

Chapter VIII

FIBROMYALGIA AND BORDERLINE PERSONALITY: THEORETICAL PERSPECTIVES

Randy A. Sansone^{1,2,} and Lori A. Sansone³*

¹Departments of Psychiatry and Internal Medicine at Wright State University School of
Medicine in Dayton, Ohio;

²Medical Center in Kettering, Ohio;

³Family medicine physician at Wright-Patterson Air Force Base in Dayton, Ohio.

ABSTRACT

Fibromyalgia is a semi-chronic syndrome characterized by diffuse muscular aches and pains. Its relationship to borderline personality disorder, an Axis II disorder characterized by chronic self-regulation difficulties, has undergone very little empirical investigation. Clinically, however, both disorders appear to intersect in a minority of patients. In this chapter, we speculate on the potential commonalities between these two disorders and offer several models of their possible interaction with each other.

OVERVIEW OF FIBROMYALGIA

Description or Definition of the Syndrome

Fibromyalgia is a syndrome characterized by diffuse aches and pains in the muscles, and their associated tendons and joints. In specific areas, the body may be exquisitely tender to the touch; these well-localized areas are referred to as “trigger points.” The syndrome is

* Correspondence concerning this article should be addressed to Randy A. Sansone, M.D., Sycamore Primary Care Center, 2115 Leiter Road, Miamisburg, Ohio, 45342. Telephone: 937-384-6850. FAX: 937-384-6938. E-mail: Randy.sansone@kmcnetwork.org.

usually accompanied by weakness and fatigue as well as sleep disturbances, headaches, and a heightened sensitivity to the environment (i.e., sensitivity to odd smells, loud sounds, touch, bright lights). Some patients have comorbid irritable bowel syndrome.

Epidemiology

The prevalence of fibromyalgia in the general population is estimated to be around 2%. Fibromyalgia is much more common in women (up to 90%) than men (Wolfe, 1990). While the syndrome can emerge in children, the typical onset is early and middle adulthood, with symptoms becoming more common after age 60 (Winfield, 2004).

In addition to the classic physical symptoms encountered in fibromyalgia, the histories of many patients are characterized by early childhood trauma and comorbid psychiatric syndromes/disorders in adulthood. Because these factors are not known to be causal in nature, we have characterized them as associated facets of the epidemiologic context of the syndrome.

Childhood Trauma in Fibromyalgia

Childhood trauma among sufferers appears to be a recurrent theme in the fibromyalgia literature. Several authors describe meaningful prevalence rates of childhood trauma among fibromyalgia patients (Weissbecker, Floyd, Dedert, Salmon, & Sephton, 2005) and these clinical impressions are supported by the empirical literature. For example, in a study comparing fibromyalgia with rheumatoid arthritis patients, Walker et al. (1997) found significantly higher rates of victimization in childhood among the former. In this study, childhood maltreatment was found to be a *general* risk factor for fibromyalgia, but *specific forms* of trauma did not statistically emerge. Eliuk (1997) found significantly more childhood psychological trauma in fibromyalgia patients versus controls. Albrecht (1998) found that childhood abuse histories were significantly more common among fibromyalgia patients compared with chronic-pain controls. Poyhia, Da Costa, and Fitzcharles (2001) found significantly higher rates of psychological trauma, including childhood trauma, among 51 fibromyalgia patients, compared with healthy controls. Among 166 women with fibromyalgia, De Civita, Bernatsky, and Dobkin (2004) found that 54.8% reported sexual abuse histories, mostly in childhood. Goldberg, Pachas, and Keith (1999), and Alexander et al. (1998) reported high rates of physical and sexual abuse among fibromyalgia patients, 64.7% and 57%, respectively. Thieme, Turk, and Flor (2004) also found high rates of childhood sexual (40.9%) and physical (20.9%) abuses among a sample of 115 fibromyalgia patients. Finally, Van Houdenhove et al. (2001) found that fibromyalgia patients had significantly higher prevalence rates of emotional and physical abuse, along with lifelong victimization. From a different perspective, Finestone et al. (2000) examined victims of childhood sexual abuse and found that nearly 70% reported a chronic painful condition that lasted more than 3 months, including fibromyalgia.

Comorbid Psychiatric Syndromes and Disorders in Fibromyalgia

As for comorbid psychiatric syndromes/disorders in adulthood among fibromyalgia patients, mood and anxiety disorders, as well as somatic preoccupation and post-traumatic stress disorder (PTSD), appear to be fairly common. With regard to mood disorders, Roy-Byrne, Smith, Goldberg, Afari, and Buchwald (2004) found that 42% of patients with fibromyalgia reported *lifetime* major depression. Epstein et al. (1999) reported high *lifetime* rates of major depression (69%) as well as any mood disorder (69%) among fibromyalgia patients, with 10% acknowledging *current* dysthymia. Thieme et al. (2004) found *current* mood disorders among 34.8%. High rates of dysthymia are described by Keel (1998). As for anxiety disorders, Epstein et al. (1999) confirmed relatively high lifetime rates (35%) among these patients—a finding that was echoed by Katon, Sullivan, and Walker (2001), and Thieme et al. who found a *current* prevalence rate of 32.2%. In addition to mood and anxiety disorders, somatic preoccupation has also been described among fibromyalgia patients (Gerson & Fox, 2003).

While the preceding psychiatric phenomena are prevalent, individuals with fibromyalgia also appear to suffer relatively high rates of trauma in adulthood, which has been examined and confirmed in several studies. For example, comparing fibromyalgia patients with non-symptomatic controls, Ciccone, Elliott, Chandler, Nayak, and Raphael (2005) found that the former had 3.1 times the rate of rape. Walker et al. (1997) also found high rates of adulthood victimization among fibromyalgia patients.

If victimization in adulthood is present, one would anticipate correspondingly high rates of PTSD among fibromyalgia patients. Several studies confirm this suspicion. For example, in the study by Roy-Byrne et al. (2004), 20% of the fibromyalgia participants met the criteria for PTSD. In studies by Bennett (2001), Sherman, Turk, and Okifuji (2000), and Cohen et al. (2002), prevalence rates for current PTSD were over 50%, 56%, and 57%, respectively. While Thieme et al. (2004) found low prevalence rates of *current* PTSD, PTSD-like symptoms were fairly common in the sample (40.9%). Following the aftermath of the World Trade Center terrorist attacks, the odds of probable PTSD were 3 times greater in women with fibromyalgia-like symptoms. Finally, from a different perspective, in patients with PTSD, 21% were found to have fibromyalgia, compared with 0% for controls (Amir et al., 1997).

To conclude, it appears that patients with fibromyalgia oftentimes have histories of childhood trauma, comorbid mood and anxiety disorders, somatic preoccupation, victimization in adulthood, and current PTSD symptoms. It is not surprising that Gerson and Fox (2003) found a higher rate of prior psychiatric treatment among fibromyalgia patients, compared with chronic pain patients.

Etiology

The etiology of fibromyalgia is essentially unknown and, in turn, there appears to be no consistent organic pathology. According to Winfield (2004), contributory variables to the syndrome may include genetics, stress, central sensitization to pain, patient beliefs or attributions about pain, coping styles, and both Axis I (e.g., mood and anxiety disorders) and

Axis II disorders. (In one study, Stearns [1988] found that fibromyalgia patients with higher levels of maladaptive beliefs regarding their pain were less responsive to treatment) These preceding variables do not exclude the potential roles of other life experiences (i.e., victimization in adulthood) and culture.

According to research, some fibromyalgia patients describe a specific triggering event—i.e., an acute and precipitating trauma that ignites the initial symptoms of fibromyalgia. In support of this possibility, in a small study by Tevens (2004), all nine patients with both fibromyalgia and chronic fatigue syndrome identified specific precipitating, or trigger, stressors that they believed resulted in their subsequent illness. The psychological themes associated with these trigger events included loss, abandonment, abuse, illness, injury, and work and life pressures. This theme of trauma precipitating the fibromyalgia syndrome has been echoed in other studies, as well (Scammell, 2001).

Diagnosis

The diagnosis of fibromyalgia is founded upon: (a) a history of diffuse and widespread muscular aches and pain; (b) the exclusion of other illnesses (e.g., several rheumatic disorders including rheumatoid arthritis, systemic lupus erythematosus, and polymyalgia rheumatica; spondyloarthropathy; inflammatory myopathy; hypothyroidism); and (c) the confirmation of high levels of touch-tenderness in 18 specific body areas that are referred to as *trigger points*. There are no specific or pathognomonic laboratory tests for fibromyalgia. Psychosocial stressors as well as physical illness (e.g., viruses) appear to exacerbate symptoms.

Course

While appropriate treatment may alleviate the symptoms of fibromyalgia, longitudinal data suggest little improvement in health status or disease severity (Wolfe et al., 1997a), nor meaningful improvements in health service utilization (i.e., health care costs; Wolfe et al., 1997b). Chronicity appears to be the rule (Wolfe, 1990). In a study comparing fibromyalgia with myofascial-pain patients, the former were found to have greater pain severity and more occupational disability, despite no other notable between-group differences (e.g., sleep, fatigue, depression; Roth & Bachman, 1993).

Disability is not uncommon among fibromyalgia patients—approximately 25% receive it or some other form of compensation (Wolfe et al., 1997b). In the Thieme et al. study (2004), only 42% of the sample were employed; over 50% were either unemployed or on disability. In a study of emergency room patients (Davidson, 2003), *all* individuals presenting with fibromyalgia were receiving disability compensation and *none* were employed. According to these collective data, fibromyalgia appears to be a chronic syndrome with significant morbidity and disability.

OVERVIEW OF BORDERLINE PERSONALITY DISORDER

Description or Definition of Borderline Personality Disorder

Borderline personality is an Axis II disorder characterized by a seemingly intact social façade with underlying disturbances in self-regulation and chronic self-destructive behavior. In the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision* (DSM-IV-TR; American Psychiatric Association, 2000), borderline personality disorder (BPD) is assigned to the Cluster B personality disorders, which are described as dramatic, emotional, and erratic. Additional features found in BPD include fleeting or transient psychotic phenomena (e.g., paranoia, dissociation, derealization, depersonalization), which typically emerge with stress; longstanding interpersonal difficulties highlighted by chaotic relationships with others; and affective instability characterized by difficulties with anger modulation and/or chronic feelings of emptiness, anger, anxiety, and/or depression.

Epidemiology

According to the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV; American Psychiatric Association, 1994), the prevalence of BPD in the general population is around 2%, with more women than men being afflicted by the disorder. While non-specific symptoms may manifest far earlier, BPD tends to clinically emerge in mid-to-late adolescence and early adulthood. In the only available study of race or ethnicity, researchers (Chavira et al., 2003) found that compared to Whites and Blacks, Hispanics evidenced higher rates of BPD. With regard to the epidemiologic context, BPD tends to be a polysymptomatic disorder with multiple comorbid Axis I and II diagnoses (Sansone, Rytwinski, & Gaither, 2003; Zanarini et al., 1998; Zimmerman & Mattia, 1999). For example, in a study by Zanarini et al. (1998), 96% of BPD participants had a lifetime mood disorder, 88% a lifetime anxiety disorder, and 56% PTSD at some point in their lives.

Etiology

BPD appears to be a multi-determined disorder. According to research findings, genetics (Skodol et al., 2002), parental psychopathology (e.g., Zanarini et al., 2000), and early developmental trauma (e.g., sexual, emotional, physical abuse; witnessing violence; for an overview, see Sansone & Sansone, 2000) are all potential contributory variables. In our clinical experience, early developmental trauma of a repetitive, malignant, and intrusive nature appears to be a predominant theme in the majority of cases. In support of this perspective, Zanarini et al. (1997) found that, in a large sample of BPD patients, 85% had trauma histories.

While there may be non-traumatic pathways to BPD (Graybar & Boutilier, 2002), the lack of an identifiable trauma history in some cases may be attributed to the victim's psychological defenses, which may include denial, repression (an unconscious process),

suppression (a conscious process), and dissociation. In addition, it is not uncommon to encounter some patients who either misinterpret the abuse (e.g., misperceiving physical abuse as discipline) or discount it (e.g., sexual abuse, if some aspect of the experience was enjoyed by the victim).

It is important to note that among various research studies in BPD, individual trauma variables (e.g., sexual abuse, physical abuse, emotional abuse, witnessing violence) appear to fluctuate in terms of their statistical significance. In other words, in some studies, physical abuse is statistically and significantly related to borderline personality psychopathology, while in others, perhaps sexual abuse is. Part of the explanation for this statistical variability is the retrospective nature of data collection as well as the fact that many of these childhood-trauma variables tend to statistically cluster or co-occur (e.g., is it possible to have physical abuse without emotional abuse?).

To summarize these various etiologic factors, Zanarini and Frankenburg (1997) describe a *tripartite model* for the development of BPD. This model highlights three key components: (a) trauma in childhood, (b) a vulnerable temperament (i.e., genetic substrate), and (c) a triggering event or series of events (i.e., acute life stressors). This model does not exclude the role of parental psychopathology.

Diagnosis

According to the *DSM-IV-TR* (American Psychiatric Association, 2000), there are nine criteria for BPD. At least five criteria are required for diagnosis. These criteria are: (a) frantic efforts to avoid real or imagined abandonment; (b) a pattern of unstable and intense interpersonal relationships; (c) identity disturbance; (d) impulsivity in at least two areas (e.g., spending, sex, substance abuse, binge eating); (e) recurrent suicidal behavior as evidenced by repeated threats or gestures, and/or self-mutilating behavior; (f) affective instability (e.g., dysphoria, mood lability), (g) chronic feelings of emptiness; (h) inappropriate or intense anger, or difficulty controlling anger; and (i) transient stress-related paranoid ideation or severe dissociation (i.e., quasi-psychotic phenomena).

An alternative and more succinct diagnostic approach is the Gunderson criteria (Kolb & Gunderson, 1980). In this approach, BPD is characterized by 5 core features: (a) fleeting psychotic episodes (e.g., depersonalization, derealization, rage reactions, paranoia); (b) longstanding impulsivity characterized by self-regulation difficulties (e.g., drug/alcohol abuse, eating disorders, promiscuity) and self-harm behavior (e.g., self-mutilation, suicide attempts, sadomasochistic relationships, high-risk behaviors); (c) a reasonably intact social façade; (d) unfulfilling and chaotic relationships with others; and (e) affective instability characterized by chronic anxiety, depression, emptiness, and/or anger as well as mood lability. Diagnosis requires some confirmed criteria in each of the five areas.

Course

BPD tends to be a chronic psychiatric disorder, even though with treatment, there can be meaningful symptomatic improvement as well as the recession of symptoms over time. The course, in general, tends to be characterized by a pattern of symptomatic improvement followed by slippage. As aging progresses, many individuals experience a decrease in their overall symptomatology (Stone, 1993; Zanarini, Frankenburg, Hennen, & Silk, 2003), although impulsivity (Links, Heslegrave, & van Reekum, 1999) and affective instability tend to be long-term and more pervasive features of the disorder (McGlashan et al., 2005).

Re-Victimization Themes in Adulthood

In adulthood, many borderline individuals tend to experience re-victimization by others (Kroll, 1988). Kroll (1988) underscores the crucial importance of re-victimization in adulthood in BPD as a “basic theme in understanding borderlines” (pg. 46). He describes how borderline individuals engage others to, “act upon [them], usually in a negative, rejecting, or aggressive way, *but sometimes in a caretaking...way.*” Kroll emphasizes the importance of such patients portraying helplessness and incompetence. These relationship dynamics oftentimes result in the borderline individual being, “infantilized, dependent, and often verbally, physically, or sexually abused or debased” by others (Kroll, 1988, pg. 51). This is not to suggest that borderline individuals are invariably to blame for what happens to them in relationships, but rather that their psychodynamics leave them vulnerable to maltreatment and abuse by others.

Borderline Patients in Medical Settings

In medical settings, patients with BPD may demonstrate “medicalized” psychopathological symptoms, rather than the traditional psychological symptoms that were previously described. Medicalized symptoms include diffuse somatic symptomatology of unverifiable pathology (i.e., somatic preoccupation; Sansone, Wiederman, & Sansone, 2001), the sabotage of medical care (e.g., interfering with wound healing, avoiding treatment to prolong illness; Sansone, Wiederman, & Sansone, 2000), the exaggeration of medical illness (Sansone, Sansone, & Gaither, 2004), and unrelenting chronic pain syndromes (Sansone, Whitecar, Meier, & Murry, 2001)—all seeming to foster the role of medical victim (i.e., a medically debilitated social role). For many, it would appear that childhood victimization culminates in adulthood victimization, which in medical settings appears to culminate in the role of the medically debilitated victim. This debility, of course, may be ultimately legitimized by society through disability compensation. In support of a relationship between BPD and disability, we found that, among disabled primary care patients, the prevalence of borderline personality symptomatology was approximately 72%, compared to 26% among nondisabled controls (Sansone, Hruschka, Vasudevan, & Miller, 2003).

In keeping with the psychological theme of victimhood, in medical settings, borderline patients may evidence other problematic behaviors related to care. For example, they may precipitate mismanagement by provoking providers into the over-prescription of medications (particularly analgesics and benzodiazepines), demand unnecessary invasive laboratory tests (e.g., laparoscopies, cardiac catheterizations) and surgeries, and submit to unusual treatment

strategies (e.g., self-administration of analgesics via catheter, intra-rectal administration of estrogen) (Sansone & Sansone, 2000). All of these behaviors reinforce the illness role and are potentially self-damaging.

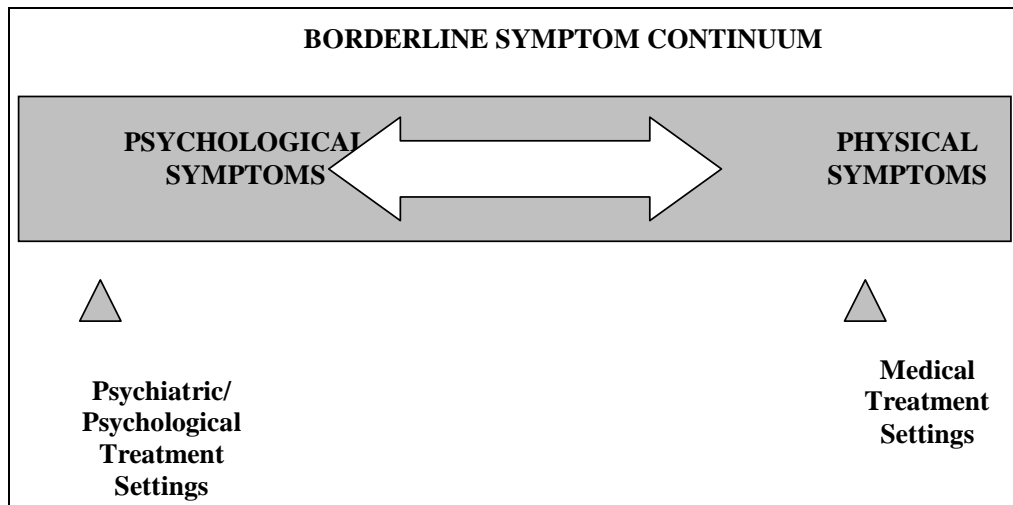


Figure 1. The Bifurcation Hypothesis of Symptoms in Borderline Personality Disorder.

The Bifurcation Hypothesis

In our previous work (Sansone & Sansone, 2003), we proposed the Bifurcation Hypothesis of symptoms in borderline personality. This hypothesis suggests that there is a wide range of self-destructive or self-sabotaging symptoms in BPD patients, and that these occur along a symptom continuum. At one end of the continuum are symptoms and behaviors that traditionally tend to emerge in psychiatric/psychological settings. These might include self-mutilation, suicide attempts, relationship difficulties, and rage reactions (i.e., “the psychological victim”). At the other end of the continuum are symptoms and behaviors that tend to appear in medical settings. These include medical self-sabotage, somatic preoccupation, the exaggeration of physical symptoms, chronic pain syndromes, and medical disability for vague “physical” disorders (i.e., “the medical victim”). Between these two extremes are patients who harbor both types of symptoms (see Figure 1).

A RELATIONSHIP BETWEEN FIBROMYALGIA AND BPD?

Although no empirical studies presently exist, we have clinically observed in a number of individuals the intersection between fibromyalgia and borderline personality. In noting this association, we wish to clarify that it seems to be relevant to only a minority of patients. In examining some of the clinical features of fibromyalgia and BPD, there are a number of interesting, if not intriguing, similarities (see Table 1).

Table 1. Clinical Similarities Between Fibromyalgia and Borderline Personality Disorder.

	Fibromyalgia	Borderline Personality Disorder
Epidemiology	<ul style="list-style-type: none"> • Prevalence: 2% • Gender: > in women • Onset: early adulthood • Context: childhood trauma • Context: comorbid mood/anxiety disorders, somatic preoccupation, and post-traumatic stress disorder 	<ul style="list-style-type: none"> • Prevalence: 2% • Gender: > in women • Onset: early adulthood • Context: comorbid mood and anxiety disorders, somatic preoccupation, and post-traumatic stress disorder
Etiology	<ul style="list-style-type: none"> • Genetic vulnerability • Childhood trauma variable (?) • Triggering event 	<ul style="list-style-type: none"> • Genetic vulnerability • Childhood trauma variable • Triggering event
Diagnosis	<ul style="list-style-type: none"> • Self-regulation difficulties (pain) 	<ul style="list-style-type: none"> • Self-regulation difficulties (e.g., eating disorders, drug/alcohol difficulties, prescription substance abuse, promiscuity)
Course	<ul style="list-style-type: none"> • Chronic medical symptoms • Victim theme (“medical victim”) • Stress-driven symptoms 	<ul style="list-style-type: none"> • Chronic psychological symptoms • Victim theme (“psychological victim”) • Stress-driven symptoms

Epidemiology

Both fibromyalgia and BPD demonstrate prevalence rates in the general population of 2%. According to available data, both predominantly affect women. BPD typically emerges in young adulthood, as can fibromyalgia. The epidemiologic context of fibromyalgia is characterized by childhood trauma. One significant etiologic substrate in borderline personality is childhood trauma. Fibromyalgia evidences a variety of comorbid psychiatric syndromes and disorders including mood and anxiety disorders, as well as somatic preoccupation and PTSD. Note that in BPD, mood and anxiety disorders are highly comorbid, as well as somatic preoccupation and PTSD (Zanarini et al., 1998).

Etiology

Both fibromyalgia and BPD may have genetic vulnerabilities (perhaps a non-specific lack of psychological resilience?) and both have possible (fibromyalgia) or confirmed (BPD) etiologic connections to childhood trauma. Particularly intriguing is the observation that both

disorders are vulnerable to symptomatic expression through precipitating psychosocial stressors, which are described in *both* literatures as “triggering events.”

Diagnosis

Perhaps the most intriguing connection between fibromyalgia and BPD is that both are characterized by inherent difficulties with self-regulation. In the case of fibromyalgia, the chronic self-regulation difficulties center around the experience of pain sensation (i.e., abnormal or dysregulated pain perception). As for BPD, there are multiple potential manifestations of self-regulation difficulties (e.g., drug/alcohol problems, eating disorders, promiscuity).

Pain-regulation difficulties and their relationship to BPD have been rarely studied. Are there any existing empirical studies that confirm a relationship between pain and BPD? We confirmed this relationship in a small sample of family-practice patients with chronic pain (Sansone, Whitecar, Meier, & Murry, 2001). Nearly 50% met the criteria for BPD using a semi-structured, diagnostic interview. These findings suggest that pain regulation difficulties can be clinically associated with BPD.

Course

Fibromyalgia and BPD are both semi-chronic disorders that undergo exacerbation and remission of symptoms throughout the lifespan as a function of psychosocial stressors. In both, there is an association between victimization (i.e., maltreatment or abuse) in childhood and re-victimization in adulthood. Importantly, for both syndromes, trauma themes echo throughout the patient’s entire life history.

POSSIBLE RELATIONSHIP MODELS

If future empirical studies confirm, among a minority of fibromyalgia patients, a relationship with BPD, what might the explicit relationship between the two be? To address this question, we might consider several theoretical models.

Independent Co-Occurrence Model

This model proposes that fibromyalgia and BPD actually have no genuine relationship to one another. Their association, or comorbid occurrence, in an individual is simply one of random chance. In other words, they independently co-occur.

Common Causality Model

This model proposes that both fibromyalgia and BPD share a common etiology (i.e. they are caused by the same phenomena), but have slightly different presentations and disease processes in the same individual. In other words, both originate from the same cause, but develop into somewhat different diseases.

Spectrum Model

This model proposes that fibromyalgia and BPD share similar etiologies as well as similar courses. Indeed, the two are not really distinct from one another, but are actually versions of the same disease phenomenon—i.e., they both exist as closely related spectrum disorders.

Predisposition Model

In this model, one syndrome precedes the other. In doing so, the first heightens the risk of developing the second. In this case, one would suspect that BPD is the forerunner disorder, which then subsequently heightens the risk of developing fibromyalgia.

Whether any of these relationship models accurately describes the comorbidity of fibromyalgia and BPD is unknown. However, the spectrum model is appealing. Regardless, these models provide an interesting panorama of possibilities for future research.

CONCLUSION

At the present time, we can only conclude that, from a clinical perspective, a number of patients harbor the symptoms of both fibromyalgia and BPD. However, the nature and extent of this relationship needs to be confirmed in large, empirical studies. In terms of epidemiology, etiology, diagnostic features, and course, there are some striking similarities between the two syndromes. Beyond clinical impressions, these similarities provide additional, albeit indirect, evidence of a possible relationship between the two syndromes.

What might that relationship be? At this juncture, the relationship between fibromyalgia and BPD remains purely speculative. However, of the relationship models presented, in our opinion, the spectrum model is most likely. This model suggests that the two may actually be the same phenomenon, just variations (i.e., spectrum phenomena). Such an interpretation would account for the observed comorbidity encountered in fibromyalgia and BPD, as well as the striking clinical similarities.

Only further research will clarify the preceding issues. We believe that future research endeavors will need to entail large populations of fibromyalgia patients, utilize both self-report measures and semi-structured interviews for the diagnosis of BPD, and integrate measures that assess for general self-regulation difficulties. If a substantial minority of

fibromyalgia patients actually manifest borderline personality psychopathology, we need to determine how this Axis II comorbidity affects medication prescription, medication response, general treatment compliance, and overall course and outcome in these patients. From our experience with BPD patients, we would suggest that those fibromyalgia patients with this Axis II disorder will evidence excessive prescriptions and high doses of analgesics, modest medication responses, erratic compliance with non-pharmacological treatment, and a chronic and debilitating overall course characterized by high rates of disability compensation. Indeed, it appears that the childhood victim evolves into the adult victim. As such, the physical and medical disabilities associated with fibromyalgia provide a ready means of establishing and maintaining the relentless identity of victim throughout one's lifetime. Unfortunately, this occurs at a significant cost to society.

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