

RESEARCH PAPER

## ‘A constant struggle’: Successful strategies of women in work despite fibromyalgia

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### Abstract

*Purpose.* This study aimed to explore, and obtain increased knowledge of, the strategies used by working women with fibromyalgia regarding control of pain, fatigue and other symptoms.

*Method.* Qualitative methods with an emergent design were used. The informants were women with fibromyalgia who had participated in rehabilitation 6–8 years earlier, and were still in work. Diaries, focus groups and individual interviews were used for data collection. Content analysis and grounded theory were used for the analyses.

*Results.* A model with three categories emerged. The core category ‘constant struggle’ contains eight sub-categories: enjoying life, taking care of oneself, positive thinking, setting limits, using pain as a guide, creative solutions, learning/being knowledgeable and ‘walking a tightrope’. The category ‘grieving process’ was a prerequisite for managing the struggle and the category ‘social support’ contained what facilitated the struggle.

*Conclusion.* The informants fought a constant struggle against the symptoms and the consequences of their fibromyalgia. Their strategies were action-oriented and evinced a positive spirit. To have grieved and accepted their situation was a prerequisite for managing, and support from the family was a help in the struggle.

**Keywords:** *Chronic pain, coping strategies, work rehabilitation, qualitative methods, content analysis, grounded theory*

### Introduction

Sick leave and disability pension cause major costs to the community [1]. Musculoskeletal pain is the most common reason for sick leave and disability pension in Sweden [1,2]. Of those receiving sickness benefit or disability pension due to musculoskeletal pain, women are in the majority [3]. In 2001, people in Sweden with ‘soft-tissue conditions’ (including fibromyalgia (FM) and similar conditions) consumed health care for €96.6 million, plus about €1.5 billion in indirect costs [4]. About 3.5% of the female population suffers from FM [5], making FM a common diagnosis among women suffering from musculoskeletal pain. Fifty to sixty percent of FM patients in Sweden are in work [6,7] compared to 76% of the female Swedish population between 16 and 65 years [8]. The symptoms of FM severely

impair the ability to stay employed [7,9]. Fatigue, perceived weakness, memory and concentration problems are the symptoms, which such patients rate as having the major negative effects on work capacity [9].

Rehabilitation back to work for patients with chronic musculoskeletal pain is an important but difficult challenge for the health care system, for the local social insurance office and for everyone with FM.

Rehabilitation differs with gender. Women often undergo the less expensive on-the-job training as rehabilitation, while men often receive education/training [10]. In an interview study of rehabilitation experience, the men expressed self-confidence as injured workers, and they felt that the rehabilitation staff supported them. The women were more ambiguous in their expressions regarding cause of

injury and goal for rehabilitation. They felt that the rehabilitation staff decided for them [11].

For women in general, being in work is associated with better health, greater economic independence and higher self-esteem, even in a low-status job, [12] compared to not having a job. Working women with FM are more satisfied with their life situation and report better health status than non-working fellow-sufferers [13–15]. To those who have to leave the labour market, loss of a work role leads to a feeling of being an outsider [16]. To be able to continue to work, most women with FM have to make adjustments in their employment situation, such as shorter working hours or changed work tasks [7,13,17].

Among women with FM, it is especially the young ones that seem to lose rapidly their ability to work in paid employment after diagnosis [6]. In a Swedish study [6] of 49 young women with newly-diagnosed FM, 35% were already on sick-leave for their FM symptoms. The work rate decreased from about 50% at the time of diagnosis to less than 30% 6 months later, where it remained at the 1-year follow up.

Patients with FM generally use many strategies for coping. [6,18–21]. These range from physical activity, meditation and treatments to bed rest and avoidance of activity [16,18,21]. Patients who have progressed from diagnosis to acceptance of their condition present more effective and balanced coping strategies [20].

Since FM can be alleviated but not cured, the only way to manage the symptoms is to learn how to cope with them. Some learn successful coping strategies and, despite the excessive symptoms, manage to avoid early full-time disability pension. Women with FM who manage to continue to work are therefore, in this study, considered as having adopted successful strategies for coping with their problems. With increased knowledge of these successful coping strategies, rehabilitation programmes could be improved and patients with FM would get more adequate support when they try to keep on working. This is especially important considering that young women with diagnosed FM lose their working ability rapidly after diagnosis. Rehabilitation needs to support them in finding ways to make it possible to continue working.

To understand more about how women with FM who manage to keep on working are coping with their symptoms, we explored the strategies they used for control of pain, fatigue and other symptoms. As the women had participated in a rehabilitation programme 6–8 years earlier, the strategies learned in that programme are probably included in the strategies presented in the current study. We cannot now distinguish which of the strategies the informants learned during the programme or developed later. The main issue of

interest of the study was how they managed to work in spite of their difficulties, not exactly when and where they learned the strategies.

## Methods

### *Study design*

The study used qualitative methods with an emergent design (Figure 2) as these are particularly suited for exploring phenomena that are poorly understood. For data collection we used diaries, focus group discussions (FGDs) [22] and thematised individual interviews.

### *Informants*

As a first step in finding former patients of the Department of Rehabilitation Medicine, Karolinska Hospital with the diagnosis FM who were working or studying 6–8 years after the rehabilitation, the medical records of FM rehabilitees at the department between 1995 and 1997 were read.

In all, 96 persons (four men, 92 women) had participated during those years (Figure 1). The records were reviewed, and the 60 (all women) who at the end of the rehabilitation were considered able to work or study to any extent, were contacted with a mailed questionnaire. Forty-nine of them answered that they were willing to participate. Telephone contact showed that 20 of them had been working or studying during the previous 12 months, and were therefore eligible for inclusion. One no longer had FM, worked full time and was therefore excluded from the study. Sixteen of the remaining 19 agreed to continue to participate. Four of these did not participate, however, one due to suspected cancer, one feeling that participation was too strenuous and two for unknown reasons.

Of the 12 informants, three kept diaries, two participated in a focus-group discussion (FGD) and seven did both. All the informants lived in the urban area of Stockholm, the Swedish capital. Background data of the 19 women with FM who were working are presented in Table I.

The patients had participated in a multi-professional rehabilitation programme with education, exercise, body awareness and relaxation training, training in ergonomic coping strategies for household and gainful employment and group discussions. The length of the programme had varied between 3 and 6 weeks.

### *Data collection and analyses*

First the informants attended a meeting set up by the first author (ML), where they got information about

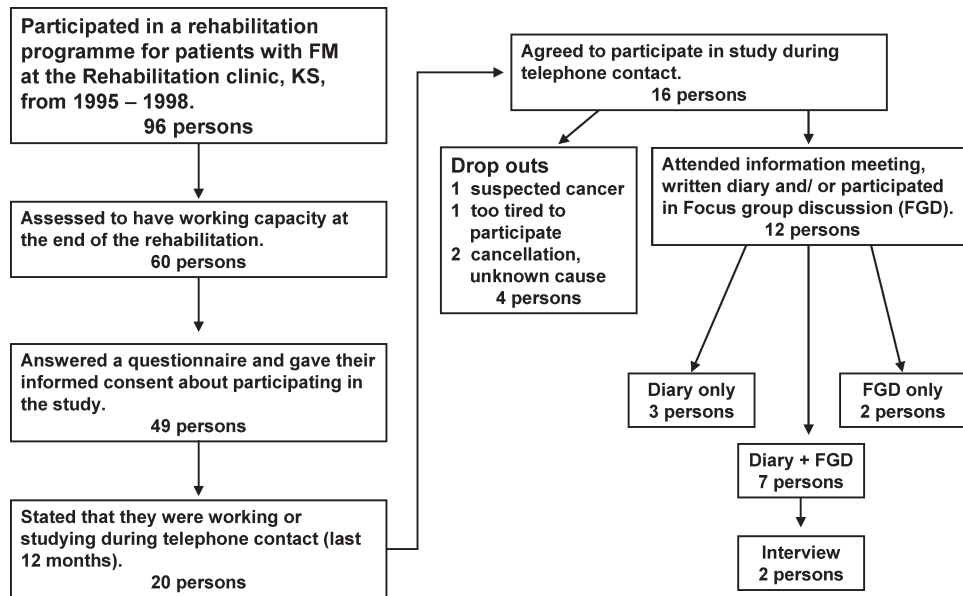


Figure 1. Flowchart illustrating the sampling process and the numbers of informants.

Table I. Background data on the 20 women with FM who were working or studying 12 months before the study. The table also shows in which parts of the study the 12 informants participated.

Age	Occupation	Co-morbidity	Civil status <sup>1</sup>	Employed (%)	Diary	FGD <sup>2</sup>	Ind int <sup>3</sup>
<i>Participants in study</i>							
59	Clerk	Diabetes mellitus	m	50	x		
30	Receptionist	Gastritis	m	75	x		
44	Receptionist	0	m	100	x		
46	Economy assistant	0	m	25		x	
63	Preschool teacher	Arthrosis	m	50		x	
36	Student, maternity leave	WAD <sup>4</sup>	m	50	x	x	
54	Librarian	0	m	50	x	x	
49	Preschool teacher	0	m	75	x	x	
58	Massage, foot care, own business	Suspected depression	m	50	x	x	x
52	Buyer	COPD <sup>5</sup>	m	50	x	x	
52	Teacher	0	m	100	x	x	
54	Physician	0	d	50	x	x	x
<i>Dropouts</i>							
36	Shop salesman	0	s	50			
47	Preschool teacher	0	m	50			
44	Sheltered employment, carpenter	0	s	50			
58	Restaurant worker	0	m	50			
<i>Working but not participating</i>							
63	Teacher	0	m	50			
38	Shop assistant	Migraine	s	50			
51	Caretaker	Disc hernia	m	50			

<sup>1</sup>Civil status (participants at time of study, dropouts and non-participants at time of discharge): m, married; d, divorced; s, single.

<sup>2</sup>Focus-group discussion.

<sup>3</sup>Individual interview.

<sup>4</sup>Whiplash associated disorder.

<sup>5</sup>Chronic obstructive pulmonary diseases.

the study, about how to write the diaries; and where they gave their informed consent.

The diaries were written either by hand in a book distributed to the informants at the information

meeting, or on computer and e-mailed to the first author (ML).

The informants were asked to write the diary for 2 weeks, 5 days or more each week. They were to write

about how they handled their pain and other symptoms with action, thoughts and wishes. Two informants chose not to write diaries because of language problems and lack of time (Figure 2).

Ten diaries were written and a first content analysis was carried out (Figure 2) [23]. First, two of the investigators (ML, AÖ) independently read the diaries carefully, summarised the most important parts of the contents and coded them separately. This was followed by comparisons and a ‘negotiated outcome’, i.e. the result of our comparisons. During the analyses central themes of how the informants felt about living with FM emerged from the diary texts. Different strategies used to cope with FM were described. For deeper knowledge of the strategies, the informants were gathered in focus-group discussions [23]. Three discussions were conducted with one interviewer (ML) and one note-taker (AÖ). Three informants did not participate: one did not want to, one moved to another city during the study and one got a new job and could not come at the set times.

The themes and strategies from the diaries were the basis for an interview guide for the FGDs. The FGDs were tape-recorded and relevant parts were transcribed verbatim. The interview themes concerned the informants’ relations with their relatives, how they paced activities, how they found balance between moving and resting, how they lowered their own demands, managed positive thinking and enjoyed life, handled bad conscience, accepted without giving up; and what they thought would be useful to learn in a rehabilitation programme.

The FGDs were analysed according to grounded theory [24,25]. During the analyses, new concepts emerged and some of the previous themes proved to be not fully explained – saturated. One theme was labelled ‘use pain as a guide’. Since this strategy was considered very complex and required many skills among the informants, we felt this theme needed elaboration. Individual interviews were considered the best data collecting method to increase understanding. Individual, thematised interviews were conducted with two of the informants who had

participated in the FGDs. In addition to the theme ‘use pain as a guide’ we included other themes such as ‘social support at work’ and ‘cooperation with the family’. After these two interviews we judged that the material was saturated. The interviews were conducted with one interviewer (ML) and one note-taker (JE). One interview was tape-recorded and transcribed verbatim, and the other was written down immediately after by the interviewer and the note taker together, due to recording failure. The analyses according to grounded theory continued after each interview. The researchers questioned and discussed the emerging categories at several meetings during the analysis. The results presented in the final model combine the content analyses of the diaries and grounded-theory analyses according to the FGD and the interviews.

To increase the scientific rigour of the study, we used the technique labelled triangulation [27]. In this study, triangulation refers to (1) data collection with three different methods, i.e. diary, FGD and interviews, (2) data analysis with two different methods, i.e. content analysis and grounded theory, and (3) a research team of three researchers representing different professional backgrounds: physiotherapy, rehabilitation medicine and public health/medical sociology. As the first author is a physiotherapist with many years’ experience of rehabilitation for women with FM we had professional knowledge of the subject. The other two investigators provided different perspectives: our combined perspectives proved fruitful in the analyses.

The study was approved by the Ethics Committee of the Karolinska Institute, North, Dnr 02-394. None of the researchers had been involved in the informants’ rehabilitation.

## Results

The content analyses of the diaries revealed five central themes representing feelings about and experience of living with FM. These themes were: An everyday struggle, Grief for the parts of life that cannot be lived, Loss of a functioning body, Anger at the pain, Vulnerability in relation to family, friends, colleagues and health care personnel.

The themes were then used in the emergent design adopted in this study as a basis for further data collection and analyses.

In relation to these themes, the informants described a number of strategies which they used to manage their symptoms (Table II). These themes are taken into consideration in the categories presented in the final model.

From grounded theory analysis and the themes emerging from the content analyses, we developed a model (Figure 3) with three categories: *a constant*

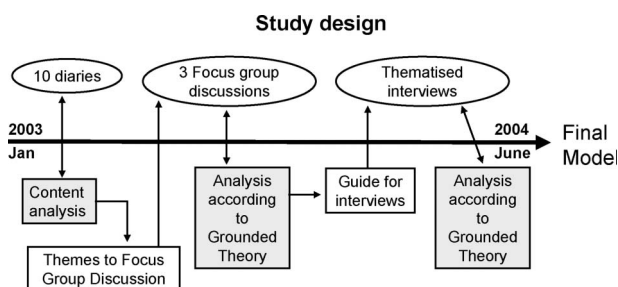


Figure 2. The emerging study design illustrated on a time axis.

Table II. Strategies used to manage the symptoms, as described in the diaries.

Strategies
Slow tempo
Split activities
Prioritise, planning
Resting
Various forms of heat
Exercise, keeping fit
Perceive signals from the body and respect them
'The pain is not dangerous'
Positive thoughts
Enjoy life as much as possible
Positive view of life
Unwillingness to give in

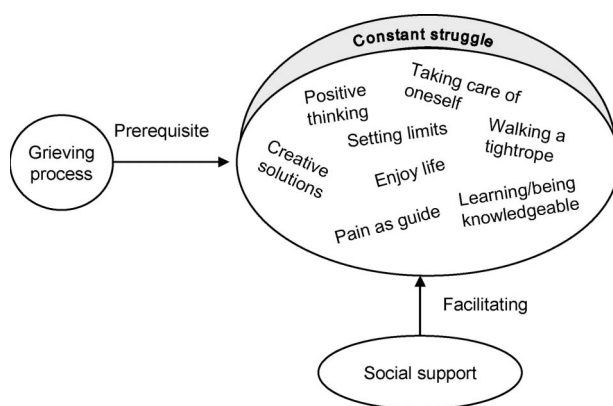


Figure 3. The model of the 'constant struggle'. The model shows the core category with its eight subcategories and the categories 'grieving process' and 'social support' which influence the core category.

*struggle, the grieving process and social support.* Under a *constant struggle*, the core category, we describe eight sub-categories: *enjoying life, taking care of oneself, positive thinking, setting limits, using pain as a guide, creative solutions, learning/being knowledgeable and 'walking a tightrope'.*

The *constant struggle* represents the life-long struggle against the symptoms and consequences of fibromyalgia, which the informants had to manage. The eight sub-categories describe informants' strategies for managing the *constant struggle*. The sub-categories show how the informants had developed strategies in relation to themselves and the pain, enabling them to act in conscious and purposeful ways. The category *grieving process* proved to be a prerequisite for developing the strategies. The category *social support* facilitates the constant struggle.

All the categories were similarly mentioned in the diaries and the FGDs. In the diaries the emphasis was on describing the everyday, constant struggle the informants had, while the FGDs emphasised different ways to cope. In the individual interviews more details about different strategies were revealed and explored.

The core category, *constant struggle*, arose from the informants' difficult lives. It was hard to manage work and social life due to symptoms and prejudices. The informants had to endure the situation, knowing that it would probably last for the rest of their lives. They had to change in every aspect of activities, constantly taking care not to overuse their limited bodily resources and justifying to others their limited capabilities. Worsening of symptoms was unpredictable, which always made the informants uncertain about what they could manage next moment or next day.

The informants had highly developed strategies in relation to themselves, their problems and their social environments. The strategies are described in the sub-categories *enjoying life, taking care of oneself, positive thinking, setting limits, using pain as a guide, creative solutions, learning/being knowledgeable and 'walking a tightrope'.*

*Enjoying life* was a mental attitude. It was an often, consciously used strategy, especially regarding the small things in life. It was about allowing and giving oneself everyday pleasures in life, such as a well-laid table with candles even when alone, enjoying good food and drink, creating nice moments of time alone or with the company of family and friends.

*Taking care of oneself* meant striving for a bodily balance in life. For most informants an easy start in the mornings was a prerequisite for making the rest of the day nice. Both exercise, mostly walking, and rest, were used; both carefully apportioned. Relaxation was important, sometimes with help from enjoying the warmth of an electric blanket or a hot bath. Taking care of oneself meant avoiding unnecessary stress and helping the body to function as well as possible.

*Positive thinking* was used consciously. To turn thoughts more positive, informants thought about being content with their life except for the FM; that they managed well, that there were some advantages in being partly on sick-leave, such as being at home more with the children, reading etc.: FM gave them a different viewpoint.

It was important to *set limits* by prioritising and lowering one's demands; it was also a matter of adapting life and oneself to one's limitations. It was difficult to learn how to keep a slow pace and divide up strenuous activities; and how to stop in time. The informants used trial and error to learn their limits.

*Using pain as a guide* was a strategy used by some informants. By paying constant attention to the body, their awareness was sensitive enough to feel its subtle warnings, such as slightly increased pain or stiffness, or other unpleasant sensory information. In these instances they had to stop their current activity immediately to prevent deterioration. They emphasised that, to be sensitive enough to sense the first sensations of pain or fatigue, they had to refrain from

pain medication, since this rendered them insensitive. As an example, when they were gardening and sensed increased pain, they could not continue to do weeding; even there was just one metre left, they had to give it up at once. If they could do this, a moment's rest was enough to relieve the pain. Where it was impossible to interrupt work, or when they regarded the activity as more important, they chose to stand the increasing pain. In these situations some informants were helped with pain medication while others knew that they just had to endure. When possible, they planned time for rest and recovery after such pain situations.

The informants were skilled at *learning/being knowledgeable* – learning everything there is to know about FM. They read the journals and the Internet and/or discussed with others. The knowledge gave them both self-esteem and respect for others similarly placed. It helped them find new ways to cope and encouraged them in thinking about their pain as not dangerous.

When there were difficult but unavoidable tasks, the informants developed *creative solutions*. At work it was important to manage stressful situations and ergonomics. One example of a stressful situation was given by an informant working at a day-care centre. When dressing the children she had them come one at a time, or when changing nappies she let them climb onto the nursing table themselves. In this way the work initially took a little longer but the informant could manage more. Other examples of how to improve the ergonomics were to have one's workplace in a quiet corner of the office or getting a room of one's own, using a vertically adjustable desk, and changing work tasks often during the day. At home it was important to plan and to divide strenuous activities: peel a few potatoes, do something else, peel a few more, and so on. Vacuum cleaning and other heavier tasks were managed in the same way.

'Like *walking a tightrope*' was how the informants described the balancing of their work situation. The smallest mistake could make them 'fall off the rope'. Work was considered as meaningful and a joy of life; the motivation to keep on working was very high. 'People with FM have to have flexible working hours', they argued. Short-term sick leave was sometimes necessary. Another way was to work more during the warm part of the year and be on part-time sick leave during the winter. The informants had to plan everything in life with regard to their work. To be at work at eight in the morning could mean that they had to wake up at five to get their bodies functioning. Resting in order to manage the next working week was an important part of the weekend. Social events and hobbies were planned mainly for the weekends with time to rest afterwards.

The informants wondered continuously how long it would be possible to keep on working, and they expressed fears over not finding a more suitable job if they had to quit.

The category *grieving process* represents the necessity of having accepted the boundaries associated with the disorder to be able to manage the struggle. To reach positive ways of looking upon oneself, and constructive ways of dealing with problems, the informants had to work through the loss of their former self and their former body. Living with FM meant difficult feelings of disappointment with life, self-blame at not being able-bodied, sadness, despair and exhaustion, regret for the parts of life that no longer could be lived. They reached a turning point through grieving and accepting the situation, and a new way to manage life could develop.

The category *social support* describes how in most cases the family, especially, supported the informants to keep struggling. Support from working colleagues was not very common. For the 11 women who were employed (one was self-employed and thereby her own manager) it was common to have an understanding manager or supervisor, while most working colleagues were not felt to be supportive. To know that family members knew, supported and understood, gave strength and helped the informants keep the self-confidence to go on struggling. Having a family meant having someone to share the responsibilities and the house-work with.

The results imply that the process of grief is important and should be facilitated for reaching successful rehabilitation. The informants also underlined the importance of support. The action-oriented strategies with the informants in control, showing a path along which patients with FM can continue to live actively. Such strategies should be taught in rehabilitation programmes.

## Discussion

The key findings in this study are the women's descriptions of their constant, everyday struggle against the symptoms and consequences of their FM, and of the ways they fight it. The strategies described by the informants tallied somewhat with the strategies taught during the rehabilitation programme they had participated in 6–8 years earlier. However, after such a long time, it cannot be assumed that the current strategies derived only from the rehabilitation programmes. This study focused on exploring the strategies used by the women with FM who succeeded in keeping on working, despite excessive symptoms. The women struggled with changes in almost every aspect of their life, and managed this with a broad variety of coping strategies. The strategies they employed for

continuing work were consciously action-oriented, with a positive spirit, and carefully applied.

To manage the struggle and develop purposeful coping strategies, the women had to grieve for the loss of their former way of life and start a new way of life. The struggle was facilitated by social support, especially important being that from their families.

In accordance to grounded theory, we did not have any specific theoretical framework during the analyses of the data, but rather aimed at developing a theoretical model.

Earlier studies have investigated what strategies women with FM in general use to cope with their problems [6,17,18,20,21]. Our contribution to the knowledge about FM focuses mainly on working women and their detailed descriptions of the strategies they use.

Patients with FM in general use different strategies for coping with pain and other symptoms. In a study of patients' experience of living with chronic pain and how they manage, five kinds of strategy were summarised: self-initiated activity, professional treatment, passivity, escape behaviour and resignation [18].

In another study, strategies used to manage their everyday situations by Swedish and American women with FM were: changes of routine, different performance of everyday activities, adjustment to changed abilities, change of life situation and attitudes to limitations [21].

Strategies for decreasing and preventing difficulties, found in yet another study of Swedish and American women with FM, were: warmth, rest, exercise, medication, listening to body, avoiding stress, a positive attitude, alternative ways of doing things and a slower pace [6].

Brown [20] explored illness experience of patients with FM, and showed how they underwent a process from experiencing symptoms, getting a diagnosis to coping with the illness. The individual nature of developing new coping strategies was essential, such as gathering information, learning extended to encompass personal experience and adoption of accommodating behaviour. Participants who had progressed from diagnosis to acceptance of their condition presented more effective and balanced coping strategies. The strategies presented by Brown are mainly described on a cognitive, intellectual level. A study exploring benefits of women with chronic pain [26] from being met with recognition in groups, presents the concept 'recovery competence'. 'Recovery competence' is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness.

Our results accord with, and add more detailed knowledge to, earlier findings. Our informants stressed positive and active strategies. They represent the 'doing' of work and a constructive attitude. They were in charge

of their lives, they were well informed about FM and tried actively to listen to their bodies and affect the consequences of FM with thought and action.

By using the strategy 'pain as a guide', some of the informants demonstrated how increased awareness of body signals can be used to prevent increased pain or deterioration. This awareness is so easily disturbed that, to feel the signals, they had to refrain from taking pain medication. This finding seems run counter to the behavioural/cognitive treatment strategy, which teaches patients not to pay too much attention to pain and to avoid pain behaviour (fear-avoidance). We argue that this 'pain-as-a-guide' strategy is something different. To use it, our informants had to explore the pain and their own boundaries, without fear. They had to become experts in body awareness and ready to respect their own bodily needs in a very sophisticated way. Informants who had accomplished this described how they could choose to use the awareness when they had the possibility to interrupt what they were doing, or to rest for a while. When work required, or they wanted to do something where rest was not possible, they used pain medication and were prepared for increased pain afterwards.

The fact that so few of the former patients were working after the rehabilitation, which aimed at restoring working capacity, can be viewed in different ways. Many patients with FM seen at specialist clinics may have more severe symptoms than those seen in primary care or in population studies. But the low return-to-work rate also demonstrates the difficulties to get women with FM back to work after long sick-listing. Workplaces often lack the required flexibility and cannot give the support these women need in order to continue working [21].

We further argue that these difficulties might also be seen as an example of how badly rehabilitation measures are adapted to supporting women with diagnoses such as FM, chronic fatigue syndrome and chronic generalised pain as they try to resume work. These conditions are today considered to have an aetiology of interacting physiological, psychological and social factors. Their rehabilitation needs a holistic approach with well-coordinated measures. After medical rehabilitation, the FM sufferer is often ready to start work-training with a gradual increase of working time up to 50% or more. The required changes at work, such as flexibility of working hours or of work-load, often require changed work tasks, which is hard to achieve in today's labour market.

The informants' approach emerging from the study was action-oriented, with a positive spirit. The strategies described in previous studies [7,15,17] of both employed and unemployed women were a mix of active and passive. Our informants mainly used active strategies, developed to afford

them control of their lives and the consequences of FM. This way of keeping control could be important for understanding how the women manage to keep on working.

The fact that the data collection covered a long time (6–8 years) after the rehabilitation programme is probably important for understanding how the informants could have developed such successful and refined strategies. They described how the programme had prompted them to accept their limits and find alternative ways of doing activities. The rehabilitation programme was often a starting-point for developing effective strategies. The informants also told how developing their strategies had required time and effort.

#### *Methodological considerations*

To increase credibility, we used triangulation in the data collection, in the analyses and by having researchers from different disciplines [27]. Triangulation is a qualitative technique, in which the phenomenon is investigated from different angles or perspectives. The technique can be used in one or several steps, e.g. using different data collection methods or data sources, different theoretical perspectives and/or engaging several investigators.

An emergent design [27] was used for data collection. Study of the diaries provided an overview and a description of the strategies. For more knowledge of how employed women with FM learn and develop their strategies, FGDs [22] were used. FGD is a suitable method to gather information about perceptions and ideas at a general level [22]. The FGDs revealed more information about the strategies and, in addition, new, more complex strategies were described. For greater understanding and knowledge of these complex strategies, individual, thematised interviews were performed. Use of the data collecting method most suitable at each step made it possible to collect relevant data. The emergent research design used in qualitative studies facilitates this approach.

Regarding group size in focus group research, we adopted the view presented by Barbour and Kitzinger [22], who argue for groups of five to six participants or even as few as three. While a theoretical standpoint made us plan for groups of four to five members, drop-outs and cancellations reduced this to between two and four.

Qualitative research explores structures and mechanisms in society that affect human beings. The abstract knowledge from this study can probably be transferred to other social contexts sharing similar structures [28]. Thus its transferability is not statistical, but theoretical, drawn from a concrete level of the data to the abstract, theoretical level.

An interesting area for future research is to explore and describe the strategies used by women recommended for disability pension after rehabilitation: how do these strategies differ from those presented by our informants? Another area of interest is the strategies used by very young women with FM. Most of our informants were middle-aged. The important question of why young women with FM lose their employment rapidly after diagnosis also needs further investigation.

In conclusion, the informants in this study fought a constant struggle against the symptoms and the consequences of their fibromyalgia. In the struggle they used a variety of strategies, which were action-oriented and evinced a positive spirit. To have grieved and accepted their situation was a prerequisite for managing, and support from the family was a help in the struggle.

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