‘This constant being woken up is the worst thing’ – experiences of sleep in fibromyalgia syndrome

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Abstract

Purpose. Sleep disturbance affects a high proportion of people with fibromyalgia syndrome (FMS). This study aims to explore people’s perceptions of their sleep quality and the influence sleep has on their symptoms and daily lives.

Method. Semi-structured interviews were conducted with sixteen participants diagnosed with primary FMS, covering all aspects of the sleep experience. The audio recorded qualitative interviews were transcribed verbatim and analysed using interpretative phenomenological analysis.

Results. Poor sleep dominated participants’ lives, affecting levels of pain and fatigue, engagement in daily activities and ability to cope. Participants reported experiencing blocks of sleep, with the most profound difficulty for participants being able to go back to sleep after a night time awakening. They also felt a lack of control in their ability to manage their sleep difficulties and use of day-time napping appeared to be the only perceived beneficial coping strategy for relieving daytime sleepiness and symptoms of fatigue.

Conclusions. Greater emphasis on screening for sleep disorders and how to manage poor sleep is needed in rehabilitation programmes provided for patients with FMS.

Introduction

Fibromyalgia syndrome (FMS) is a chronic condition of unknown aetiology, although emerging evidence suggests a disruption to the neurotransmitters in the central nervous system and/or dysregulation of the sympathetic nervous system [1]. FMS is characterised by the experience of persistent widespread pain (for 4–3 months) and self-reported pain in 11 of 18 tender points on digital palpitation (with the amount of pressure sufficient to blanch a finger nail). Other symptoms include fatigue, cognitive dysfunction (such as difficulty concentrating and word retrieval) and sleep disturbance [2]. These symptoms can have a disabling effect on people’s lives, with many people forced to leave work or reduce their working hours because of their symptoms [3]. Population estimates have revealed that FMS may affect up to 11% of the general population [2,4–6] and is associated with high individual and societal health care costs [7–9]. Longitudinal studies of patients with FMS have revealed that over half of patients receiving standard medical care report only slight improvement, no change or a deterioration in their symptoms 3 years later [10].

Poor sleep quality is a significant problem for people with chronic pain conditions [11] and in patients with FMS the prevalence of sleep disturbances is even higher, with up to 99% of participants reporting some form of sleep disturbance [12,13]. People with FMS have also been found to be five times more likely to have insomnia than a comparison group of patients with rheumatoid arthritis [14]. The implications of poor sleep quality are profound, with poor sleep linked to increased morbidity, risk of accidents, absenteeism from work, increased health care costs and mortality [15,16]. For people with FMS the effects of poor sleep may also exacerbate other symptoms such as pain, fatigue, cognitive impairment and lead to difficulties in maintaining...
social relationships and engaging in rehabilitation [12,17].

Extensive research has explored the quality of sleep using objective measures such as polysomnography and has revealed that people with FMS have increased stage 1 light sleep [18] and less stage 4 slow wave sleep [19,20]. People with FMS are more easily awoken [21] and compared to healthy controls have higher levels of physical activity during the night [22,23]. A longitudinal study exploring sleep and pain in patients with FMS over the course of 1 year, found that poor sleep quality at baseline was predictive of pain and sleep quality at 1 year, but baseline pain did not significantly predict sleep quality at 1 year [24]. Sleep disturbance may therefore have an important role in both the aetiology and maintenance of symptoms for patients with FMS.

Previous studies using quantitative research methods have provided a useful overview of the scope and nature of sleep difficulties in people with FMS. However, as sleep quality is primarily a subjective experience, understanding what poor sleep means to people with FMS and how it affects their daily lives, is essential to inform how rehabilitation can address patients’ needs. To increase our understanding of the sleep difficulties people with FMS experience and the impact sleep has on their daily living, a qualitative approach is needed to explore the phenomena in more detail.

Despite the high prevalence of sleep disturbance in FMS, poor sleep quality often receives little attention in current treatment of the condition. If poor sleep quality is addressed, the most common treatment approach is the prescription of hypnotic or tricyclic antidepressant medications. Clinical trials have demonstrated the efficacy of these medications to reduce symptoms of sleep disturbance in the short term. However, there is little evidence of the efficacy of medications after prolonged use and treatment effects often disappear after discontinuation and may result in ‘rebound insomnia’ that can lead to dependence [25]. Common side effects of hypnotic and tricyclic medication (such as drowsiness and confusion) can also exacerbate other symptoms of the condition such as fatigue and cognitive difficulties and may not be well tolerated by some patients [26,27].

Because of the complex nature of symptom presentation in FMS and limitations of current pharmacological treatments, current management guidelines suggest the need for a multi-disciplinary treatment approach [28–30] to improve patient outcomes and quality of life. However, a greater understanding of sleep difficulties in FMS is needed to inform specific recommendations as to how sleep disturbance can be effectively managed in this population.

The interpretative phenomenological approach (IPA) aims to explore how participants make sense of their world and the meaning that experiences have for them and is ‘ideally suited to exploring topics in health, social and clinical psychology where there is a need to discern how people perceive and understand events in their lives’ (p. 36) [31]. The IPA approach has not previously been used in FMS. To expand on previous quantitative findings, this study aims to increase understanding of the meaning that sleep has for patients and the impact of poor sleep on patient’s everyday lives using IPA.

Methods

Participants

The IPA approach aims to identify the commonalities of people experiencing a specific phenomenon and therefore participants are purposively sampled to ensure that they can offer a meaningful perspective on the phenomenon being investigated [32]. For this study, participants were purposively recruited through FMS support groups in the South-East of England. They were given an information sheet about the study and also offered verbal information through presentations at support group meetings, and those interested in the study were asked to contact the researcher. Participants were advised that they did not have to be experiencing sleep difficulties to take part in the study, to enable the exploration of the effect of both good and poor sleep quality in FMS. Individuals were included if they had a diagnosis of FMS and were aged over 18 years. People were excluded if they were unable to speak or understand English or if they had a diagnosed sleep disorder with an underlying physical cause (such as sleep apnoea or restless legs syndrome). After confirming that the participants had received and read the participant information sheet and had been given the opportunity to ask any questions they had about the study, a mutually convenient time was arranged to conduct the interview. The study received ethical approval from the University of Surrey Committee of Ethics.

Data collection

A brief semi-structured interview schedule was developed to guide the interview asking broad questions about the participant’s illness, symptom experience and daytime functioning (Table I). The schedule developed by the authors (who are both Chartered Psychologists) enabled the interviewer to explore areas relating to the research question, while providing the flexibility for the participant to talk about the issues that were important to them and for the
Table 1. Interview schedule.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness experience – how would you describe your quality of life with fibromyalgia?</td>
<td>Diagnosis e.g. how did you receive a diagnosis?</td>
</tr>
<tr>
<td></td>
<td>Description of symptoms e.g. what are your main fibromyalgia symptoms?</td>
</tr>
<tr>
<td></td>
<td>Impact on everyday living e.g. what affect does having fibromyalgia have on your life?</td>
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<tr>
<td></td>
<td>Perceived cause e.g. what do you believe to be the cause of your fibromyalgia?</td>
</tr>
<tr>
<td>Sleep quality – How would you describe the quality of your sleep?</td>
<td>Description of sleeping pattern e.g. when would you usually go to bed?</td>
</tr>
<tr>
<td></td>
<td>Description of a typical daily routine e.g. could you describe a typical day living with fibromyalgia?</td>
</tr>
<tr>
<td></td>
<td>Description of evening routine e.g. could you describe a typical evening when you are preparing to go to bed?</td>
</tr>
<tr>
<td>Causes of poor sleep e.g. what affects your sleep quality?</td>
<td>Causes of poor sleep e.g. what affects your sleep quality?</td>
</tr>
<tr>
<td>Management of Symptoms – how do you cope with your fibromyalgia symptoms?</td>
<td>Management of Symptoms – how do you cope with your fibromyalgia symptoms?</td>
</tr>
<tr>
<td>Coping e.g. what do you do if you can’t get to sleep?</td>
<td>Coping e.g. what do you do if you can’t get to sleep?</td>
</tr>
<tr>
<td>Effect of quality of life e.g. how does your sleep quality affect you?</td>
<td>Effect of quality of life e.g. how does your sleep quality affect you?</td>
</tr>
<tr>
<td>Support e.g. what support have you received?</td>
<td>Support e.g. what support have you received?</td>
</tr>
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</table>

A researcher explored interesting concepts emerging during the interview. All the interviews were conducted by one of the authors (AT) within the participant’s home. All interviews were recorded using a digital voice recorder and later transcribed verbatim.

Data analysis

The data were analyzed and coded using the recommended IPA approach [32]. Two researchers analyzed the interviews independently. The interview transcripts were read several times to increase familiarity with the data, and preliminary interpretations were noted in the margin. The approach acknowledges that the researcher plays an active role in interpreting people's experiences and identifying underlying concepts that the participant may articulate but may not be consciously aware of [31].

Emerging themes were identified from the coded notes and discussed between the two researchers. Themes were then clustered together and reapplied to the interview transcripts, noting any inconsistencies between participants and exploring negative cases [33]. The overarching and sub-themes were then formed from the identified sub-themes.

Results

A sample of 16 participants took part in the interviews (14 females and 2 males) that lasted between 20 and 65 min. As the aim of IPA is to obtain a detailed understanding of individuals' personal experiences small samples are used so that such an in-depth analysis is feasible [34]. Participants were aged between 21 and 61 years (mean age 45.90 years, SD: 11.94). All participants had completed secondary education, with 31.25% of them attending college or university. Only one participant was in full-time employment, five were working part-time, five were retired and five were no longer working due to ill-health. The mean duration of fibromyalgia symptoms was 17.25 years (SD: 14.77) with an average length of time since diagnosis of 4.13 years (SD: 4.37). Most participants were using some form of pain relieving medication on a regular basis (62.5%) and just over half of participants were prescribed medication to aid sleep (56.3%).

The interviews with participants revealed four overarching themes: (1) sleep disturbances, (2) inter-relationship between symptoms, (3) coping with disturbed sleep, and (4) impact on daily living. Each theme encompassed subordinate themes which are outlined below and illustrated by direct quotations from the interview transcripts.

Theme 1: sleep disturbance

Onset of poor sleep. There was considerable individual variability in the onset of sleep difficulties. Four participants reported experiencing sleep difficulties for most of their life, six participants could not identify when their difficulties started and six participants described that their sleep difficulties occurred around the time of onset of other fibromyalgia symptoms;

‘I don’t know what other reason there could be, other than the fact that I’m less active now than I used to be you know, but you know it seems to have come on roughly about the same time’.

Existence of possible sleep disorder. Three participants described experiences that were indicative of a sleep disorder that had not been diagnosed such as bruxism, sleep walking and restless legs syndrome;

‘You toss and turn, you can’t keep still, I’m not being funny but my legs have spasms, they just jump around like someone’s putting an electric shock through you every 5 seconds, your limbs jump and twitch’.

Blocks of sleep. It became apparent that the main difficulties participants experienced with their sleep were waking up during the night and feeling un-refreshed the following day. Fifteen of the 16 participants described waking up several times a night on a regular basis that caused a considerable degree of frustration;
A typical night if you can describe the sleep as typical, is I go to bed around 10, 10:30, I fall asleep straight away (clicks fingers) drop of a hat, head on the pillow and I’m away, I’ll sleep for 2 or 3 hours, then I’m up for between 2 or 3 hours, then I’ll sleep for 2 hours and then I’m up’.

Another participant added;

‘I can sleep I can go to off sleep but if I don’t take anything, I do lie awake, just lie awake or I get woken up this constant being woken up is the worse thing’.

Participants described that when they woke up during the night, they would wake-up suddenly, feeling very alert and this made it difficult to try and go back to sleep;

‘I go to bed about 10, I’m always tired and I invariably 90% of the time go straight to sleep and I will wake 1–2 hours later feeling as if it is time to get up’.

Un-refreshing sleep. In the morning several participants also described feeling un-refreshed which may be a result of the disturbed sleep throughout the night;

‘I’ve quite often woke up feeling more tired than when I went to bed’.

Negative thoughts and worry about sleep. For several participants, going to bed had become a negative experience due to their sleeping difficulties, and some participants reported developing negative thoughts and expectations about sleep. Many had simply resigned themselves to the belief that their sleep quality would be poor;

‘sIf there’s something on my mind, that makes me a bit worried about sleeping, I don’t know what it is but I sort of need to try and get to the bottom of it, but I sort of have this fear of going to bed’.

Four participants also reported that they often worry about daily events and concerns while lying in bed, which may prevent sleep onset;

‘If you’re worried about one of the children or there’s something particular you’re worried about..., you tend to sort of go over that in your mind’.

Other triggers of disturbed sleep were identified as drinking alcohol, stress, worry, and the need to urinate during the night.

Theme 2: inter-relationship between symptoms

Effect of sleep on symptoms. Eleven participants felt that a poor nights sleep was directly associated with reduced overall functioning the following day;

‘There is no typical day, I wake up and it depends on what kind of sleep I’ve had, how broken and how bad a night I’ve had’.

Reduced coping ability. The majority of participants felt that the quality of their sleep was related to feelings of fatigue and pain. Three participants elaborated that they believed that feeling tired after a poor nights sleep made it harder to cope the following day, affecting their perceptions of pain;

‘In some ways it’s more difficult because I’m so tired I don’t have the energy to cope with things, so I think they get me down a bit more’.

Waking up due to the pain. Sitting or lying for long periods of time was perceived to lead to increased pain during the night and participants often highlighted that they needed to keep changing positions or were restless at night to stay comfortable in bed. Eleven participants stated that being in pain woke them up during the night;

‘Lack of sleep affects your pain and er, and if you’re in a lot of pain and you roll over, the pain will wake you up’.

Expectation. All of the participants interviewed had experienced disturbed sleep for a number of years and almost expected to sleep poorly, especially if they were experiencing high levels of pain and fatigue;

‘You almost know, that’s psychological again, you almost know you’ve had a fairly bad period you’re not going to sleep well either or is it a fact?’

Theme 3: coping with disturbed sleep

Searching for answers. Little information had been given to participants from health professionals on how to manage their FMS effectively. As a result, participants appeared desperate to seek answers and described trying a whole range of things including mattresses and pillows to improve their sleep quality;

‘I put ear plugs in and I find when I put ear plugs in I seem to sleep different... although I don’t like things in my ears, if it means I’m going to sleep a bit better, so whether that’s about noise, although it’s very quiet where I live, so I don’t know, I think I’m just looking for answers.’

Rest and recuperation. To manage their symptoms and engage in everyday activities participants described the need to plan and pace their activities, including rest periods throughout the day;

‘It can be up to an hour, at least an hour, even if I didn’t sleep, I just have to get off my legs and just lie back and
you know, very often I just lie back with nothing on, no television, nothing, just, just alone’.

Participants reported that extended periods of inactivity increased levels of pain and muscle stiffness. Participants described the need to balance rest periods with the need to keep moving around;

‘That’s the thing about fibromyalgia, you need to rest but at the same time you need to move . . . you kind of just want to stay in bed or whatever but you, you it’s hard but you need to keep moving but at the same time you need to rest as well.’

Although two participants avoided napping during the day, the other participants found that daytime naps helped to re-energise them particularly if they were feeling fatigued in the afternoons, enabling them to carry on with daily activities;

‘I might have to go to bed for a couple of hours and then I’ll be alright for the evening, because I know they advise you not to go to bed don’t they, but I can’t physically not and I find it makes me feel better actually if I do, so for me it works better, so you I’ve learnt to do what suits me rather than what I’m told to do you know they say you muck up your body clock up if you sleep in the day but for me it doesn’t work that way’.

Nocturnal coping strategies. On awakening at night, participants described utilising a range of approaches to help them return to sleep. Many participants reported keeping the light low and trying to relax in order to return to sleep when they wake up too early;

‘Sometimes I think I can get back to sleep, so I wait to see if I can and I think come on and I just lie there and hopefully I can get back to sleep easily again, um, but more often than not, I can’t so after I try for about 15 to 20 minutes and if I can’t get back to sleep after that time then as I say I put the television on and it’ll refocus me and if I fall back to sleep, good’.

However, many participants reported being awake for up to several hours during the night and being unable to get back to sleep;

‘Oh I just get up, it’s just ridiculous trying to sleep and you can’t sleep, you know you get to hate your bed after a while because you get fed up tossing around and trying to get to sleep the whole time’.

Change to routine. Participants demonstrated a high level of awareness of the principles of sleep hygiene to aid sleep quality and many described avoiding large meals and stimulants such as caffeine in the evening;

‘I tend not to watch TV too late unless there’s something really good on but I try and make an effort, like I used to really like watching DVDs late at night and now I don’t do that as much or I’ll listen to the radio, it’s a bit more chilled really, yeah drink herb tea just sort of wind down’.

Medication as a last resort. Ten participants had been prescribed medication to aid sleep; however, participants reported being reluctant to take their medication – they had been discouraged from taking it by their clinicians – and they said the effects were limited in reducing night-time awakenings;

‘I suppose it helps a little bit but I wouldn’t say it makes a tremendous difference you know, I suppose I’d rather take it than not take anything, any help is better than no help, but I still find myself waking up quite frequently every night’.

Theme 4: impact on daily living

‘A juggling act’. The concern about trying to ensure a good night’s sleep before going to work caused anxiety amongst participants;

‘The not sleeping and then not being able to function the next day when you need to perform at work . . . when you’re being paid and you’re meant to work and you can’t function, it’s horrible, it’s really horrible because you feel like a failure’.

Effect on others. Participants were concerned about the impact of a poor night’s sleep on their bed partners and the pressure this placed on relationships;

‘I think it was half the trouble with my husband, I think it caused the problem there, as I can remember him saying oh you kept me awake by tossing and turning’.

The effect of a poor night’s sleep also impacted on families and friends through the need to cancel or reschedule activities, rest and nap during the day if their sleep had been disturbed;

‘It does concern me a lot, but they’ve adjusted and they know that If I’m bad that they’re find with me laying down, whereas before it would have been, they wouldn’t handle it at all, you know, but now they just know it’s part of life really and that I need to have a sleep’.

Reduced spontaneity. Participants described the need to plan and pace their activities to manage their pain and fatigue and the need to schedule in times to rest and sleep caused some frustration and resentment;

‘All I know is, is that I never used to need a lot of sleep, never, and I now really resent that fact that I need so much, I’m not saying my life is so exciting but when it’s,
just now I think oh, I have to plan it round, oh can I have a lay in this weekend, can I do this, can I do that, I find that very hard to cope with’.

The perceived impact of poor sleep on physical functioning also caused apprehension regarding life decisions such as starting a new job with early starting hours or having a baby;

‘We’re wanting to start a family, so that’s kind of an issue regarding sleep, actually; yes that’s a massive issue, because we’ve been wanting to start a family for ages, we’re not even doing that because I don’t think I could have that sort of sleep deprivation’.

Discussion

This study explored participants’ experiences of sleep in FMS. Four overarching themes emerged from the interviews: sleep disturbance, interrelationship between symptoms, coping with disturbed sleep and impact on daily living. Poor sleep was revealed to be a core part of the symptom experience in FMS, as coping with the sleep disturbance and striving to achieve a good night’s sleep dominated participants’ lives.

Participants’ descriptions of experiencing nighttime awakenings and restless sleep are consistent with previous research using objective measures of sleep [21,22]. Many participants described a pattern of sleep consisting of several blocks of sleep lasting 2–3 h during the night with periods of wakefulness in between. Participants found it difficult to find and maintain a comfortable position at night and they were often woken by pain. The need to keep changing position to prevent pain, and stiffness also disrupted their sleep. The perception of feeling unrefreshed after sleep appeared to result from the disrupted sleep pattern and caused them the greatest concern.

In contrast to previous research focusing on other chronic pain conditions, the majority of participants in this study did not report difficulties with initial sleep onset when they first went to bed [35]. However, participants stated that it was hard to go back to sleep when they woke-up during the night and described feeling very alert on awakening. This sleep pattern may be supportive of a hyperarousal model of insomnia [36]. This model proposes that people with insomnia are more alert than would be expected after having experienced poor sleep. This may be due to an increase in brain activity, basal and central nervous system metabolic rate and body temperature. In addition, compensatory strategies that people engage in when they experience poor sleep, such as going to bed before the natural decline in body temperature, worrying about sleep or ruminating about daily events may also have an adverse effect on their sleep quality. Factors believed to be linked to the aetiology of FMS such as dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis are also likely to affect sleep quality in FMS [37].

There was some disparity between participants about the most effective way to manage night time awakenings. Participants described adopting a wide range of strategies from using instrumental supports, cognitive coping approaches and engaging in passive activities such as listening to relaxing music. Many participants had actively sought information and had often spent large sums of some of money trying to improve their sleep quality, even if there was little clinical evidence of effectiveness. It became evident that all participants felt a loss of personal control over their sleep and were desperate for answers. This may have resulted from the lack of information and support available on how to specifically manage FMS and sleep difficulties. Evidence from people experiencing primary insomnia has revealed that non-pharmacological group interventions including the provision of information about sleep and application of cognitive and behavioural components, can effectively improve sleep quality with benefits lasting over several years [36]. There is increasing evidence that cognitive and behavioural interventions may be beneficial to improve sleep quality in patients with chronic pain [37,38], and it is likely these interventions may benefit people with FMS and more methodologically robust clinical trials are required [37].

Research evidence has revealed that people who engage in higher levels of exercise have improved sleep quality [39], and therefore another approach to improve sleep quality for this population could involve increasing levels of activity in people with FMS. However, research specifically exploring the effects of physical activity in FMS has rarely explored the effect on sleep [40,41] and the available results are inconsistent [42–44].

A strong theme that emerged in this study was the impact of napping during the day on symptoms and sleep quality. Many participants described that when they felt severely fatigued during the day – usually mid afternoon – napping was beneficial in relieving pain and fatigue, enabling them to continue their daily activities. Napping was often actively planned into a daily schedule if participants were planning on going out in the evening or seeing friends and family to enable them to cope. Interestingly in this study participants reported that they had been advised to avoid napping during the day by health professionals because of the negative effect daytime napping may have on subsequent sleep quality. This supports previous findings that patients with chronic pain report limited use of daytime napping [38,45]. In the
general population, daytime naps of 530 min duration have been found to have beneficial effects on excessive daytime sleepiness, mood and cognitive performance [46–48]. However, current clinical guidelines do not provide any specific guidance on managing sleep disturbance [28] and clinical recommendations regarding the use of daytime napping appear to be highly diverse. Previous research on the effects of daytime napping have only been conducted in people without underlying medical conditions, and it is currently unclear as to whether these findings can be effectively applied to people with FMS or other chronic pain and fatigue conditions. Therefore, further research exploring the use of daytime napping in patients with chronic pain and fatigue conditions including FMS is needed to inform clinical guidelines.

Despite the high prevalence of sleep difficulties in the participant sample, only half of the participants were taking medication to improve their sleep. This may reflect that some patients are reluctant to ask for medical support about their sleep difficulties or alternatively that clinicians may not see treating the sleep difficulties with medication as necessary or appropriate. Interestingly, the half of the participants who had been prescribed hypnotic medication described feeling reluctant to use it. This was due to being discouraged by their clinicians, concerns that their prescription may not be renewed if they used too much and perceptions that the medication had limited effectiveness. Participants also stated that as their sleep was often unpredictable, it was difficult to know when they would need to take the medication (as they are usually required to take the medication an hour before going to bed). Participants described that they mainly felt the need for the medication in the early hours of the morning to help them get back to sleep after a particularly disrupted night. The use of pregabalin and gabapentin have been found to significantly improve pain and sleep quality in FMS [49–51]; however, this study revealed that participants taking these medications still experienced significant sleep disturbance that disrupted their daily lives, supporting the need for a multifaceted treatment approach.

The ability to generalise the findings from this study may be reduced as the small sample of participants were recruited from patient support groups and the sample may therefore not be representative of the population of people with FMS. However, one of the aims of IPA is to identify a relevant homogenous sample for the research question to conduct a detailed exploration of the research question and the individual experience. Variations in sleep quality may exist between patients with different degrees of disease severity or due to other aspects of patients’ history and further study is needed.

It is of concern that three participants described experiences that were indicative of a sleep disorder that had been undiagnosed and it became evident that they had not undergone any screening or investigation. Some sleep disorders with an underlying physical cause such as sleep apnea can be effectively managed using specific medical treatments once diagnosed [52]. The findings of this support the European League against Rheumatism (EULAR) recommendations, suggesting that patients should be screened for sleep disorders as part of clinical evaluation.

The European League against Rheumatism (EULAR) recommends that due to the complexity of FMS, comprehensive evaluations including analysis of sleep quality are needed to identify individual needs. Optimal treatment of FMS should then be based on a multidisciplinary approach (including both non-pharmacological and pharmacological interventions) tailored to the identified needs [21]. These findings strengthen the increasing body of evidence that sleep quality plays an important role in the exacerbation of symptoms in FMS [22].

Conclusion

People with FMS find that sleep difficulties are one of the most challenging symptoms to cope with, since exacerbation of pain, fatigue and cognitive difficulties seem to be strongly related to poor sleep. Awakening at night in a high state of arousal after a short block of sleep is the most disruptive sleep problem. Recommendations specially addressed to patients with FMS on how to identify and manage sleep disturbance need to be included into clinical management guidelines.

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References