suffering, psychogenic factors related to FM pain. We also approached, through the interview, if they had psychotherapeutic follow-up.

This study was conducted through data collection and semi-structured interviews that, according to Cervo & Bervian (apud OLIVEIRA, 2011) is one of the main techniques, and can be performed through face-to-face conversations by the research team, following the method and ethics, in order to obtain the data information related to the proposed research. This content analysis consists of General reading of the collected material (interviews and audios); Coding for the formulation of analysis categories, using the theoretical framework and the indications brought by the general reading; Clipping of the material, in comparable units of record (words, sentences, paragraphs) and with the same semantic content; Establishment of categories that differ thematically in the registration units (passing from raw data to organized data). The formulation of these categories follows the principles of mutual exclusion (between categories), homogeneity (within categories), relevance in the transmitted message (non-distortion), fertility (for inferences) and objectivity (comprehension and clarity); grouping of registration units into common categories; progressive grouping of categories (initial → intermediate → final); inference and interpretation, supported by the theoretical framework. The Brazilian Resolution of the National Health Council 466/2012 was followed. This research has pledged to safeguard the integrity of all stakeholders, preserving privacy, seeking benefits, and protection. It gives free consent and clarification. It was submitted to the Research Ethics Committee (REC) and approved. According to Oliveira, (2013, apud FREITAS et al, 2015), the RECs were created to defend the interests of the research subjects, with the purpose of protecting the integrity and contributing to its development through evaluation and monitoring within the ethical standards. “Having as guiding principles the referential of justice, equity, beneficence and non-maleficence” (OLIVEIRA, 2013, apud FREITAS et al, 2015, p.02).

Theoretical Framework

According to Ferreira (2015), one of the first doctors to try to define the set of signs and symptoms that is now known as fibromyalgia was Frederick Wolfe, director of the Arthritis Research Center in Wichita, Kansas, who was interested in this clinical condition in the decade. Like many other rheumatologists, he had seen an increasing number of patients who complained of diffuse muscle pain but who, upon physical examination, showed no evidence of injury or inflammation. Laboratory tests, X-rays, biopsies, and muscle tissues showed no evidence of the pathology. The lack of blood markers made it difficult to diagnose and, therefore, to treat. Only in 1990, however, did the term “fibromyalgia” formally receive a medical nomenclature, designating a condition of persistence. FM may involve genetic factors, inflammatory states, sleep disturbances, and various psychological factors.

The body is not just a set of skin and bones. By carrying meanings, the body becomes the main constituent of personal and social identity. Pain is understood as an unpleasant sensory and emotional experience associated with present damage or potency in terms of injury. This is the most common definition of pain, even described by the International Association for the Study of Pain - IASP. It was officially launched on May 9, 1974, and its official journal, pain, was published in 1975. The question that has been asked for many years and is hardly answered is: is pain organic or psychogenic? Today we seek to answer this question in another way: pain is a biological, psychological, and social experience. It is therefore, biopsychosocial (MATOS, 2012).

According to Turk and Flor (apud TOMÁS, 2009) there are three underlying assumptions in the biopsychosocial aspects of patients with FM, the first of them concerns the biological issues that participate in their physical disorder; the second refers to psychological factors that influence the psychosomatic aspect of pain; Finally, social issues stimulate the patient's physical perception, which automatically changes his behavior. According to Turk and Melzack (apud TOMÁS, 2009) it is essential to understand the symptoms of FM, which go beyond isolated psychological and biological factors; this understanding is an effect of the interaction between social environment, body, and mind. Mainly because the central symptoms of FM, such as chronic pain, change all areas of personal progress, such as physical, emotional, social, and family relations.

According to Berber et. al (2005) FM patients have a poorer quality of life compared to other chronic diseases such as rheumatoid arthritis, cancer, chronic obstructive pulmonary disease, and systemic lupus erythematosus, due to FM symptoms patients suffer a sudden break in routine, This impact tends to be permanent, where there is a destabilization of social contact, as well as family relationships, as patients are constantly forced to adapt to their new condition. Given this scenario, Reich (apud MACEDO, 2015) says that there are worrying factors for both the patient with FM and the people who live with him, these factors refer to the frequency and intensity of symptoms, this generates a level of insecurity very great within this social life.

Berber et. al (2005) inform that psychosocial factors play an essential role in the evolution of FM, such as behavioral, cognitive and social factors, each viewed separately, but forming a set, examples, risk behavior and poor adaptation of coping forms, loss of self-control and victimization, interferences of the individual's activities in society. Given the chronic pain these problems can harm the patient, who moves away from friends, begins to have financial problems due to possible job loss and has no desire to perform physical activities, as the patient has cognitive impairment he has not adequate coping ability culminating in depressive symptoms and generating a vicious circle. According to Helfenstein Junior et. al (2012), social and psychological factors can directly influence the feeling of disability of FM patients, but this is not unique to these patients, but of all chronic pain patients, after all, the body is the physical environment of the subject.

According to Helfenstein Junior et al. (2012) the diagnosis of FM is clinical, the central point is generalized chronic pain, but in addition, there is diffuse musculoskeletal pain, fatigue, muscle stiffness, multiple tender points, pain after physical exertion, sleep alterations, may you also have symptoms of depression, memory impairment, anxiety, tension or migraine headache, dizziness, dizziness, paraesthesias, irritable bowel syndrome or restless leg syndrome, among other symptoms related to the locomotor system.

[...] Fibromyalgia as a paradigm of chronic diffuse pain represents the well-finished summary of the interrelationship between human neurological - immune - endocrine - behavioral control systems. We now know that dysfunction in any of these sectors can translate into pain, which depending on the characteristics of each person, may vary from phenotype. To put it further, momentary imbalances in the control of various stressors are common and do not cause disease, until they reach a critical level, either by the intensity of the stimulus or by the weakness of the individual's defense. Thus, the painful scenario represents the tip of the iceberg of a continuum, which becomes unbearable and requires medical attention. There is no doubt about the pathophysiological changes in patients with Fibromyalgia. The quality of life of these patients is poor, and regardless of their emotional state at that time (FELDMAN, 2008, p. 318).

Because it presents so many inconveniences to the patient's health, it is common to search for a pathology to explain the symptoms, and according to Sá et. al (2005) there is much controversy regarding the etiological and physiological causes of FM, of course, there is no denial that pain and symptoms exist, but there is no concrete laboratory evidence, even therapeutic approaches share this blurring. First indication that the diagnoses may be different depending on the medical specialty the patient is, such as going to the infectologist will be considered to have chronic fatigue syndrome, gastroenterology irritable bowel syndrome; rheumatology may eventually be diagnosed as Fibromyalgia. According to Kossoff (apud SÁ, 2005) other factors are being the focus of investigation, such as genetic factors, because FM can happen in certain families, scientists have pointed out a possible genetic vulnerability that, being triggered by a traumatic event could trigger the disease.

Helfenstein Junior et. al (2012), states that FM is influenced by environmental, hormonal, and genetic issues, triggering changes in the level of neurohormonal receptors. Any severe stressor could lead to a change in the pituitary-hypothalamic-adrenal axis that could involve the sympathetic and serotonergic nervous system. It is concluded that the pituitary-hypothalamus-adrenal axis plays an essential role in the lasting of FM symptoms. The psychosocial factors deserve particular attention, encompassing all facets of the life of this subject, such as possible psychiatric aspects, trauma experiences, financial problems, in short, a cultural perspective of pain. Therefore, as the individual is a group, the patient's entire experience is analyzed to obtain a better psychic understanding of the patient (SÁ et. Al 2005).

Oliveira (2000) suggests that pain can be a manifestation of psychological symptoms, such as psychiatric illness, depression, anxiety, and psychosis. However, some factors lead to FM classification, where phenomenological aspects predominate. Even some FM pictures are related to depressive patients, but there is no definition as to whether depression can lead to a FM picture or the opposite. Berber et. al (2005) tells us that FM causes feelings of vulnerability and helplessness due to its unknown origin and cure. The prevalence of depression among these patients ranges from 49% to 80%. Depression can influence FM symptoms, causing functional limitations, worsening the subject's quality of life. Helfenstein Junior et. al (2012) inform that FM can be diagnosed at any age, being much more frequent in women, according to studies conducted 40.8% of these women are in the age group of 35 and 44 years old. The prevalence of psychological symptoms in these patients worsens the clinical picture resulting from another study conducted in Brazil found that 30% of fibromyalgia patients had severe depression and 34% moderate depression, 70% of patients with FM had significant anxiety, and 88% had significant anxiety. The author mentions that the combination of depression and FM causes the exacerbation of symptoms, impairing coping strategies, he emphasizes the psychological profile of these patients, who present severe self-criticism, perfectionism and obsessive search for details.

However, according to Berber et al. (2005) depression worsens the course of the disease because it ends up increasing the sensation of pain, prevents adherence to treatment, deregulates the hormonal and immune system, and destabilizes the social support of the patient who is isolated. Every sick person seeks a reason for their illness, a name for their illness, something that can justify their suffering. This nonconformity leads to the search for meanings for its physical limitation. In numerous studies, a close relationship between FM and psychopathological disorders can be noted. According to Branco (apud SÁ et al, 2005) there is some difficulty in distinguishing FM from other somatic functional syndromes and psychiatric disorders, such as depression and anxiety. Because of the emotional distress associated with physical pain, as well as limitation and diagnostic uncertainty, the picture worsens, also taking into account frustrating therapies and anxiety for relieving fibromyalgia pain.

Chiozza (apud. LIMA, 2008, p.02), say "the substitution of meaning carries with it a magnitude of affection sufficient to give it significance." Montagna (apud LIMA, 2008) also says that the reading of one's feelings by the subject, through verbal language, is full of gaps, voids, and it is up to the psychoanalyst to try to unravel and elucidate these feelings. From the cognitive point of view, this same author points out that verbalizing a traumatic experience, modifies memory, and organizes the emotional experience into something that can be more easily elaborated and worked on, in order to be put aside. According to the DSM-V, despite the classification of somatic symptom disorder, it is not appropriate to give a diagnosis of mental disorder simply because it cannot be proven by medicine. The medical diagnosis also does not exclude the possibility of a comorbid mental disorder. The presence of somatic symptoms of uncertain etiology is not in itself, sufficient to justify a diagnosis of somatic symptoms disorder. The symptoms of many people with fibromyalgia would not meet the criteria required to diagnose somatic symptom disorder (ARAÚJO, 2014). El-Hage et al. (apud MATOS et al., 2012), declares that when there is a chronic pain that is undiagnosed through a scientific explanation, it may be of psychological origin, a somatized suffering. Since fibromyalgia does not present real physiological changes in most cases, it gives room to believe that this is a psychopathology. Biomedical specialties fail to reach a diagnostic consensus, and many patients are referred to psychiatric outpatient clinics and subsequently diagnosed with depression. This is due to Western scientific medical rationality - the legitimacy of pathologies from imaging examinations. What then presents to the subject with FM, is a disease without a cure, which presents itself without a visual diagnostic examination, and limiting the functionality of the patient's body, leading him to the obligation to accept losses by him.

Chronic pain produces a permanent change in an individual's life. As stated by Angelotti (apud. LIMA, 2008), this permanent change modifies his behavior, his insertion in the family and in society. Chronic pain has psychological consequences, triggers low self-esteem, insomnia, anger, feeling of abandonment, and a high rate of depression (STRAUB, apud MILANI et al., 2012). "To fall ill is to endure something unpleasant, especially when one does not have the means to act on the causes and before which escape is impossible." (DANTAS & TOBLER, apud MILANI et al., 2012, p.03). According to Coelho (apud MILANI et al., 2012), every significant loss that happens in life, in the case of the patient with FM is health, it is necessary an elaborative process, which is accompanied by process of bereavement. Grief is an excruciating process of emotional elaboration, where there is the "farewell" of a person, condition, or situation so that it can adapt to the new reality that the subject is inserted. The pain of loss of health, physical abilities, social life, or limits is something that undermines the emotional structure of the chronic pain, and causes deep discouragement, a significant disinterest in the outside world, a loss of ability to produce.

Martinez (apud PROVENZA, JR et al., 2004), states that in addition to the suffering caused by pain, the worst consequence of fibromyalgia is the loss of quality of life. The fibromyalgia patient has his daily activities affected, limiting his social life and may even compromise family ties. For Kubler-Ross (apud VALIM, D'AAGOSTINI, 2018) the terminally ill patient goes through five stages: Denial, Anger, Bargaining, Depression, and Acceptance. These stages are also experienced by fibromyalgia sufferers. These stages are defense mechanisms, and there is no chronology between them, and the patient may go through one of these stages more than once. Desriaux (apud MATOS et al., 2012) says that musculoskeletal disorders are first among recognized occupational diseases. These disorders are sources of severe disabilities that compromise the health, employment, and life of those affected.

According to research by Sá et al. (apud MATOS et al., 2015), they find that between the onset of symptoms (pain) and the diagnosis, the delay is five to eight years. The fibromyalgia patient is labeled for years as a psychiatric patient, which despite complaints of widespread pain and fatigue, these are not justified. It is biomedicine's inability to deal with a subjective malady that categorizes these patients as psychiatric. However, according to Sasdelli and Miranda (apud LIMA, 2008), as the patient verbally externalizes the pain and its representations, the patient has more experience and understanding about the pain itself and can move from passive mode to a more active growth posture. However, it should be noted that pain, in many cases, will be present as a companion for the person who will have to undergo some restrictions. It is necessary to give meaning to the disease process.

Coelho (apud LIMA, 2008), the basis of the personality structure of the chronic patient comprises regression tendencies, which may facilitate primary care, as it adapts to the condition of 'patient', but also contributes to its chronicity. That is, the patient conforms to the position of dependent, fragile, and in a way this condition contributes to the fact that being cared for can be somewhat comfortable, and conformist. Through various studies in the early 1960s, psychiatrist Aron T. Beck developed Cognitive Behavioral Therapy (CBT) to address current depression problems and modify individuals' thoughts and behaviors through psychotherapy. According to Beck (1997), Cognitive Behavioral Therapy is a cooperative process of empirical investigation, a set of strategies and therapeutic techniques for the purpose of changing thought patterns, which are identified as automatic and dysfunctional. This process can take anywhere from three to six months, where strategies are worked out to deal with suffering. It intends to modify, during the sessions, the cognitive processes that are considered responsible for the behavior that happens outside the session. The main symptoms of fibromyalgia, especially chronic pain, disturb all areas of personal functioning, physical, emotional, social, family, and occupational functioning (TURK & OKIFUJI, 2002).

Camacho and Aarte (2001), empirical studies indicate that external attribution and catastrophic thinking contribute to pain intensity. Cognitive therapy, as described above, is the approach of choice for modifying such biases in patient information processing. Turk & Okifuji (2002), declare that pain is progressively recognized as a sophisticated perceptual experience, due to the influence of a broad range of psychosocial factors, which integrate the socio-cultural background, the social context and the surrounding environment, the meaning attributed to the pain, emotions, beliefs, expectations and personal attitudes. For Bailey et. al, (2003) chronic pain is really a demotivating condition for the patient, because in addition to facing the stress triggered by pain, also has to continue to deal with other "stressors" of their daily lives.

Psychological screening is an essential procedure in the comprehensive assessment of all fibromyalgia patients, aiming to refer patients with psychological evaluation. Screening consists of obtaining sufficient information about the impact of symptoms on the patient's physical condition, mood, and perceptions of the responses of other significant people (Turk et al., 2002). For Bradley and Mckendree-Smith (2001), it is necessary to clarify to patients that psychological assessment aims at exploring and identifying interactions between psychological (emotions, cognitions, and behaviors) and altered physiological processes that influence symptoms and persistent pain, disability and social and family activities. Brandão (1999), mentions that pain generates essential psychological and social dysfunctions. Chronic pain is not suitable for one type of treatment because it is subject to a series of control mechanisms that act on the nervous system as a whole. In addition to medications should be used, other procedures that help reduce symptoms. According to the literature, patients who are diagnosed with fibromyalgia exhibit behaviors that need to be modified and / or replaced in order for people with the syndrome to cope better with their pain and, consequently, with their symptoms in a healthier way. This does not rule out the possibility of a combined treatment: rheumatologist, psychiatrist, physiotherapist, and psychotherapist. Based on the authors Turk, Meichenbaum and Genest (1983), through exercise, the patient can learn to identify pain-related negative emotions and stressful events and recognize dysfunctional thoughts and cognitive biases associated with them. With exercise, he can gain better control over the symbolic processes related to pain management and experience.

Results

Laurence Bardin (apud CAMARA, 2013), professor at the University of Paris V, content analysis is one of the data approach techniques in qualitative research. Another aspect raised by Bardin is that content analysis has been used for a long time since humanity's first attempts to interpret holy books, being structured in the 1920s as a method by Leavell. The definition of content analysis comes only in the 40-50s with Berelson, aided by Lazarsfeld, Bardin's work came to be published only in 1977 "Analyze de Contenu" in which the technique was adjusted to the minutiae that serve as direction today (CAMARA, 2013).

[...] The term content analysis refers to: "a set of communication analysis techniques aimed at obtaining, by systematic procedures and objective description of the message content, indicators (quantitative or not) that allow the inference of relative knowledge. The conditions of production / reception (inferred variables) of these messages (BARDIN, 2011, p. 47, apud CAMARA, 2013 p. 182).

Godoy (apud CAMARA, 2013) states that content analysis from Bardin's perspective is a methodological technique that can be applied to all types of expression and communication. In this analysis, the researcher seeks an understanding of the characteristics, structures, or models that are hidden in message elements that are considered. The analyst has two functions: understanding the meaning of communication as if it were his own, as well as seeking another meaning, another message, which can be seen through or beside the first.

Bardin (apud CAMARA, 2013) content analysis is a method that can be applied to both quantitative and qualitative research. In order to answer the research objectives, we prioritize the use of Bardin's Content Analysis for the discussion of data, by dividing and associating narrative excerpts, based on thematic similarities, for the formation of categories. The division into categories is a result based on analysis, aiming at the systematization of internal contents, subjective in nature.

The categories discussed below each have their specificity and thus result in the subject's pure and particular experience content. Due to the analysis of the interviewees' statements, we reached the following initial categories: Physical and social limitations; Dependency; Difficulties at work; Memory and concentration; Ache; Tiredness; Acceptance of the diagnosis; Guilt and Frustration; Depression and anxiety; Self image. These categories concern the first interpretations. Later, in continuity with the analysis of thematic similarities, we find three final categories: Implications of the diagnosis in Social Relations; Diagnostic repercussions on quality of life; Psycho-affective symptoms experienced by fibromyalgia patients. The table below presents for better visualization of the correlation between final categories and the first categories.

Table 1 – Category analysis procedure

Final Categories		Initial categories	
1.	Implications of diagnosis in social relations	1.	physical and social limitations;
		2.	Dependence;
3.	Diagnostic repercussions on quality of life	4.	Difficulties at work;
		5.	Memory and Concentration;
		6.	Pain;
		7.	Tiredness;
8.	Psycho-affective symptoms experienced by fibromyalgic patients.	9.	Acceptance of the diagnosis;
		10.	Guilt and Frustration;
		11.	Depression and Anxiety;
		12.	Self Image

We interviewed 10 female patients with fibromyalgia. The table below shows the sociodemographic data of the interviewees studied. The average age of the interviewees is 40.2 years; most of them are married, highly educated, and have children.

Table 1 - Sociodemographic characteristics of respondents with fibromyalgia

Sample	10
Age	40,2 years (32-49)
Marital Status	
Single	2 (20%)

Married	8 (80%)
Educational Level	
High School	3 (30%)
Univeristy Degree	4 (40%)
Pos-grad	2 (20%)
Master	1 (10%)
Childres	
Yes	7 (70%)
No	3 (30%)

The interviews conducted pointed to a significant loss of health, which according to WHO, health is a "state of complete physical, mental and social well-being and not only due to the absence of disease or illness" (Revista Saúde Pública 1999). Moreover, as a result of this lack of well-being, 100% of respondents said that the physical limit was compromised, and as a result, 90% of them stopped going out, doing something they had done socially before. According to Millani (2012), the pathology is real and debilitating, and the fibromyalgia patient experiences persistent and widespread body pain. Even the pains get worse because of the pain of misunderstanding. The conditions of the patients affect the productive life of this person. Interviewee 4 reports:

"I am no longer in the mood for many things. It had a huge impact on my life. Because I was always very active. For example: gym, if I go, I'll just do a treadmill. I can get nothing more. I was very antisocial. I don't like to be with people anymore. I can't explain, I think I'm kind of impatient. Meetings, birthday parties, other parties, all night at the party today, I don't like it, I don't go, I don't have patience anymore and I get tired and irritated. I'm not very nice anymore. And even in the church I can't stand it. Also even play with my 5-year-old son. I get tired, it hurts me. And I can't play with him anymore. "

Most of the interviewees pointed out difficulties as much for work as for those who studied as well. Even Goldenberg (apud MILANI, 2012), mentions that the worst consequence of fibromyalgia, due to pain and other symptoms, the patient ends up limiting both social contacts and there are cases of breakup with family members. However, the consequences of a chronic illness are a person's life compromised, and depending on the emotional state even before the onset of the illness. Those consequences get even worse. The pain is so intense that the limiting aspects can be inferred in many areas of patients' lives, which can be noticed in the interviewee's speech 2:

"I stopped working, stopped doing activities I liked in the church, walking also became difficult."

Often there is nothing that can be seen physically in the body of patients with chronic FM pain. However, the individual complains of pain, and the slightest tasks at home can be cumbersome. These limitations can be interpreted as unwillingness, laziness, exaggeration by family and friends. For this reason, people who live with the patient have difficulty validating symptom complaints. According to interviewees 1 and 3:

"It stirred the mood - total physical limitation. It stirred my family, it stirred my activities, I worked, I don't work anymore. With the family, I was that mother who gave the reinforcement, and now I can't anymore. There were so many medicines I need to take, the spending on the medicines."

"To do things by hand, especially in the morning. I also can't do the things I did before, like going out to parties, I get tired soon and I want to go to bed. "

The impact that FM has on the patient's life, whether social, individual or family, involves considerable social limitation. Failure to live the life she lived affects the social circle of this patient. According to Santos et al (apud LIMA, 2008), research conducted in São Paulo, which points out the precarious life of FM patients compared to people considered healthy. This research reports that the physical symptoms of the subject with the syndrome lead to a decline in vitality and functional skills. Even some of the interviewees said they missed who they were before. Although the disease is not visible, simple tasks are left undone, such as walking in a mall, hanging out with friends, socializing with family, and people's misunderstanding makes the pain even greater. As reported by interviewee 1:

"I wanted to go out with friends, I can't, but they do not understand, they ask me to react as if it was something I had in my control."

These FM carrier disruptions have an impact on quality of life. It was observed in the interviewees' speech a frustration about bringing dependence on other people, as interviewee 1 said:

"I do not accept. I hope that one day I will get rid of these pains. It is very difficult to live dependent on others."

When we look at the interviewee, we can see that it is not only she who suffers, but a human being who belongs to a family, to a society that suffers, and this subject with his particular subjectivity and history that is compromised. In this respect, Le Breton (apud. MATTOS, 2012) "pain is not only a physiological fact, but mainly a fact of existence". Not only the patient suffers from pain, but what this patient represents as an individual in the social life that gets sick. Thus, what was observed is that the physical, mental and social impairment of the patient reflects directly on the quality of life of this subject.

According to the interviewees, there is a considerable decline in quality of life, where almost 100% of them mention that tiredness, lack of memory, disposition, decreased libido and especially pain end up being factors that generate a significant disability, such as It was also seen only 40% of them can do physical exercises. While, it is called “quality of life”, or assessment of global health, the determination of the personal, physical, psychological and social impact of the patient, imposed by the disease (MARTINEZ et. Al, 1998).

“I can no longer live as before, before I was faster, pain all the time, all joints hurt when I'm in crisis. When I am not in crisis, there is some pain in parts of the body. Or the head, or the spine, or another. Examinations show inflammation, but nothing visible. Marriage changes, I can't have libido anymore. ” Interviewee 2.

“I also can't do the things I did before, like going out to parties, I get tired soon and I want to go to bed.” Interviewee 3.

“Stuck intestines, Tiredness, blurred vision, tingling, very sensitive soles, forgetfulness (memory), fluctuating mood, irritability, weight gain, lack of concentration and much anxiety” Interviewee 4.

“I walk 3 times a week” Interviewee 2.

Velkuru (apud ABREU, 2011) says that FM does not have such a dominant diagnosis if affected patients make use of the broad spectrum of therapeutic specificities, patients who are more committed and motivated manage to have a "normal" quality of life while discouraged and non-collaborative patients have more severe clinical conditions.

On the other hand, this lack of disposition may be linked to secondary symptoms such as depression. Santos et. al (2006) states that fibromyalgic patients have a lower quality of life, where there may be a relationship between FM and depression. Depressive symptoms compromise the quality of life of patients with FM, increasing the sensation of pain and the perception of functional disability. In fact, depression is an independent predictor of variation in physical performance in these patients so depressive symptoms should be controlled to ensure improved quality of life (HOMANN et. Al, 2012).

“Stomach pain, depression, difficulty sleeping, irregular bowel, weight gain, physical limitation, and as I said, tiredness. It's a pain we don't want for anyone. ” Interviewee 5.

Loose bowel, sleep too much, weight gain, tired waking, depression, isolation, sensitive hearing. And what disturbs me the most is the memory. I took vitamins and tests accused nothing. Frustration. Foot pain. Horrible ”Interviewee 6.

The impact that Fibromyalgia has on patients' quality of life after diagnosis, mainly due to physical symptoms, is a disabling consequence. They begin to feel frustrated that they cannot be as they were before their illness, unable to do what they did when they were in full health, leading to social isolation, creating a dependency on others, and especially being hostage to their new condition.

"The routine for sure. Today my routine began to adapt according to Fibromyalgia. I had to adapt my work at home, there was a need to transfer my office here home, because I make my schedule and if I feel bad, I can go to my room and work the time I feel better. Today my husband is worried even when I'm driving, the drugs are drowsy and I ended up avoiding driving more". Interviewee 9.

"Yeah, I had a very nice life. Full of friends, going out every weekend, playing volleyball, and now I'm here, in pain. I'm not active anymore, I just want to know about my house, my bed." Interviewee 7.

Martinez et. al (1998) states that Fibromyalgia significantly affects patients' quality of life. Degradation is expressed in various areas, such as functional capacity, sleep quality, sexuality and working life. Patients with Fibromyalgia should receive a multidisciplinary approach, not only in relation to complaints and musculoskeletal function, but mainly due to the presence of psycho-affective symptoms.

The research participants had a high prevalence of psycho-affective symptoms considering depression and anxiety at higher levels, but other symptoms were emphasized, considering their individual and social consequences, such as guilt and frustration for being a chronic syndrome with undefined etiological factors, emotional instability in the process of accepting the diagnosis, support and understanding of family members and the changes they suffer in their self-image.

The contents of the answers are strong because they portray the psychic suffering caused by pain, as we can see below:

“In the crisis I get completely in bed. I can not do anything. Lots of fatigue. It strikes an anguish, a sense of abandonment and even being unable. Here comes the cry of pain that depresses us. ” Interviewee 5

“I get anxious, nervous, I want to go home soon. I feel too tired. I don't want to go anywhere, just lie down, very tired. I think this is worse. People don't understand, they think it's freshness. And because of all this, I isolate myself, and it's even making me afraid of reunion. ” Interviewee 6.

“I had a very nice life. Full of friends, going out every weekend, playing volleyball, and now I'm here, in pain. I'm not active anymore, I just want to know about my house, my bed ... I can't settle for it. I know I need to obey my body, but I ask God for healing. I don't know how I will live like this. I take medications and how will I live taking medications all my life? ”. Interviewee 7.

As well portrayed by Berber (2005), the predominance of psychiatric imbalances, especially depression, is high among patients with fibromyalgia, ranging from 49% to 80%. Depression can trigger or aggravate the characteristic symptoms of fibromyalgia, leading to reduced functionality, greater perception of stress, and greater intensity of depressive symptoms than healthy individuals. (HOMANN et al, 2012).

According to Straub (2005), fibromyalgia patients, suffering from chronic pain, have psychological consequences and triggers feelings of abandonment, low self-esteem limiting their social life and may even compromise family ties.

“The marriage changes, I can't have libido anymore, I gained a lot, I'm ashamed. I can no longer have a nice sex as before. Everything has changed, I feel guilty, I feel heavy, I feel frustrated because I can't make food anymore, I can't do the cleaning. I cry constantly because I can't get my house dirty, and staying home without work is very frustrating and I feel very guilty. ” Interviewee 2

“My son's father, he reads, has heard, but doesn't help me, doesn't understand the disease, so he does nothing to help me in the crisis. It's no use knowing if you don't understand. He doesn't work, does nothing to help. I'm the one supporting the house. Even my marriage is falling apart. ” Interviewee 4

“They didn't understand, and I didn't feel understood. They don't understand ... They think I'm not fighting, I'm not trying. It's too bad, I don't feel welcomed. People want me to drive, to drive, and I can't anymore. But I have to put up with it. ” Interviewee 6.

The statements also point to feelings of vulnerability and helplessness due to the demotivating conditions of the origin of the unknown diagnosis and cure. The simultaneous appearance of psychic disorders causes more significant functional limitations, negatively impacting people's quality of life, both in physical, intellectual, and emotional aspects, and reducing the ability to work, family, and social life (TORRES, TRONCOSO & CASTILLO, 2006).

"I was very fast at work, and now I can't anymore. I am slow. This is not me, and having no prospect of improvement is very sad. Doctors even give me vitamins, change my diet, but I can't improve. And I didn't want to live on prescription drugs. And I have many thoughts of inferiority, unable to do certain things." Interviewee 6

"All. It stirred the mood - total physical limitation. It stirred my family, it stirred my activities, I worked, I don't work anymore. With the family, I was that mother who gave the reinforcement, and now I can't anymore. There were so many medicines I need to take, the spending on the medicines." Interviewee 1

In this sense, as portrayed by Sasdelli and Miranda (2001), pain is associated with the psychological functioning of the singular being, and when approaching the subject, it is essential to consider that it is fundamental to use the condition of empathy, to put oneself in the other's place. try to understand what pain represents to him, try to understand if the patient can have any secondary gain with it.

According to the authors, as the subject expresses verbally about pain and its representations, the subject has more significant experience and greater understanding about it, being able to leave the passive position of experience and assume a posture of growing in the experience. It is also noteworthy that pain, in many cases, will be an eternal companion of the person, who will have to undergo some restrictions. It is necessary to give meaning to the disease process.

"Thanks to this follow-up with the psychologist I didn't get into a deep depression. The follow up with the psychologist helped me in this acceptance process. Because the pain is demotivating you. But today I already accept." Interviewee 8

The data collected validate with the literature, regarding the impact that these psychological symptoms can have on patients with fibromyalgia, either through the intensification of pre-existing psycho-affective symptoms or the production of additional symptoms. According to Coelho (apud BRADLEY, LA & Mckendree-Smith, 2001) the pain of loss of health, physical abilities, social life, or limits is something that shakes the emotional structure of the chronic pain subject, and causes deep discouragement, a critical disinterest in the outside world, loss of ability to produce, do and be.

FINAL CONSIDERATIONS

The development of the present study sought to analyze the possible biopsychosocial causes that interfere in the process of fibromyalgia syndrome. For this, we sought to describe the biopsychosocial aspects of Fibromyalgia Syndrome; identify the possible meanings to suffering, seeking to contribute to elucidate the psychogenic phenomena related to the pain of Fibromyalgia Syndrome; as well as seeking to investigate the benefits of the interviewees who do psychotherapeutic follow-up regarding the symptoms caused by the chronic pain of Fibromyalgia. It is important to emphasize that this comorbidity brings severe pain, limitations, and that Fibromyalgia has no prospect of cure so far. Therefore, the implications that this syndrome transfers to the patient go beyond the biological aspects, bringing social and psychological implications. Through semi-structured interviews with ten women with FM, it was observed that the interviewees had different degrees of suffering. Similarly, different coping with comorbidity, both physical, exercise, adherence to medical and psychological treatment.

It was concluded that there is a considerable aspect of psychological distress for these subjects. Also, both patients who have to deal with this disease daily and people who are in some way connected with the diagnosed individuals, in any of the aspects mentioned during the work, we observed some kind of dazzle of positive points by the affected. However, it was noted that the carriers who are accompanied psychotherapeutically, showed a better coping with the syndrome, and consequently worked more positively their frustrations and limitations that Fibromyalgia imposed on them.

Fibromyalgia has proved to be a complete mystery in many ways, it has no cause leading to it, it has no cure, so many authors associate the disease with psychological factors, such as extensive trauma that some people cannot internalize, for students. Psychology has been a subject of much learning and clarification to help in the search for new knowledge about this so distressing syndrome of living, to understand how these women mostly coexist with this disease and how it completely affects their lives, family, your social circle, your body and your mind. Due to these particularities, it has proved to be a topic of fundamental importance for the health area in general, not only physical but also primarily mental. Therefore, this study is only one among several that seek to understand and help people who have this pathology, with information to explore understanding in the face of suffering in chronicity. It was a work of extensive acquisition in the academic context and with possible paths to broader and deeper contexts on the subject in question.

For psychologists, understanding how the chronic pain patient is affected globally by the implications of this comorbidity is very essential. Fibromyalgia Syndrome is in fact a pain that exceeds the physical, due to the biopsychosocial losses that the subject suffers. In this fact of no longer being healthy, no longer who he was before, the individual goes through many emotional pains and needs to elaborate all this suffering, so that he can resignify his new physical, emotional and social condition. In this respect, the reception and psychotherapeutic accompaniment are critical. As researchers, we could understand the extent of the details surrounding fibromyalgic individuals.

By doing the interviews with the carriers, we were able to experience interview cancellations because the interviewee was unable to receive. We also note that there is a great need to exchange experiences with other carriers and to have a place where this individual can open. We offer psychotherapy at the University through the Psychology Clinic. We also offer to email the survey to the carriers interviewed. The contribution to the unfolding of other researches on the same theme is fundamental so that new knowledge can be acquired.

REFERENCES

ABREU, Daniela; PEREIRA, Rogério. Impacto da fibromialgia na qualidade de vida dos pacientes. Porto, 2011. Available on < file:///C:/Users/user/Desktop/T_18299.pdf>. Access on: 30/10/2019.

ARAUJO, Álvaro Cabral; LOTUFO NETO, Francisco. A nova classificação Americana para os Transtornos Mentais: o DSM-5. Rev. bras. ter. comport. cogn. São Paulo, v.16, n.1, p. 67-82, apr. 2014. Available on <http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1517-55452014000100007&lng=pt&nrm=iso>. Access on: 05 Set. 2018.

ARAÚJO, E.F de; SANTOS, M.C. dos; WELLINGTA, dos S.; JUNIOR, S.J.R.R.; FENÔMENO SUBJETIVO DA DOR E A SÍNDROME DA FIBROMIALGIA, UNIVERSIDADE INTEGRADA TIRADENTES, Available on https://editorarealize.com.br/revistas/conbracis/trabalhos/TRABALHO_EV071_MD1_SA13_ID2008_14052017220710.pdf Access on 24/10/2019

BAILEY, B. E., Freedenfeld, R. N, Kiser, R. S., &Gatchel, R. J. (2003). Lifetime physical and sexual abuse in chronic pain patients: psychosocial correlates and treatment outcomes [versãoelectrónica]. Disability&Rehabilitation, 25(7), 331-342. Available on: http://repositorio.ul.pt/bitstream/10451/2196/1/22416_ulfp034948_tm.pdf Access on: 31 Aug. 2018.

BECK, J. S. (1997). Terapia cognitiva: teoria e prática. Porto Alegre: Artes Médicas. Available on: https://www.cetcc.com.br/wp-content/uploads/2017/02/Edneia-Maria-de-Souza-Oliveira.pdf Access on: 31 Aug. 2018.

BERBER,Joana; Kupek, Emil; Berber, Saulo. Prevalência de Depressão e sua Relação com a Qualidade de Vida em Pacientes com Síndrome da Fibromialgia. RevBrasReumatol, Santa Catarina, v. 45, n. 2, p. 47-54, mar/apr, 2005 Available on <http://www.scielo.br/pdf/rbr/v45n2/v45n2a01>Access on: 28 Set. 2018.

BRADLEY, L. A. &Mckendree-Smith, N. L. (2001). Assessment of psychological status using interviews and self-report instruments In D. C. Turk & R. Melzack (Eds.), Handbookof pain assessment (pp. 292-319). New York: The Guilford Press. Available on: http://repositorio.ul.pt/bitstream/10451/2196/1/22416_ulfp034948_tm.pdf acesso em: 31 Aug. 2018.

BRANDÃO, Marcus Lira. Dores Crônicas. In: GRAEFF, Frederico Guilherme; BRANDÃO, Marcus Lira. Neurobiologia das doenças mentais. 5 ed. rev. E ampl. São Paulo: Lemos, 1999. p. 179-197. Available on: http://newpsi.bvs-psi.org.br/tcc/AnaPaulaMagagnin.pdf Access on 30 Sep. 2018.

CAMACHO, L. &Aarte, M. (2001). Importancia de lascreenciaseneldolor crónico. Apuntes de Psicología, 19, 453-470. Available on:http://www.scielo.br/pdf/prc/v18n1/24816.pdf Access on: 25 Sep.2018.

CAMARA, Rosana Hoffman. Análise de conteúdo: da teoria à prática em pesquisas sociais aplicadas às organizações. Gerais, Rev. Interinst. Psicol., Belo Horizonte, v. 6, n. 2, p. 179-191, jul. 2013.Available on <http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1983-82202013000200003&lng=pt&nrm=iso>. Access on 27 oct. 2018.

CASTANHO, Pablo. Uma Introdução aos Grupos Operativos: Teoria e Técnica. Vínculo, São Paulo, v. 9, n. 1, p. 47-60, jun. 2012 . Available on <http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1806-24902012000100007&lng=pt&nrm=iso>. Access on:28 oct. 2018.

DURET, P.; ROUSSEL, P. Le corps et ses sociologies. Paris: Nathan, 2003. MATTOS, Rafael da Silva; LUZ, Madel Therezinha. Quando a perda de sentidos no mundo do trabalho implica dor e sofrimento: um estudo de caso sobre fibromialgia. Physis, Rio de Janeiro, v. 22, n. 4, p. 1459-1484, 2012. Available on <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-73312012000400011&lng=pt&nrm=iso>.http://dx.doi.org/10.1590/S0103-73312012000400011.Acessoem: 05 Sep. 2018.

FELDMAN, Daniel. Fibromialgia e síndrome miofascial – vai ou não vai, 2008. Available on < http://www.scielo.br/pdf/rbr/v48n6/02.pdf > Access on: 30 Sep. 2018.

FERREIRA, Axel João Oliveira. Fibromialgia conceito e abordagem clínica, 2015 https://estudogeral.sib.uc.pt/bitstream/10316/30455/1/Fibromialgia%20conceito%20e%20abordagem%20cl%C3%ADnica.pdf, Acessoem: 05 Sep. 2018.

FREITAS, Hermínia Dias de; VASCONCELLOS, Lahana Giacomini de; STEFANO, Luciana. Pesquisas com seres humanos: a ética e a relevância dos comitês de ética. 2015. Available on <http://www.psicologia.pt/artigos/textos/A1025.pdf> Access on:30 Oct. 2018.

HELFENSTEIN,Junior, Milton; Goldenfum, Marco Aurélio; Siena, César. Fibromialgia: aspectos clínicos e ocupacionais. RevAssocMedBras, São Paulo, v.58, n.3, p.358-365, 2012.Available onhttp://www.scielo.br/pdf/ramb/v58n3/v58n3a18Access on 28 Aug. 2018.

HOMANN, D. et al. (2012) - Percepção de estresse e sintomas depressivos: funcionalidade e impacto na qualidade de vida em mulheres com fibromialgia. Revista Brasileira de Reumatologia. 52:319-330.

JUNIOR, M. H., GOLDENFUM, M. A., FAVARO, C. A., Artigo de Revisão: Fibromialgia: aspectos clínicos e ocupacionais, 2012. http://www.scielo.br/pdf/ramb/v58n3/v58n3a18.pdf Access on 08 Jun 2019.

LIMA, Cláudia Pietrângelo; CARVALHO, Cristina Vilela de. Fibromialgia: uma abordagem psicológica. Aletheia, Canoas, n. 28, p. 146-158, dez. 2008.Disponívelem <http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1413-03942008000200012&lng=pt&nrm=iso>. Access on: 26 Aug. 2018.

MACEDO, Danielle Constancia Felício et al . Representações sociais de conjugalidade e fibromialgia: desdobramentos na dinâmica conjugal. Temas psicol., Ribeirão Preto , v. 23, n. 4, p. 987-1002, dez. 2015 . Available on <http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1413-389X2015000400015&lng=pt&nrm=iso>. acessos em 18 nov. 2018. http://dx.doi.org/10.9788/TP2015.4-14.

MATTOS, Rafael da Silva; Fibromialgia: O mal-estar do século XXI. Phorte Editora Ltda. São Paulo, SP. 2015.

MATTOS, Rafael da Silva; LUZ, Madel Therezinha. Quando a perda de sentidos no mundo do trabalho implica dor e sofrimento: um estudo de caso sobre fibromialgia. Physis, Rio de Janeiro, v. 22, n. 4, p. 1459-1484, 2012. Available on <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-73312012000400011&lng=pt&nrm=iso>. Access on: 05 Sep. 2018.

MILANI, Rute Grossi et al. A dor psíquica na trajetória de vida do paciente fibromiálgico. Aletheia, Canoas, n. 38-39, p. 55-66, dez. 2012. Available on <http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1413-03942012000200005&lng=pt&nrm=iso>. Access on: 29 Aug. 2018.

OLIVEIRA, Cristiano Lessa de. Um apanhado Teórico-conceitual sobre a pesquisa qualitativa: Tipos, Técnicas e características. Publ. E-revista.unioeste, vl.2, n.03, 2008. Available on <http://e-revista.unioeste.br/index.php/travessias/article/viewFile/3122/2459>Access on: 28 oct. 2018.

OLIVEIRA, José; Aspectos Comportamentais das Síndromes de Dor Crônica. ArqNeuropsiquiatr, Minas Gerais, v.58, n.2-A, p.360-365, 2000. Available on <http://www.scielo.br/pdf/%0D/anp/v58n2A/58n2aa27.pdf> Access on 29 Aug. 2018.

OLIVEIRA, Leonardo Hernandes de Souza et al. Práticas corporais de saúde para pacientes com fibromialgia: acolhimento e humanização. Physis, Rio de Janeiro, v. 27, n. 4, p.

1309-1332, dez. 2017. Available on <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-73312017000401309&lng=pt&nrm=iso>. Access on: 07 Sep. 2018.

OLIVEIRA, Maxwell Ferreira de. Metodologia científica: um manual para a realização de pesquisas em administração. Catalão: UFG, 2011.<https://adm.catalao.ufg.br/up/567/o/Manual_de_metodologia_cientifica_-_Prof_Maxwell.pdf> Access on 27 oct. 2018.

PROVENZA, JR et al. Fibromialgia. Rev. Bras. Reumatol.São Paulo, v. 44, n. 6, p. 443-449, Dec. 2004. Available from <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0482-50042004000600008&lng=en&nrm=iso>. http://dx.doi.org/10.1590/S0482-50042004000600008. Access on: 07 Sep. 2018.

Revista Saúde Pública. 1999. Fleck MPA, Louzada S, Xavier M, et al. Aplicação da versão em português do instrumento de avaliação de qualidade de vida da Organização Mundial da Saúde (WHOQOL-100). Revista Saúde Pública 1999; 33(2): 198-205.

SÁ, Eduardo, Veiga; Carolina, Matela, Sílvia, Morais, Rita, Silva, Raquel, Seixas, Ana Rita, Gonçalves, Sofia, A dor e o sofrimento: algumas reflexões a propósito da compreensão psicológica da fibromialgia. Revista Portuguesa de Psicossomática [enlinea] 2005, 7 (janeiro-dezembro):Available on:< http://www.redalyc.org/pdf/287/28770208.pdf> ISSN 0874-4696. Access on: 05 Sep. 2018.

SASDELLI, E. N. & Miranda, E. M. F. (2001). Ser: o sentido da dor na urgência e na emergência. Em V. A. Angerami-Camon (Org.), Psicossomática e Psicologia da dor (p. 93-110). São Paulo: Pioneira.

SANTOS, AMB et. al 2006. Depressão e qualidade de vida em pacientes com fibromialgia. Revista Brasileira de Fisioterapia, 10 n°3, pp. 317-324.

STRAUB, R. O. (2005). Psicologia da Saúde. Porto Alegre: Artmed.

TOMÁS, Mónica. Mestrado Integrado em psicologia: Estudo exploratório de fatores psicossociais associados à fibromialgia:

Contributos das narrativas de vida de mulheres portadoras, 2009. Available on< http://repositorio.ul.pt/bitstream/10451/2196/1/22416_ulfp034948_tm.pdf >Access on: 30 oct. 2018.

TORRES A., L., Troncoso E. S., & Castillo, R.D. (2006). Dolor, ansiedad, depresión, afrontamiento y maltrato infantil entre pacientes fibromiálgicos, pacientes reumáticos y un grupo control. Revista Latinoamericana de Psicologia, 38(2), 285-298.

TURK, D. C., &Okifuji, A. (2002). Psychological factors in chronic pain: evolution and revolution. Journal of Consulting and Clinical Psychology, 70(3), 678–690. Available on:http://repositorio.ul.pt/bitstream/10451/2196/1/22416_ulfp034948_tm.pdf Access on: 30 Aug. 2018

TURK, D., Meichenbaum, D. & Genest, M. (1983). Pain and behavioral medicine: A cognitive–behavioral perspective. New York: Guilford Press. Available on: http://www.scielo.br/pdf/prc/v18n1/24816.pdfAccess on:29 Sep.2018

VALIM, Francielle Bernardi; D’AGOSTINI, Carmen Lúcia Arruda de Figueiredo; Morte e Luto: Reações da equipe multidisciplinar diante da morte do paciente; Pesquisa em Psicologia | Anais Eletrônicos, 2015. Access on: 28 Sep. 2018.