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HURTING ALL OVER

With so many people in so much pain, how could fibromyalgia not be a disease?

BY: JEROME GROOPMAN

In 1990, the term "fibromyalgia" formally entered the medical lexicon. It designated a condition of persistent muscle pain throughout the body, pain that is often accompanied by severe fatigue, insomnia, diarrhea and abdominal bloating, bladder irritation, and headache. Now, ten years later, nearly six million Americans are said to be suffering from fibromyalgia—more than four times as many as will develop cancer this year, and six times as many as are living with H.I.V. Ninety per cent of the afflicted are women, and the majority are Caucasian. Many cases follow a traumatic event, such as surgery, but others have no apparent cause.

Because of the vast number of people affected and the degree of debility it can cause, fibromyalgia has recently become a matter of national concern: it is featured with increasing regularity in newspapers and magazines and on television, and it is the focus of hundreds of Internet sites. Specialized clinics have been established, and pharmaceutical companies, realizing that the illness is chronic and therefore potentially lucrative, have been marketing to the afflicted. Support and advocacy organizations have lobbied Congress so effectively that the National Institutes of Health is now funnelling millions of dollars into fibromyalgia research. And yet virtually every aspect of this condition, down to its very name, is contested in the medical community. The debate over diagnosis and treatment has become so heated that it has polarized medical specialists; choosing a doctor has become tantamount to adopting an ideological position.

One of the first doctors to attempt to define the cluster of symptoms now known as fibromyalgia was Frederick Wolfe, the director of the Arthritis Research Center Foundation, in Wichita, Kansas, who became interested in the condition in the nineteen-seventies. Like many other rheumatologists, he was seeing an increasing number of patients who complained of diffuse muscle pain but who, upon physical examination, showed no evidence of inflammation; subsequent laboratory tests, X-rays, and tissue biopsies failed to show any muscle pathology. He found nothing in the clinical textbooks to explain these mysterious muscle complaints, so he decided to assess as many such patients as he could, and to enter the clinical data into his computer.

In 1987, Dr. Wolfe brought together twenty rheumatologists from across the United States and Canada to codify the unknown disorder. Its name is derived from the Greek "algia," meaning pain, "myo," indicating muscle, and the Latin "fibro," indicating the connective tissue of tendons and ligaments. Their diagnostic criteria were as follows: when a doctor firmly pressed on eighteen designated points where muscle, tendon, and ligament attach to bone, a patient who felt pain at eleven or more of those points had fibromyalgia. The American College of Rheumatology endorsed

these criteria, and the fibromyalgia syndrome became an officially recognized disorder. At the time, Wolfe and his colleagues saw this as a great step forward: the criteria would not only enable doctors to make a diagnosis but also provide researchers with a defined population of patients, so that they could better search for a cause and methodically assess the risks and benefits of specific treatments.

Dr. Don Goldenberg, a professor of medicine at Tufts University School of Medicine, who helped Dr. Wolfe develop the criteria for fibromyalgia, has been the director of the Arthritis/Fibromyalgia Center at Newton-Wellesley Hospital since 1988, and he is considered one of the most passionate advocates for those who suffer from the condition. His commitment is rooted in personal experience. In the late seventies, his wife, Patty-"the most upbeat, outgoing person I know," Goldenberg says-became suddenly and inexplicably afflicted with pain, insomnia, and profound exhaustion. She was ultimately diagnosed with fibromyalgia.

Last spring, I attended an educational meeting that Dr. Goldenberg had organized for fibromyalgia patients in the Westin Hotel, just outside Boston. The meeting was free, its costs underwritten by pharmaceutical companies, which had set up marketing booths in the entryway. Nearly all the participants were white women between the ages of twenty and sixty. Some walked with canes that had a four-point base, others wore braces on their wrists or ankles, and many limped. The cavernous hotel ballroom, which seats more than seven hundred and fifty people, was filled beyond capacity.

Goldenberg's opening slides addressed the concerns that he knew were on the minds of every patient in the audience: "What Is Fibromyalgia? A Medical Illness? A Syndrome? A Psychiatric Illness? Is It All in the Head?" "It's not all in the head," he declared. "Only a third of patients manifest major depression, anxiety, or panic. It becomes a chicken-and-egg problem. People are anxious and depressed from their pain and their suffering. Labelling fibromyalgia a psychiatric illness is stigmatizing." How could there be no disease, he asked, when those afflicted are in such pain? He cited cases of fibromyalgia that have followed viral infections, like the flu, physical injuries, or emotional traumas, and then likened the pain to that of a phantom limb: "Whatever trauma initially triggered fibromyalgia is long gone. But the pain persists."

Goldenberg criticized physicians who were skeptical of the condition and who dismissed it-along with chronic fatigue and irritable bowel-as a "wastebasket" syndrome, meaning it does not fit into established categories of physical disease. The message implicit in such a term is that the patient's symptoms are clinically insignificant, a hodgepodge of complaints without physical explanation. In this forum, however, such patients would not be dismissed. "You are not crazy," he assured his listeners.

Goldenberg then introduced Dr. Robert Bennett. Bennett is a rheumatologist who was a member of Wolfe's criteria team and is now the chairman of the division of arthritis and rheumatic diseases at the Oregon Health Sciences University, in Portland. He told the audience that Alfred Nobel, the inventor of dynamite and the founder of the prizes that bear his name, suffered from fibromyalgia and irritable-bowel syndrome. A slide showed a quotation from Nobel's writings: "I am more seriously ill than my doctors think." Bennett looked at the audience. "Statements like that

make it sound like you and Nobel are all hypochondriacs." There was nervous laughter in the audience.

New data, Bennett said, proved otherwise. Using a series of graphs, diagrams, and images of brain scans to illustrate his argument, Bennett said that people with fibromyalgia have a number of neurochemical and circulatory abnormalities that make them unusually sensitive to pain. "I believe the answer is that you suffer from a disorder of sensory processing, so there is amplification of sensory nerve impulses-increased input from muscles, bowel, bladder, and the organs of taste and smell." The complexity of Bennett's data did not blunt the eager attentiveness of the audience: here at last was a plausible explanation for a maddeningly elusive condition.

Not long after the conference, I visited Dr. Goldenberg in his office at Newton-Wellesley Hospital. About fifteen patients a week are referred to him for evaluation of symptoms that indicate fibromyalgia; one of the patients I met was a woman I will call Paula Cortez, a thirty-four-year-old of Portuguese heritage from a mill town in southern Massachusetts. A large woman with auburn hair and brown eyes, Mrs. Cortez offered a tentative smile as Dr. Goldenberg greeted her in the waiting room. She let go of her five-year-old son's hand and walked slowly into the office, leaning on a four-point cane.

Dr. Goldenberg listened intently as Mrs. Cortez recounted her story. In 1995, when she was five months pregnant, she developed a pain in her hips so intense that she was unable to walk. The pain did not abate after her son was born; in fact, it spread "everywhere in my body, from the neck down." She saw many doctors and had numerous blood tests and three M.R.I. scans. All these evaluations were negative for any bone, joint, or muscle disease. The pain was worst in her back. "I feel like I have two knives stuck in there," she explained. This makes it impossible for her to sleep for more than an hour or two at a time. Such "non-restorative" sleep is characteristic of fibromyalgia, Dr. Goldenberg said.

Mrs. Cortez thought that perhaps the baby had depleted her calcium levels, and so she began drinking large amounts of calcium-enriched orange juice and took calcium supplements, but without effect. She takes Motrin and Tylenol strengthened with codeine for the pain, and sleeping pills for her insomnia. She has also been given different psychiatric medications by her primary-care physician, and recently began taking Prozac. "Now I have a big pharmacy in my house," she said. Nothing, however, works particularly well.

"Sometimes when I go to the doctor, he doesn't spend more than five minutes with me," Mrs. Cortez said. Her experience with a chiropractor was similarly unhelpful. "He moved me like this," she said, making a twisting maneuver with her hands. "It didn't get me better." Dr. Goldenberg asked if she thought she was depressed. "Of course I am depressed-my house is a mess, my life is a mess. I don't work. I don't have any money. I have no social life."

When I asked about her husband, she looked away, and then explained that when she got married, in 1991, her husband was not a legal immigrant and didn't have a green card, so he couldn't work: "We were fighting all the time. I felt trapped." Mrs. Cortez said she had begun to put on weight, and over the past eight years had gained some eighty pounds. Her husband was

unsympathetic to her condition. "It's hard when you have tests and the tests don't show anything," she said. They are now separated.

We moved to the examining room. Mrs. Cortez exhibited no evidence of arthritis, and seemed to have full range of motion in her fingers, wrists, elbows, and neck, and even in her painful hips. Dr. Goldenberg then explained to Mrs. Cortez that he was going to apply pressure to different parts of her body. "If you feel pain, not just pressure, when I press, then tell me. Say the word out loud-'pain.'" Dr. Goldenberg began at her wrists, exerting with trained fingers nine pounds of pressure, in accordance with the criteria of the American College of Rheumatology.

"Oh-pain. Pain. Pain." At nearly every point, Mrs. Cortez winced.

"Mrs. Cortez, you have fibromyalgia," Dr. Goldenberg said. An expression of relief crossed her face.

Language is as vital to the physician's art as the stethoscope or the scalpel. A doctor begins by examining the words of his patient to determine their clinical significance. He then translates the words into medical language, describing how the condition came to be, what it means, and how it may evolve. Of all the words a doctor uses, the name he gives the illness has the greatest weight. It forms the foundation of all subsequent discussion, not only between doctor and patient but also between doctor and doctor and between patient and patient. With a name, the patient can construct an explanation of his illness not only for others but for himself. The name of the illness becomes part of the identity of the sufferer-"P.W.A." (person with AIDS), or "cancer survivor"-and indicates the status the person has gained from his experience; it is shorthand for his odyssey, akin to "veteran of foreign wars" or, in Muslim lands, "hajji," for one who has made the hajj. The name can also provide an instant community.

At the end of the afternoon, I accompanied Dr. Goldenberg to a small conference room adjoining his office, where Mrs. Cortez and several other patients he had just evaluated were assembled. "There are no known cures for fibromyalgia, although charlatans promise them," Dr. Goldenberg said. "And while it is usually a chronic condition, there is hope of alleviating the symptoms. Low doses of tricyclic antidepressants, like Elavil, can be beneficial. So can a gradual program of exercise. Pain medicines like Ultram may afford relief. We work as a multidisciplinary team here with a psychiatrist down the hall and a physiatrist." In essence, Dr. Goldenberg's care consisted of judicious doses of psychotropic medicines and analgesics, a graduated exercise program, and-perhaps most significant-the promise that the patient's suffering would be taken seriously.

I left Dr. Goldenberg's office wondering how Mrs. Cortez's experience might compare with that of someone of a different socioeconomic and educational background. I spoke with a close friend of some thirty years, a fifty-one-year-old woman I'll call Liz Albright. Liz, who teaches at an elite New England college, has received a diagnosis of fibromyalgia with associated chronic-fatigue and irritable-bowel syndromes. Her troubles began in 1994, after she underwent surgery for sinus infections. She never recovered her sense of well-being, and suffered from insomnia, fatigue, headaches, and deep muscle aches in her arms and chest. "My internist told me that it was all tension, that I'm middle-aged, and reacting to the stress of raising two kids, five and eight," she

said. At that time, she had other stresses as well. She had recently been divorced, and she and her ex-husband closed a business they had managed together.

Liz had had episodes of depression in the past, but this felt very different. One specialist she consulted thought that her pituitary gland might have been nicked during the sinus surgery, but extensive endocrinologic testing showed otherwise. A gastroenterologist suggested that she might have celiac disease, or sprue—a rare allergic reaction to the gluten in wheat, rye, and barley—and Liz underwent endoscopies of her stomach, small bowel, and colon, and multiple analyses of stool to try to confirm the diagnosis. "When all the tests came back negative for sprue, he completely lost interest in me," she said. She came to Boston and saw other specialists, none of whom could do more than offer the diagnosis of fibromyalgia and chronic-fatigue syndrome.

Liz's experience of being shunted from doctor to doctor is typical. In the era of managed care, doctors have neither the time nor the incentive to listen to a seemingly endless list of inexplicable symptoms. Fibromyalgia patients often set off a game of clinical hot potato, with each doctor eager to pass the patient on to a colleague as quickly as possible. One doctor referred to these patients as "the bane of the medical profession."

Unable to get help from physicians, Liz turned in desperation to alternative healers. A Vietnamese monk performed acupuncture, which was of no apparent benefit. A chiropractor told her that a car accident she had had at the age of sixteen had "messed up" her neck: "Crack, crack, he moved me around, took several hundred dollars, and tried to sell me pillows." An osteopath told her that she would be on painkillers for the rest of her life.

Liz now goes to a local internist. "The first thing I said to him was 'You need to believe I am really sick, not just complaining.'" For her fatigue, she was given Ritalin, and for her insomnia she was given Ambien. "I am probably addicted," she said, "but the doctor keeps giving them because he has no answers." Recently, she began taking Prozac, but it has not made much difference. She closely follows reports on the Internet and in fibromyalgia and chronic-fatigue newsletters, searching for possible solutions. "I've tried everything," she went on. "I have two shelves in my kitchen cabinet that contain every supplement imaginable. I've taken coenzyme Q10. I taught myself to inject bovine-liver extract. Because some people think it is hormonal, I took birth-control pills to try to even out symptoms of menopause. But they were not beneficial." Liz, who was reared as an Episcopalian but is a longtime agnostic, wondered whether will power and prayer might help her. "I went on the road to Damascus, but that hasn't helped, either." Finally, last year, she gave in and took time off from teaching because of the pain, fatigue, and episodes of what is commonly referred to as "fibro-fog," or an inability to think clearly.

We talked about the nomenclature, and about how fibromyalgia seems to be merging with chronic-fatigue syndrome. "Chronic fatigue has become a humiliating term—the yuppie disease, begging to be laughed at," Liz said. "Fibromyalgia is more socially acceptable." When I mentioned that doctors call fibromyalgia a wastebasket diagnosis, she bristled: "They'd love to throw me away."

Careless and disparaging language can certainly further alienate patients who are in desperate need of care, and yet opponents of the current treatment of fibromyalgia say that

unquestioning acceptance of the condition may be equally harmful. Some, like Dr. Thomas Bohr, a neurologist at Loma Linda University School of Medicine, in California, and Dr. Arthur Barsky, a professor of psychiatry at Harvard, contend that even honoring this bundle of symptoms with a medical label may be doing more to make people sick than to cure them. These doctors don't claim that the symptoms of fibromyalgia are not real, only that their origin lies in the mind and not in the peripheral nerves of the body.

But what about the physiological research cited by Dr. Robert Bennett? Like many other neurologists, Dr. Bohr considers these studies deeply flawed. "It is well established that depression, anxiety, and other disorders show abnormalities on scans and in biochemical markers," he told me. "You need as controls people with comparable psychiatric problems and levels of distress." Each year, he continued, there is excitement about the discovery of some new chemical or protein in the brain. "First there was serotonin, then growth hormone, and now substance P. None of the data are convincing," Bohr said. He also disputes the analogy Goldenberg draws between fibromyalgia and phantom-limb pain. "With phantom limb, you have a real lesion-the limb has been cut off! Nerves and muscle and bone are damaged. People with fibromyalgia have intact limbs and no evidence of pathology like severed tissues." Moreover, with fibromyalgia the pain is not localized in an area of past injury but generalized throughout the body, and cannot be explained by the anatomical connections of nerves to brain.

Many Americans suffer the symptoms associated with fibromyalgia, according to Dr. Barsky: he cites data showing that a third of healthy people at any one time will have aches and pains in their muscles, and a fifth will report significant fatigue. Furthermore, nearly ninety per cent of a general healthy population report at least one somatic symptom, like headache, joint ache, muscle stiffness, or diarrhea, in any two-to-four-week period. A typical adult has one such symptom every four to six days. Barsky thinks that for people prone to fibromyalgia the everyday somatic symptoms become a growing focus of attention. "They become trapped in the belief that their symptoms are due to disease, with future expectations of debility and doom. This enhances their vigilance about their body, and thus the intensity of their symptoms."

Barsky traces fibromyalgia back to the nineteenth century, to neurasthenia, a condition of severe nervous exhaustion. "Over different historical times, these syndromes rise, morph into one another, subside, and then reëmerge before our eyes. They are manifestations of the same sociocultural process. Only now, with the Internet and mass media, they spread more quickly and more widely." He also points out that there are powerful groups with vested interests in the perpetuation of these syndromes, including doctors and other practitioners who run clinics, lawyers involved in disability litigation, and drug companies marketing treatments of unsubstantiated benefit. This locks the patient into a closed circle of belief.

Dr. Bohr is distressed that even responsible medical advocates who believe in the syndrome have been able to do very little for their patients. During the late eighties and nineties, a group of researchers that included Goldenberg and Wolfe monitored more than five hundred patients who were receiving care at some of the top fibromyalgia centers in America. After seven to ten years, there was no significant diminution in pain, psychological distress, or degree of disability. "I'm labelled as Dr. Unempathy, because I scientifically criticize the label 'fibromyalgia,'" Bohr said. "But these people are not being helped, and they desperately need to be helped. We have to change

the words. We have a huge problem with Descartes here. I am a monist. I don't split mind and body. In America, physical disease travels first class, but psychiatric disorders are considered less than coach—they are cargo. We can call it a chronic-pain syndrome, or drop the stigma and see it as linked to a psychological disorder."

Both Bohr and Barsky believe that learned behavior can be unlearned, and that a reclassification of the syndrome could encourage new approaches to treatment. Recent studies in England, for example, in which cognitive-behavioral techniques were applied to those suffering from chronic-fatigue syndrome, have been very promising. First, patients are told that they cannot injure themselves by engaging in tasks that increase their pain. (This is contrary to the general assumption that pain is a physiological red flag.) They are challenged to perform increasingly strenuous activities and are shown that they have the physical capacity needed to complete them. This experience shifts their focus away from their symptoms and somehow reduces their perception of pain and fatigue. Nearly two-thirds of the study's participants improved in their ability to work, compared with only one-fifth in the controls; three-quarters were assessed to have a satisfactory outcome versus one-quarter who were treated with the usual therapies.

Dr. Barsky is trying to conduct a controlled study similar to the ones done in England. Unfortunately, he has found it difficult to attract volunteers: many patients who have been approached have declined or are not eligible because they are taking certain medications or are involved in compensation litigation. Not long after speaking to him, I called Liz Albright, and told her that there were several studies suggesting significant benefits from cognitive-behavioral therapy. "The distress I have is from my illness, not from social forces," she replied. Her voice cracked, and she paused for a moment to compose herself. "It's like being in prison in your body." She would never see someone like Dr. Barsky, she explained. "I won't see any doctor who questions the legitimacy of what I have."

Perhaps the most unlikely opponent of the fibromyalgia diagnosis I encountered was Dr. Frederick Wolfe, the very man who helped bring the term into being. Now he wishes that he could make it disappear. Although he describes Dr. Goldenberg as a "saint" for his dedication, he has largely embraced the position articulated by Bohr and Barsky. "For a moment in time, we thought we had discovered a new physical disease," he said. "But it was the emperor's new clothes. When we started out, in the eighties, we saw patients going from doctor to doctor with pain. We believed that by telling them they had fibromyalgia we reduced stress and reduced medical utilization. This idea, a great, humane idea that we can interpret their distress as fibromyalgia and help them—it didn't turn out that way. My view now is that we are creating an illness rather than curing one."

His experience suggests that the number of tender points in patients with fibromyalgia correlates most closely with their degree of unhappiness: many of his patients have a history of psychiatric illness, smoking, obesity, marital trouble, or childhood sexual abuse. "When I press, I am not just saying, 'Does that hurt,'" he told me. "I am saying, 'How is your life?'" Dr. Wolfe believes that an often cited study claiming that there is no higher incidence of psychiatric illness among patients with fibromyalgia than there is among general medical patients is flawed, since the control group had a very high rate of psychological illness compared with the general population. "I do believe there are some people who hurt all over and have no psychiatric disorder," Wolfe says. And he also believes that his fibromyalgia patients are experiencing genuine pain. "But, if you give

them the diagnosis of fibromyalgia, pain is allowed to dominate their life. By receiving this diagnosis and taking medications, people become card-carrying members of the fibromyalgia club."

The proliferation of legal cases concerning fibromyalgia and its possible causes is a source of great irritation to Wolfe. Fibromyalgia is a very convenient diagnosis for lawyers to use in arguing for disability, since it is essentially self-reported. Data from a study Wolfe did of 1,604 patients at six medical centers indicate that more than a quarter of fibromyalgia patients receive disability payments. In Wichita, before the American College of Rheumatology criteria for fibromyalgia were introduced, the disease accounted for less than twenty-five per cent of Social Security disability awards; afterward that figure increased to forty-six per cent. "Lawyers call me and ask, 'Does the patient have fibromyalgia?' I know that if he doesn't have it he will soon."

Wolfe says that it's not that people lie; it's simply that, in these cases, there is no objective measure of who is ill and who is not. Wolfe would be the first to acknowledge that the diagnostic criteria for fibromyalgia have not fulfilled their original purpose. How, then, should doctors respond to its spread? "If we underplay this, it will come down to a more minor level or disappear. We should diagnose it less. I think we should stop using the 'F' word with patients, since it doesn't help them get better.: Wolfe paused. "Of course, not using the word doesn't mean that they will get better, either."

Wolfe's pessimism was not unusual; the anger and despair engendered by fibromyalgia have infected physicians as well as patients. In fact, fibromyalgia has become such a contentious medical topic that most of the doctors I spoke with specified that their views were off the record. Some feared that any hint of sympathy would cause a deluge of referrals; others worried that voicing skepticism about the syndrome would make them vulnerable to public attack. Dr. Bohr, for example, has received more than two hundred pieces of hate mail, and has been lambasted by fibromyalgia advocates on the Internet and in newsletters.

Many doctors were also gloomy about the long-term prognosis for fibromyalgia sufferers; the published data on patients like Paula Cortez and Liz Albright-patients who have been cared for in specialty rheumatology clinics and have received the usual combination of psychiatric medication, analgesics, and stretching exercises-have been extremely discouraging. And yet these same doctors regularly refer patients to clinicians like Dr. Goldenberg. They are ready to forgo the income and tacitly endorse a generic program in order to park the patient with someone who believes in the malady and is willing to oversee a condition that is not likely to improve.

The vocabulary of medicine is woefully inadequate when it comes to describing the complex interactions between mind and body. Although we are gradually accepting their interconnectedness (it is all right to say, for example, "I am under a lot of stress at work, and my lower back is killing me"), no terms exist to describe how physical experience-Liz Albright's sinus surgery, Paula Cortez's pregnancy-is imprinted on the molecules in the brain. No terms explain how emotion and perception-thoughts and fears and uncertainties, formed by electrical charges at neuronal synapses and by hormones on cellular receptors-transform themselves into what we feel as physical pain. So we fall back on language that is incomplete, encompassing only fragments of a biology beyond our comprehension. While we claim to be monists, we still think in terms of soma and psyche, and these ancient words inform our approach to therapy.

Daniel Rooks, who directs the Be Well program at Boston's Beth Israel Deaconess Medical Center, has sought to move away from the divisions over nomenclature and meaning. Forty-three years old, with thinning black hair, wire-rim glasses, and a precise manner, Rooks has a doctorate in physiology and a special interest in how exercise may alleviate pain and improve mobility in patients with rheumatic diseases. In the past, he has worked primarily with patients who have osteoarthritis; recently, however, he has seen more and more patients with fibromyalgia. A newcomer to the field, he was shocked not only by how much misinformation he found on the Web but also by the mantra-like insistence among patients and doctors alike that it is a chronic disorder. Without any pathology in muscles or tendons, he thought, why conclude that the prognosis is so dire? He set out to prove that patients could get better.

In 1998, he did a controlled twenty-week study. The population he studied was physiologically and psychologically heterogeneous: "tall and short, heavy and thin, wired and laid back, senior V.P.s in major companies and people who are homemakers." Seventy-eight patients who had received a diagnosis of fibromyalgia (many of whom had been followed for years by rheumatologists) entered the trial. Fifty-six completed it, and the results were extremely encouraging. The study included a three-times-a-week program of escalating cardiovascular exercise and flexibility and strength training. In addition, a discussion group with very strict rules was set up: "It was not a gripe session about how angry everyone feels toward doctors, or how nothing has helped, but a discussion of how to problem-solve." After twenty weeks, the patients showed a statistically significant increase in upper- and lower-body strength, a decrease in pain and fatigue, and an increase in over-all level of functioning—all objectively measured.

Rooks feels that to debate the appropriateness of the label "fibromyalgia" now, ten years after it was coined, is almost beside the point. "The term won't change soon," he says. "What is key is that I tell the patients I accept them for who they are—we're not judgmental." In essence, the Rooks program is a form of cognitive behavioral therapy, but, unlike Barsky's, it is not presented as such: rather, it is cast outside the mind-versus-body paradigm. In his program, one could say, action precedes rather than follows from language. "You don't tell the patients they can get well—you show them," Rooks says. "This is what finally breaks down the barriers in the mind. The person proves to himself every time he does the exercise that he can succeed." The next step is for Rooks to determine how long the improvements last and what can be done to sustain them.

Fibromyalgia has largely been defined by physicians. Rooks's study has shifted the focus of patients' hopes away from the medical establishment, and this can be liberating. "What was most gratifying for the patients was that they were doing something for themselves that made them better," Rooks told me. "They saw they did not have to be so dependent on doctors."