Abstract

Purpose:

To explore the experiences of individuals with fibromyalgia (FM) through written narratives (WN) and to preliminary investigate the potential value of these narratives for healthcare professionals in assessing the overall perceived severity and disability experienced by individuals with FM.

Materials and methods:

This cross-sectional study was conducted with 46 participants with a FM diagnosis. They were asked to complete a WN task that aimed to capture their personal experiences. The degree of severity and disability expressed in their texts was assessed by researchers, and participants were also asked to complete the Revised Fibromyalgia Impact Questionnaire (FIQR), the Hospital Anxiety and Depression Scale (HADS), and the Tampa Scale for Kinesophobia.

Results and conclusions

Eight main themes were identified after qualitatively analysing the narratives provided by participants: story of their illness, FM characteristics, other illnesses, impact, coping strategies, social support, pain triggers and treatments. Pain emerges as a profound symptom affecting mental, physical, and social well-being, with diverse triggers and coping mechanisms. Participants highlighted difficulties in the diagnosis process, used multiple treatment strategies, and expressed a lack of understanding from healthcare professionals and society. There were significant correlations between researchers' assessments of severity and disability of the writings and FIQR and HADs scores. This study emphasizes the value of narratives in capturing the multifaceted nature of FM experiences and hints at their potential for clinical understanding and management.

Keywords: Fibromyalgia; Written Narratives; Qualitative research; Chronic Pain

Introduction

Fibromyalgia (FM) represents a chronic and often debilitating disease characterized by widespread musculoskeletal pain, heightened pain sensitivity, general fatigue, sleep disturbances, joint stiffness, depression, and cognitive challenges (Wolfe et al., 2016; Pérez-Aranda et al., 2018).

Despite its recognition as a clinical entity, FM remains a condition with limited visibility, subject to skepticism, and often poorly acknowledged (Briones-Vozmediano, 2017; Wolfe & Walitt, 2013).

Given this context, it is necessary and important to explore the experiences of people with FM from their point of view. Adopting a qualitative approach yields invaluable insights into how individuals comprehend, perceive, and cope with the persistent pain linked to this condition. Such an approach unravels subjective, intricate, and multifaceted details that standardized questionnaires fail to capture (Morse et al., 2015). Along these lines, there is a substantial quantity of research using qualitative methodologies to explore FM experience (Sim and Madden, 2008). Some studies offer a general exploration of the experiences of those living with FM (e.g. Arnold et al., 2008; Ashe et al., 2017; Boulton et al., 2019; Climent-Sanz, 2020; Vall-Roqué et al., 2024), while others delve into specific aspects, such as healthcare services utilization, medications or particular interventions (e.g., Beltrán-Carrillo et al., 2013; Durif-Bruckert, 2014; Mailen, et al., 2021; Mcllroy et al., 2022). Some also include perspectives from health professionals (Briones-Vozmediano et al., 2013). However, the majority of available literature relies on interviews or focus groups. Research from a narrative point of view has been claimed valuable but scarcely used (McMahon et al., 2012; Eik et al., 2022). To our knowledge, prior studies using written narratives (WN) to approach experiences of people living with FM are practically non-existent.

Equally important is the limited research assessing the clinical relevance of qualitative reports. Insights gleaned directly from individuals can significantly inform healthcare professionals, aiding in the delivery of more tailored and effective treatments (Climent-Sanz, 2020). However, the connection between this first-hand information and standardized outcomes remains largely unexplored.

The main objectives of this study are twofold. Firstly, it seeks to explore the experiences of individuals grappling with FM through WN aiming to gain a deeper understanding of their perspectives and the nuances of chronic pain associated with this condition. Our focus lies in analyzing and describing the themes prevalent in these narratives. Secondly, we aim to investigate the potential value of these WN for healthcare professionals in assessing the overall perceived severity and disability experienced by individuals with FM; and to what extent these assessments are related with standardized questionnaires.

1. Materials and Methods

1.1. Epistemological assumptions

The study was grounded in a phenomenological theoretical framework. Phenomenology focuses on understanding the meaning and significance of experiences, asserting that a phenomenon is inseparably connected to the individual who experiences it, thus rejecting the dismissal of any experience as false (Husserl, 1962; Moustakas, 1994). We used this approach as we aimed to capture the lived experiences, meaning and reality as expressed by participants themselves.

1.2. Procedure

The study was conducted in February 2022. To recruit participants, we explained the study to a group of individuals that was going to participate in a multicomponent intervention for FM. The program integrates Pain Neuroscience Education, Cognitive Behavioral Therapy and Exercise, to improve functioning in people with FM. Participants enrolled in this program retain the option to join subsequent program waves (following again the program). Each wave corresponds to an opportunity for further participation, with associated research projects gathering data across all waves.

Participants that expressed interest in this particular study received the narrative task by email as part of the pre-intervention assessment (see *Written Narrative Task and Measures* section).

The whole study was approved by the ethics committee of the Hospital in which it is offered.

1.3. Participants

A total of 46 people completed the WN task and conformed the sample for this study. Inclusion criteria were (1) to fulfil the 2010/2011 American College of Rheumatology FM diagnostic criteria. The diagnosis was verified by a rheumatologist of the Central Sensitivity Syndromes Specialized Unit; (2) age 18 or over; and (3) to provide written informed consent. Exclusion criteria were having terminal illnesses or programmed interventions that could interrupt participation in the study.

1.4. Written Narrative task and measures

The narrative's objective was to capture personal viewpoints on participants' experiences and feelings with FM. To achieve this, our guidelines and instructions were meticulously crafted and discussed by the research team after reviewing the instructions used in our prior studies (Authors 1, Authors 2). We aimed to be clear, motivational, and inclusive, fostering a space for diverse perspectives and opinions. The sheet included the following cues/points that participants could use to compose the narratives:

- Describe your pain now and how you manage it.
- Describe your pain over time: how it began, if it has changed or stayed the same, and what has affected changes over time.
- Describe your feelings and how pain has made you feel (in the family, work and social contexts) over time.
- Describe how pain has affected your daily life over time.
- Describe whether pain has affected the way you see your future and the things you would like to do.
- Describe treatments you have followed and what effect(s) they have had.

Participants were reassured that the provided cues were purely illustrative, emphasizing their freedom to select topics based on their unique perspectives and write as extensively as they wanted. Participants were given the option to complete the task in either Spanish or Catalan.

Apart from that, as a part of the usual procedure for the baseline assessment in the service, participants were asked about sociodemographic variables and to complete several measures. Of these, we used the following questionnaires in this study:

- *Revised Fibromyalgia Impact Questionnaire* (FIQR; Luciano et al., 2013). It is a 20-item questionnaire that measures functional impairment over the last 7 days. It has 3 dimensions: physical dysfunction (scores from 0 to 30), overall impact (scores from 0 to 20), and intensity of symptoms (scores from 0 to 50). Total scores range from 0 to 100, and higher scores indicate a greater impact. The Spanish version shows adequate internal consistency (Cronbach α = .93) (Luciano et al., 2013).

- *Hospital Anxiety and Depression Scale* (HADS; Luciano et al., 2014). This is a commonly used questionnaire that evaluates the severity of anxiety and depression symptoms with two scales (comprising 7 items each one). Scores of each scale range from 0 to 21, with higher scores indicating greater severity of symptoms. The Spanish version has shown adequate internal consistency both for anxiety ($\alpha = 0.83$) and depression ($\alpha = 0.87$) subscales in individuals with FM (Luciano et al., 2014).
- *Tampa Scale for Kinesiophobia* (Kori et al., 1990). This scale is composed of 11 items, which are answered on a 4-point Likert scale. The scale quantifies fear of movement or (re)injury, and total scores can range from 11 to 44, where higher scores indicate a greater fear of pain and movement. The Spanish version shows adequate internal consistency ($\alpha = .79$) (Gómez et al., 2011).

1.5. Researchers' assessments of Severity and Disability

Two independent reviewers read all the writings. For each text, they assessed the level of severity and disability expressed by participants on a scale from 0 (indicating absence) to 10 (representing maximum levels), based on their interpretation of the texts. To ensure consistency in their evaluations, severity was defined as the perceived magnitude of FM concerning pain and overall suffering conveyed in each participant's text. Disability, on the other hand, was defined as the perceived extent to which FM disrupts the usual activities and life of the writers.

2. Analysis

A qualitative thematic analysis was performed (Braun & Clarke, 2006). Five researchers familiarized themselves with the data and coded independently different narratives, searching for initial themes. Then, they met to share the patterns and themes they identified. From this meeting, a preliminary coding system was created, and two researchers proceeded coding 25% of all the narratives. After this coding, they met and discussed the coding system, making all the necessary changes. Then, they coded another 25% of writings, having a new meeting to discuss any potential change and review themes. After this, the remaining writings were divided and each of the two researchers coded half of them. Finally, each researcher reviewed the narratives coded by the other, and any divergences were discussed in a final meeting, where the final themes and subthemes were established.

Correlations between the scores of severity and disability from the two observers' assessments were computed as a measure of agreement. Also, correlations with mean scores of the assessments made by the two observers and FIQ-R and TSK-11 scores were performed.

3. Results

3.1. Sample description:

Mean age was 51.04 (SD:8.26; range:34-72), and 93.5% were women (N=43). Other descriptive statistics are presented in Table 1.

INSERT TABLE 1 HERE

3.2. Qualitative descriptive analysis:

A total of eight themes were identified in the writings. Each of them included different subthemes that are presented in Table 2 and described in detail in this section.

INSERT TABLE 2 HERE

Story of their illness

Participants wrote about the trajectory of their illness, focusing especially on the time period when their symptoms began and when their diagnosis took place. They commented about the *"Time since symptoms onset*". In general, a long time had passed since the beginning of FM symptoms. However, a more recent symptom onset was reported in some cases (< 3 years). Some women described having diffuse symptoms at the beginning, which made it difficult to estimate the illness onset. In addition, participants wrote about *"Life events related with symptoms onset".* These included complicated personal specific moments (e.g., traumatic events such as losing a brother or specific traumatic events such as a motorcycle accident), while others explained having repeated complicated or traumatic situations:

"My older brother, a medical student and a Red Cross volunteer, died while on duty at the [popular race event]. He was my friend and my best companion, I lost my direction and my life fell apart..." (Woman; 57 years; FIQR: 56.5)

Work-related accidents, or very demanding jobs in physical terms, were also related with the beginning of FM symptoms.

Participants also wrote about their "*Diagnosis process*": before reaching the final diagnosis, participants visited several specialists. They attended general practitioners, rheumatologists, neurologists and mental health professionals, among others. Some also consulted alternative professionals, such as naturopaths. In some cases, friends or family members told them they had FM before having the official diagnosis. Usually, the diagnosis process was long and hard. Some participants described feeling abandoned once they received the diagnosis, as for example:

"I left the appointment feeling sicker than when I went in, and following that, I felt

completely abandoned by the health care system ([I was allowed] an appointment every 8 months and that's it)." (Woman; 36 years; FIQ-R: 71.17)

Others expressed feeling judged or depressed when they received the diagnosis. In contrast, for some participants finally having a diagnosis was positive since they found an explanation for what happened to them:

"And that's how I finally had a name for what I was suffering from! Without knowing the causes, or all the possible symptoms, and without treatment, but with a name! And I wasn't going to die from Fibromyalgia! Great!" (Woman; 50 years; FIQ-R: 71.83)

Finally, participants wrote about the *"Course of the illness"*, describing how their symptoms evolved throughout the illness. In general terms, they did not experience a relief in their condition nor a worsening since the beginning. An example quote was: *"Pain over the years has been increasingly affecting my daily life. In the last six years, it's been worse, I have to cut back on my activities, prioritizing work at the expense of other areas of my life." (Woman; 50 years; FIQ-R: 71.83)*

Fibromyalgia characteristics

This theme reflected participants' descriptions of their illness. They mentioned different *"Physical Symptoms"* that are usually reported in people with FM such as: generalized pain, sleeping difficulties, stiffness, fatigue, dizziness, weight gain or loss, feelings of numbness and tingling, high noise and temperature sensitivity, and digestive problems/diarrhea. Common *"Psychological Symptoms"* such as the following ones were also reported: cognitive problems (e.g., memory loss, concentration problems, spatial disorientation or difficulties in finding the correct word to use or in solving problems), mental fatigue, feeling stressed, irritated, angry, not useful or depressed, and having the feeling of losing their identity (not knowing who they are).

Pain was reported as one of the most prominent symptoms. They commented about "*Pain intensity"*. They expressed having intense pain (or having had intense pain episodes), having experienced an increase in pain intensity, or not having had pain relief. A few participants described feeling less pain at the moment, or reported variations in their pain intensity. "*Pain location*" was also mentioned. More specifically, generalized pain was frequently mentioned, although some participants reported that pain was especially prominent in body extremities, the pelvic area, and the back and head area. Some of them also expressed that pain locations varied. Finally, regarding *"Pain frequency",* most participants reported having long-lasting, constant pain.

Impact

This theme reflected the consequences of FM in participants' lives. More specifically, FM was reported to have an impact on different domains that were grouped within this theme. A negative impact on *"Mental Health"* was commented on. This is similar to the subtheme *Psychological Symptoms,* but in this case participants explicitly referred to psychological consequences derived from the illness, while in the other they focused on psychological manifestations of FM. Depressed mood, hopelessness, desperation, sadness, apathy, feeling overwhelmed, negative and catastrophic thoughts and suicidal ideation were reported as consequences of the illness:

"I am very angry, and although I do not think about taking my life, I can't help but think that I wouldn't mind if I were to die in an accident and stop suffering…" (Man; 48 years; FIQ-R: 58.5)

Anxiety attacks, uncertainty, fear, worry, being in a state of alarm, frustration and feelings of uselessness and helplessness for not being able to carry out their lives, were also reported. Moreover, living with FM led to having feelings of injustice for suffering the illness, anger or ambivalence feelings. Changes in consequences in mental health over time were also reported.

FM also had a clear impact on "*Daily Activities*". Participants explained that doing activities was hard for them: they were not able to perform activities to the level they wanted, and they considered that it was much harder for them to do their activities compared to individuals without FM. Planning or organizing activities was also difficult, and they often needed to ask for help:

"I can't plan for tomorrow because I don't know how I'll be feeling." (Woman; 51 years; FIQ-R:70.17)

The most difficult activities to perform were the following ones: getting dressed, taking care of themselves and others, doing home chores, going shopping, walking, climbing stairs, carrying weight or doing computer work. However, a few expressed that their daily habits had not changed.

Another consequence of FM involved preventing participants from doing "*Physical exercise*" or difficulting their performance. FM also impacted the *"Work/Education*" domain. Several participants reported that they had to quit their jobs as a consequence of the FM-related symptoms, and this represented an important loss/change in their lives:

"In the work domain, it's been tough. I had a hair salon for almost 25 years, and in November 2021, I had to close it with a heavy heart. I've been working since I was 15 when I started as an apprentice, and I loved my job. I enjoyed it so much that it's been very hard for me to have to let it go (...)"(Woman; 51 years; FIQ-R:70.17).

Others wrote about having to take a sick leave multiple times, and some expressed that FM interfered with their education. In fact, only a few were working at the moment, and it was hard for them:

"I do the bare minimum because I save all the possible energy to be able to work, and I end up more defeated. It takes a toll on me professionally." *(Woman; 53 years; FIQ-R: 93.83).*

This interference in their work life had an impact on their "Financial situation*"*. Also, participants wrote about FM interfering with their "*Social Activities*" in general, and their *"Family functioning"* in particular. They experienced difficulties when being with their partners, taking care of children or enjoying family activities: *"Now my life isn't nice. I don't have a partner because I'm embarrassed to be with someone and constantly trying to hide everything, pretending that it doesn't hurt, when I can't because when I get up, everything hurts, and I need time to stand up."* *(Woman; 50 years; FIQ-R: 76).*

Other illnesses

Apart from FM, participants reported having or having had a variety of *"Other Physical Illnesses"* such as renal insufficiency, breast cancer, migraine or chemical sensitivity syndrome. Also, some reported having or having had *"Other Psychological Illnesses"* not related directly to FM, such as major depression, specific phobias, agoraphobia or generalized anxiety.

Coping strategies

Coping strategies represented the different ways of coping with FM. Some participants commented about "*Pain acceptance*" as a useful mechanism, and others wrote about pain *"Reconceptualization"* as a coping strategy, which included understanding and reframing pain (and the situation), having a positive attitude, knowing how to manage pain and leaving pain in the background:

"I've had very difficult days, but I came to the conclusion that neither the pain nor the fatigue could control me. I started a strong battle against both of them with a lot of willpower and prioritized my own judgment over the pain, and that's how I continue until today" (Woman; 72 years; FIQ-R: 40.33).

"Re-organizing" their activities considering their pain, limitations or overall situation was another mentioned strategy.

Some women wrote about "*Searching for information*" about the illness or about pain management strategies as a coping strategy. This information was usually found on the internet, in self-help books or in patients' associations. "*Activity*", especially walking, was reported by some as a coping strategy, and others commented on *"Maintaining Healthy Habits"* in general. *"Relaxation"* and *"Distraction techniques"* also appeared in the texts:

"I manage it by enduring it, and I try to distract myself with something to avoid thinking about negative things." (Woman; 56 years; FIQ-R: 73.33).

Some participants reflected on *"Prioritizing their wellbeing*" and *"Striving"* as strategies to deal with their negative situation:

"I've had more crises, and it's getting harder for me to do things, but I push myself a little more every day to achieve goals." (Woman; 64 years; FIQ-R: 68.33). Finally, some commented on "*Taking medication*", including marijuana seen as a medicine, for coping with pain.

Social Support

Social support reflected the psychological, physical, and financial understanding and help provided by the participants' social context (e.g., family, friends, neighbours, and community).

The first subtheme was labelled *Perceived support and understanding about the illness*, and included, on the one hand, commentaries referring to the fact that other people did not have enough awareness, experience and information about the illness. This involved a lack of sensitivity and knowledge in healthcare professionals:

"When I was diagnosed, the doctor labelled me, saying that it was a chronic illness and that I had to learn to live with it. He mentioned that eventually, I would need a wheelchair, I would have to buy myself a cane to go to work, and that my partner would have to do everything for me, because I would be gradually losing abilities. He also blamed my mother for what was happening to me, saying that it was her who, having rheumatoid arthritis, passed on her genetics for me to end up with this illness (she was with me in the consultation). (Woman; 36 years; FIQ-R: 71.17).

The lack of knowledge about the illness (by family members, friends, professionals, or the society in general) led to some participants feeling judged, or feeling a lack of social support: *"In the family context, I don't feel understood. The magical phrase is 'tomorrow, for sure, you'll feel better,' but what I need is someone I can explain how I feel to and feel supported by (...)."(Woman; 56 years; FIQ-R: 65).*

On the other hand, some participants expressed that they felt understood and supported by family and friends, or indicated that they often needed to ask for support from their close others.

The second subtheme was *"Unwanted social interactions/support":* some participants explained that they did not feel the need of interacting with others, receiving their support or taking part in social activities, or they felt bad in social situations because they constantly had to explain and justify their situation:

"Another thing I struggle with a lot is that I don't feel like socializing with my family and friends because it seems like I always have to talk about my illness since they ask me

about it, and they don't quite understand what I'm going through." *(Woman; 51 years; FIQ-R: 70.17).*

Triggers

Different aspects were coded as triggers of pain episodes (or factors worsening symptoms). "*Activity*", including exercising and any type of physical activities, triggered pain or worsened FM symptoms for some:

"We've gotten a puppy that brightens my days a bit, and some days I've taken her for a walk with my daughters, but then maybe I have to rest all afternoon." *(Woman; 55 years; FIQ-R: 84.83).*

"Psychological Factors", basically stress and fear, also triggered pain. *"Stressful life events"* were mentioned as related with the onset of FM, but also as pain triggers. One specifically harmful event mentioned by some of them was the "*COVID-19 Pandemic*"; both the global situation and the fact of being infected by the virus were mentioned as triggering factors for intense episodes of pain:

"During Christmas 2021, I had COVID, and my muscle and joint pains, fatigue, memory, and concentration issues have increased." *(Woman; 50 years; FIQ-R: 55.5)*.

"Environmental Conditions" such as cold weather, humidity or change of seasons were also mentioned as triggers. Finally, perceived *"Lack of Understanding", and "Overweight"* were also mentioned as triggers but less frequently.

Treatments

Several specific modalities of interventions were commented and grouped in different subthemes. There were comments about consulting a *"Physician"*, which included general practitioners and specialists. Participants commented on *"Pain medications"* and the doses they took, and some explained having tried different types of medications. Some women mentioned taking *"Medication for mental health disorders"*. Receiving interventions in different "*Specialized facilities"* such as FM units, specialized pain units or a specific specialist was also stated by some participants. "*Alternative therapies*" such as herbal products, taichi, Bach's flowers, or homeopathy also appeared in the writings. Some specifically commented about *"Treatments' effectiveness"*: in general, women expressed that it was hard for them to find a treatment that could actually improve their condition, and there were side effects related to some of the medications.

"Medications help, yes, but they don't cure you; they just alleviate symptoms, and sometimes the pain persists regardless of the amount of medication you take…" (Woman; 37 years; FIQ-R: 87.33).

It was also frequent to comment on going to *"Psychotherapy"*, which included (among others) individual and group psychotherapy, attending to a psychiatrist, or doing coach sessions. In the same way, they reported having attended *"Physiotherapy"* sessions in a wide meaning, including acupuncture, massages, and osteopathy among others.

3.3. Correlations between questionnaire scores and observers' scores of disability and severity based on the writings

All correlations are presented in Table 3. Correlations between observers' ratings of disability and severity after reading each text (computing the mean of ratings from the two observers both for disability and for severity) and FM impact as measured with the FIQ-R total scores were positive and statistically significant. The same pattern was found for the FIQ-R overall impact and intensity of symptoms subscales, and for the two sub-scales from the HADs: that is, higher levels of disability and severity perceived in the writings were positively and significantly associated with higher scores in the mentioned subscales. In contrast, there were no significant correlations between perceived disability and severity in the writings and fear-avoidance beliefs (TSK-11 scores) or physical dysfunction (FIQ-R subscale). Finally, correlations between severity and disability scores were also high (r=0.90; *p*<.001). Agreement between the two different observers was high, as deduced from the correlations of their individual scores for severity (r=0.75; *p*<.001) and disability (r=0.73; *p*<.001).

INSERT TABLE 3 HERE

DISCUSSION

WN proven to be valuable to explore the experiences of individuals with FM. Participants discussed 8 different themes, including sub-themes. With regards to the themes "Diagnosis", "Treatments" and "Social Support", our results suggest that FM remains inadequately understood by professionals and society at large (leading to feelings of being misunderstood and/or not trusted). The diagnosis remains challenging, and the provided treatments are often inadequate or insufficient, aligning with previous literature findings. For example, Sim and Madden (2006) found, in their metasynthesis of qualitative studies, that people with FM have problems related to the perceived legitimacy of their symptoms. This was due, among other factors, to the difficulties in finding a clear physical sign, to the fact that people with FM can have a "good" physical appearance besides being unable to do their usual activities, or to the fact that they usually undergo multiple tests to exclude other problems before they receive the diagnosis. Despite being consistent with existing research, it is surprising that we continue to encounter these results in the present context, given the substantial body of evidence advocating for a biopsychosocial approach to understanding and managing FM (Turk & Adams, 2016). Undoubtedly, more efforts are imperative to bridge the gap between scientific results and clinical practice. This involves not only steering professionals away from inadequate conceptualizations (Beneitez & Nieto, 2017), but also requires broader societal efforts to foster understanding and support for individuals dealing with FM and other chronic pain issues. Increased economic investment is essential to establish accessible units capable of providing necessary treatments promptly. Considering the outcomes from available treatments (e.g., Serrat et al., 2020), the value and importance of these efforts are indisputable.

The majority of our participants had had FM for an extended period of time, and some attributed its onset to traumatic experiences, a correlation also observed in other qualitative studies (e.g., Lemp et al., 2009; Raymond & Brown, 2000). Among the symptoms associated with FM, pain emerged as the most frequently reported and impactful, affecting various facets of life—mental, physical, and social—, a finding that aligns broadly with earlier studies (e.g., Arnold et al., 2008; Lempp et al., 2009; Raymond & Brown, 2000). Additionally, the pain triggers reported mirrored those identified in prior studies (Sim & Madden, 2008). To face symptoms and triggers, our participants used several coping strategies (apart from following specific interventions). Broadly, they discussed utilizing strategies that have demonstrated efficacy in existing literature such as relaxation techniques, distraction, maintaining healthy habits, or activity. Notably, our study highlighted the use of what we term "reconceptualization" as a coping strategy, involving understanding the situation and subsequently embracing acceptance. This notion of pain acceptance, identified in other qualitative studies (e.g., Raymon and Brown, 2000; Hamama and Itzhakim, 2022), has garnered increased attention in recent chronic pain literature, particularly within the realm of FM. Acceptance can lead to focusing on achieving one’s own objectives which are related to one’s values, besides having pain (Nieto et al., 2019). However, participants also mentioned taking medication as a coping strategy, which, though helpful, could potentially have adverse effects. Similar concerns were raised regarding certain treatments, such as alternative therapies, indicating potential drawbacks associated with their usage.

Concerning the second objective, we found intriguing and novel findings. Observers’ assessments of severity and disability based on the analysis of participants’ writings displayed significant correlations to FIQ-R (Total Scores, Overall Impact and Intensity of Symptoms) and HADs scores (Anxiety and Depression subscales), aligning with expectations. This suggests the potential use of WN to evaluate the degree of severity and disability in individuals with FM or other pain-related conditions. Moreover, these narratives can serve as valuable guides for the evaluation process, enabling clinicians to delve deeper into crucial aspects outlined in the writings by employing questionnaires or other tools. For instance, if a person with FM mentions always resting during pain episodes, clinicians may seek further insights into their coping strategies and consider designing interventions to promote activity. Therefore, writing narratives could efficiently initiate the process of understanding and managing an individual's situation. However, further studies should explore whether individuals prefer utilizing narratives (and feel comfortable doing so) to articulate their experiences, or if they favor other methods like interviews or standardized questionnaires. Additionally, investigating the feasibility of automatically assessing written narratives using artificial intelligence could significantly aid clinicians and researchers, providing an initial outline of the person's key topics and expressed severity, thus optimizing the process in terms of time efficiency.

Besides presenting very innovative results, we have to acknowledge some limitations of our study. First, sample size is reduced. This is something usual in qualitative research due to its nature, but it could be very useful to replicate our study with a bigger sample size for the second objective. Secondly, we did not explore the satisfaction of people explaining their experiences using WN. Future research should address this issue and also compare the time required for doing that in comparison to using standardized self-reported measures. Third, we did not involve people with pain in the process of establishing the guides for producing the WN nor in the analyses of results. They could have offered an interesting perspective and should be included in future studies. Finally, most participants included in the study were women. Future research could benefit from exploring the experiences of men and individuals who do not identify within the binary gender system living with FM.

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Table 1. Participants' characteristics

Civil status	**N (%)**
Married / With partner	31 (67.4)
Divorced	9 (19.6)
Single	5 (10.9)
Widowed	1 (2.2)
Educational level	
Unfinished primary education	3 (6.5)
Primary education	12 (26.1)
Secondary education	22 (47.8)
University education	8 (17.4)
Master's degree or PhD	1 (2.2)
FIQ-R	**Mean (SD; range)**
Total scores	73.07 (15.39; 40.33-100)
Physical dysfunction	21.21 (6.13; 4.67-30)
Overall impact	14.13 (5; 1-20)
Intensity of Symptoms	75,46 (6.82; 41-100)
TSK	29,46 (7.93; 12-44)
HADs	
Anxiety	12.95 (4.5; 1-21)
Depression	11.48 (4.14; 2-21)
Observers' assessment of severity *(mean of ratings from the two observers)*	7.32 (1.45;3.5-10)
Observers' assessment of disability *(mean of ratings from the two observers)*	6.89 (2.02;2.5-9.5)

Table 2. Themes and subthemes

Theme	**Subthemes**
Story of their illness	Time since symptoms onset
	Life events related with symptoms onset
	Diagnosis process
	Course of the illness
Fibromyalgia characteristics	Physical Symptoms
	Psychological Symptoms
	Pain intensity
	Pain location
	Pain frequency
Impact	Mental Health
	Daily activities
	Physical Exercise
	Work/education
	Finantial situation
	Social activities
	Family functioning
Other illnesses	Other physical Illnesses
	Other psychological Illnesses
Coping strategies	Pain acceptance
	Reconceptualization
	Re-organizing
	Searching for information
	Activity
	Maintaining healthy habits
	Relaxation techniques
	Distraction techniques
	Prioritizing their wellbeing
	Striving
	Taking medication

Social Support	Perceived support and understanding about the illness
	Unwanted social interactions/support
Triggers	Activity
	Psychological factors
	Stressful life events
	COVID-19 Pandemic
	Environmental conditions
	Lack of understanding
	Overweight
Treatments	Treatments’ effectiveness
	Pain medication
	Specialized facilities
	Psychotherapy
	Physiotherapy
	Medication for mental disorders
	Alternative therapies

Table 3. Correlations between observers assessment and variables studied.

	FIQ-R (Total Scores)	FIQ-R (Physical dysfunction)	FIQ-R (Overall Impact)	FIQ-R (Intensity of Symptoms)	TSK-11 (Fear-Avoidance)	HADs-Anxiety	HADs-Depression
Severity	0.41*	0.19	0.41*	0.47*	0.14	0.33***	0.43*
Disability	0.42*	0.25	0.40*	0.42*	0.12	0.35***	0.43*
FIQ-R (Total Scores)	-	0.81**	0.89**	0.88**	0.2	0.68**	0.69**
FIQ-R (Physical dysfunction)	-	-	0.59**	0.49**	0.08	0.45*	0.43*
FIQ-R (Overall Impact)	-	-	-	0.73**	0.18	0.63**	0.63**
FIQ-R (Intensity of Symptoms)	-	-	-	-	0.25	0.66**	0.71**
TSK-11 (Fear-Avoidance)					-	0.08	0.26
HADs-Anxiety					-	-	0.82**

*p<0.01; **p<0.001; ***p<0.05