# Fibromyalgia: The Disease That Needed a Drug

An Essay on Manufactured Diagnoses and the Body’s Refusal to Go Numb

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Fibromyalgia has no blood test. No biomarker. No distinguishing physical finding on examination. No imaging signature. No laboratory abnormality. After twenty-five years of searching, researchers concede that a reliable diagnostic biomarker remains unavailable “for the foreseeable future.”[1] The diagnosis rests entirely on a patient’s subjective report of pain and a clinician’s judgment — which, as multiple studies confirm, varies so widely between practitioners that different sets of published diagnostic criteria identify entirely different groups of patients.[2]

In 2007, Pfizer’s Lyrica became the first FDA-approved drug for this condition that cannot be objectively confirmed. By 2017, Lyrica’s global revenues peaked at $4.6 billion annually.[3] Pfizer spent $24.6 million on television advertising for the drug in a single month.[4]

A condition with no objective diagnostic criteria generated billions in pharmaceutical revenue. What fibromyalgia actually is, who benefits from its existence as a category, and whether the millions of people carrying the diagnosis have been helped or captured by it — these are not abstract questions. They have answers.

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## A Diagnosis Looking for a Disease

The trajectory of fibromyalgia as a medical entity tracks suspiciously well with pharmaceutical interests.

For most of medical history, what we now call fibromyalgia was simply "muscular rheumatism" — a descriptive term for widespread pain without joint involvement, documented as far back as the sixteenth century.[5] In 1904, Sir William Gowers renamed it "fibrositis," implying inflammation of fibrous tissue. But researchers never found inflammation. The name was wrong from the start.

In 1976, the term "fibromyalgia" was coined by P.K. Hench to describe non-articular rheumatism — pain without inflammatory damage.[6] The

following year, Smythe and Moldofsky proposed the concept of “tender points” as the distinguishing diagnostic feature.[7] In 1990, the American College of Rheumatology published formal classification criteria: widespread pain lasting at least three months, plus pain in at least 11 of 18 specific tender points when pressed.[8]

That tender point examination — a clinician pressing their thumb into predetermined spots on a patient’s body to see if it hurts — was the closest thing fibromyalgia ever had to an objective test. By 2010, even this was abandoned. The revised ACR criteria dropped the physical examination entirely, replacing it with a symptom severity questionnaire that patients fill out themselves.[9] A diagnosis that had always been subjective became exclusively self-reported.

Interdisciplinary guidelines from Canada, Germany, and Israel, developed independently, arrived at a striking consensus: fibromyalgia syndrome is “characterized by subjective complaints without physical or biomarker abnormality” and is “neither a distinct rheumatic nor mental disorder, but rather a cluster of symptoms, not explained by another somatic disease.”[10] In plain language, fibromyalgia is a collection of symptoms that cannot be objectively verified and does not constitute a specific disease.

Dr. Tom Cowan puts this more directly. The clinical criteria for fibromyalgia amount to a person who has chronic musculoskeletal pain, and when you press on certain points, that pain increases. “There’s nothing that’s very specific or distinguishing about that,” he observes. “Most of us have pain at certain points, and most of us would have times when, if you pushed on certain points, it would be more painful than others.”[11]

This is the diagnostic category that pharmaceutical companies spent billions promoting as a treatable medical condition.

## The Lyrica Machine

Pfizer's pregabalin (Lyrica) was initially approved in 2004 as an anti-epileptic drug for seizures and neuropathic pain.[12] By itself, this was a modest market. But fibromyalgia — affecting an estimated 2-4% of the population, predominantly women — represented an enormous untapped revenue stream. The establishment attributes the sex difference to genetics, for which, as Cowan notes, "there's no evidence."[11] A more plausible account: women carry disproportionate emotional labour, are more likely to suppress trauma responses to maintain family function, and are more frequently prescribed pharmaceutical interventions that compound toxic burden. The condition concentrates where stress concentrates. No genetic explanation is required. But the genetic framing forecloses that inquiry — and a closed inquiry is a captive market.

In June 2007, the FDA approved Lyrica as the first drug for fibromyalgia, granting it priority review status.[13] Pfizer's press release described the approval as "a breakthrough for the more than six million Americans who suffer from this debilitating condition who previously had no FDA approved treatment options."[14] From 2008 through 2018, Pfizer ran extensive direct-to-consumer advertising campaigns promoting Lyrica for fibromyalgia and nerve pain.[4] The drug's global revenues reached $14 billion cumulative, with more than half generated in the United States.[4]

In 2009, the U.S. Department of Justice fined Pfizer $2.3 billion — at the time, the largest healthcare fraud settlement in history — for illegally promoting four drugs, including Lyrica, for unapproved uses. Federal prosecutors described the company as "a repeating corporate cheat" and revealed that Pfizer had plied doctors with free golf, massages, and resort junkets to promote off-label prescribing.[15] One whistleblower, former sales representative John Kopchinski, was blunt: "We were actually putting patients in danger."[16]

The fine was absorbed as a cost of doing business. Lyrica's revenues continued climbing for another eight years.

The pattern is familiar to anyone who has studied pharmaceutical market creation: fund awareness campaigns that turn contested symptom clusters into recognized conditions, secure FDA approval for a drug to treat the newly legitimized condition, then spend hundreds of millions on direct-to-consumer advertising to drive patients into doctors' offices already asking for the product by name. The disease awareness campaign doesn't mention the drug. The drug advertisement doesn't need to create the disease. Together, they manufacture demand from both directions.[17]

Researchers at a 2006 conference on "disease mongering" described the mechanism precisely: "a de facto alliance between pharmaceutical marketers, journalists, and patient advocacy groups. They aren't consciously working together, but they have converging interests."[18] Fibromyalgia, along with restless legs syndrome and adult ADHD, was highlighted as a paradigm case.

The question is not whether people diagnosed with fibromyalgia are suffering — they are, and the pain is real. The question is whether packaging that suffering under a pseudo-specific diagnostic label serves those patients or primarily serves the companies selling the drugs.

## The Mind-Body Question Nobody Can Answer

When patients present with a fibromyalgia diagnosis, Cowan starts with a question that sounds simple but proves disorienting: "How do you feel?"

For many fibromyalgia patients, this produces a characteristic response. They do not describe their own experience. Instead, they describe the condition in the third person: "People with fibromyalgia have pain all over 24/7 and it's getting worse." They speak about the disease category rather than their own body.[11]

Cowan noticed this pattern repeating — not occasionally, but frequently — with two diagnoses in particular: fibromyalgia and Lyme disease. Patients arrived having already absorbed a disease narrative, and they presented that narrative rather than their direct experience. They described "people with fibromyalgia" rather than saying "I feel this specific pain in this specific place at this specific time."

He began listening for exaggerations — not to catch patients lying, but because exaggeration reveals something important about the relationship between a person and their pain. "Nobody actually has pain 24 hours a day because people sleep," he observes. "And there's reasons why people exaggerate their symptoms."[11] "Everywhere hurts" is another. "Your tooth doesn't hurt, and probably your big toenail doesn't hurt. It's not everywhere. It's always somewhere specifically."[11]

He would press for specificity. How do you feel when you wake up in the morning? Does eating breakfast change anything? The responses continued in the third person: "People with fibromyalgia, when they wake up, it's usually the worst time." "People with fibromyalgia have trouble digesting their food."[11]

Patients sometimes became frustrated. "I thought you knew about fibromyalgia. I thought you could help me."[11] They interpreted his insistence on first-person description as ignorance about their condition. In reality, he was refusing to engage with the condition as a category and insisting on engaging with the person.

Cowan is careful about the question that inevitably arises: "Are you saying it's all in my head?" His response dissolves the premise. "I always used to ask them if they could please tell me where their mind stops and their body starts, or vice versa, then I could tell them whether it's in their mind or their body. And because I can't tell that, I can't make that distinction."[11] The mind-body split that underpins modern medicine — physical versus psychological, "real" versus "imagined" — is an assumption, not a finding. No one has ever demonstrated where one

ends and the other begins. Medicine has built its entire diagnostic architecture on a distinction it cannot define.

## Finding the Anvil

Cowan's clinical approach with every patient centers on finding the precipitating event — what he calls "the anvil." If you never had headaches, and then an anvil fell on your head, and now you have headaches, it's probably from the anvil. The logic is straightforward. The application is not, because most fibromyalgia patients don't remember their anvil.

The absence of an obvious precipitant doesn't mean one doesn't exist. It means the inquiry needs to go deeper. Cowan describes the process: "Did you have a vaccine around that time? Did you change your diet? Did you start taking any medicines? Did you have anything happen in your family, in your living situation? Did you get a new cell phone? Did you put a new smart watch on your wrist? You need to get into the absolute details of what happened in their life."[11]

This detailed questioning does something beyond gathering clinical history. It invites the patient's own intuition into the conversation. "When you do that process with people, you're actually inviting their intuition and their remembering into the space, and they will start to remember something that they had thought of as the precipitating cause and that they had somehow buried."[11]

The memories that surface carry a specific linguistic signature. Patients often say: "I always wondered if it was that" — followed by whatever the buried event was. A vaccination. An unwanted change in life circumstances. A death. A trauma. The phrasing itself — "I always wondered" — reveals that the knowledge was never absent. It was present but unintegrated, buried beneath the diagnostic category that had been layered over it.

## Pain as Purpose

The clinical observation that Cowan kept encountering — the third-person narration, the inability to specifically describe one's own pain, the buried precipitating event — led him to a hypothesis about what fibromyalgia frequently represents.

Many of these patients, he concluded, had experienced something — emotional trauma, sexual trauma, physical trauma, poisoning, a profound conflict — that had essentially caused them to "go numb." The trauma was severe enough that the body's response was to shut down sensation. And then the body faced a choice.

"If I was somebody's body, and I had a choice between feeling nothing or feeling pain, even chronic pain, even as unpleasant and debilitating as that is, which would I choose? And I would choose feeling pain, because at least then you can have the impulse, the impetus to do something about it."[11]

Pain as an act of biological intelligence, not pathology. The body, confronted with the prospect of total numbness — of disconnection from sensation and therefore from life — chose pain as a way of maintaining engagement. The pain says: don't go numb, don't shut down, stay with it, stay with life.

This framework aligns with observations from Cowan's broader clinical philosophy. In his New Year 2026 webinar, he discussed the parasympathetic shutdown response — the observation that trauma can paralyze the vagal complex, leaving a person stuck in a partially shut-down state for years or decades. Animals shake after traumatic experiences, resetting their nervous system. Humans, with their capacity for narrative and suppression, often don't. They absorb the trauma, bury the memory, and live with the consequences.[19] Emotional and psychological stress is one of the four fundamental insults to the body's terrain — alongside toxic exposure, nutritional deficiency, and

electromagnetic disruption. It is not a separate category from “physical” disease. It is a direct cause of it.

“I don’t think we’re victims of these traumatic experiences,” Cowan clarifies. “I think it has to do with how we process it and what we make of it, and what we tell ourselves, and that determines whether the so-called trauma will become something that’s disease forming for us, or something that we can actually shake off like an animal and then go on about our way.”[19]

There is a physical mechanism behind this pattern. Norman Doidge, in *The Brain’s Way of Healing*, documents a pain specialist who suffered a skiing accident, underwent a small operation, and remained in chronic pain for two years on painkillers. His own assessment of the problem was precise: his body had gotten into the habit of firing pain signals. The original injury had healed. The pain pathway had not. It had become self-reinforcing — a neural groove worn so deep that the signal no longer needed a source.[20]

His approach was cognitive and relentless. Every time a pain signal fired, he visualized a pain-free brain scan. After two and a half weeks — no improvement. This is the point where most people abandon the effort. By the end of the third week, the pain was gone. The neural pathway had been overwritten. He went on to teach this method to patients. Some achieved total restoration. Some didn’t. The difference, as health educator Barbara O’Neill observes in recounting this case, was relentlessness — the sustained willingness to challenge a habituated pattern rather than accommodate it.[20]

This is the neuroscience of what Cowan observed clinically. Chronic pain, once established, creates physical pathways in the brain — actual structural grooves that fire reflexively, independent of tissue damage. The longer the pattern runs, the deeper the groove. A diagnosis reinforces it. A community of fellow sufferers reinforces it. A pharmaceutical that partially suppresses the signal while leaving the

pathway intact reinforces it. The only thing that disrupts it is a cognitive intervention that addresses the pathway itself — which is precisely what happens when a patient shifts from third-person narration to first-person ownership of their pain.

The connection to fibromyalgia becomes clear. A person who has adopted a diagnostic identity — who speaks about "people with fibromyalgia" rather than "my pain" — has layered a medical narrative over the original experience. The diagnosis becomes another form of burial. Instead of directly encountering the pain and the event that precipitated it, the patient encounters a category, a community of fellow sufferers, a set of prescribed treatments. The numbness that the body tried to override with pain gets reinforced by the very system that claims to address it.

## The Turning Point

The clinical evidence for this framework comes from what happened when patients shifted.

"When I would get people who had this situation to actually essentially own and acknowledge and accurately describe what was happening — that was the turning point, and that was what led to them getting better."[11]

The shift had identifiable components. The patient would move from third-person narration to first-person ownership: this is my pain, not "fibromyalgia pain." They would identify the precipitating event — not as a clinical history detail, but as something genuinely acknowledged. And they would arrive at an understanding that the pain was purposeful: "Yes, something happened to me, and I was at risk of going numb. And it was at that point that this pain started."[11]

Cowan describes what followed: "You can then feel gratitude for the pain. You can acknowledge that it's there and it's telling you — don't go

numb, don't give up, don't go to sleep, stay with life, stay with the process."[11]

The practical consequences were immediate. Dietary changes, red light therapy, natural remedies — interventions that had previously failed to produce results — began working. Not because the interventions changed, but because the patient's relationship to their own body changed. The remedies required the foundation of ownership to have any effect.

And the patients who couldn't make this shift? "The people who couldn't shift from the diagnosis seemed to never get better. No matter how many natural medicines or turmerics or red light or anything I gave them."[11] The best-formulated supplement protocol, the most carefully designed treatment plan, would fail if delivered to a person who hadn't first reclaimed their own experience from underneath a diagnostic label.

## The Suppression Trap

The deepest implication of this clinical picture concerns the standard treatment approach — and not only the pharmaceutical version.

Codeine, anti-inflammatories, pregabalin — these drugs suppress pain signals. That's their stated purpose. In the context of fibromyalgia as Cowan understands it, suppressing pain means deepening the very numbness the body was trying to overcome. "Any attempt to suppress the symptoms by giving codeine or anti-inflammatories just may risk making the person more numb, and then it would never end. And that's exactly what happens."[11]

This creates a treatment trap. The patient takes the drug. Pain is partially suppressed. The body's alarm signal — its insistence on staying engaged with sensation — gets muffled. The underlying numbness deepens. When the drug wears off, the body escalates. Stronger pain

signals. Higher doses. Additional medications. A lifetime of managing symptoms that were never the problem.

But Cowan's observation goes further than a critique of pharmaceutical approaches. "It didn't seem to be any better or any different, even if they were natural medicines."[11] Turmeric as an anti-inflammatory operates on the same logic as ibuprofen — suppress the inflammation, reduce the pain signal. The ingredient changes; the paradigm doesn't. Any approach that treats the pain as the problem rather than the body's purposeful response to a deeper problem risks the same trap.

O'Neill's clinical work with natural remedies provides a striking physical confirmation of this. She uses ginger poultices — grated ginger applied directly to painful joints — as both treatment and diagnostic tool. In most patients with inflammatory pain, the skin over the affected area becomes intensely hot within thirty minutes as the ginger draws the body's repair response to the surface. But in some patients, the poultice produces no heat at all. Her conclusion is direct: if ginger doesn't produce heat, the pain isn't being generated by an active tissue repair process.[21] The body is telling you, through a simple physical test, that the standard anti-inflammatory approach — pharmaceutical or natural — is aimed at the wrong target. Even where the body's repair response *is* present, suppressing it with anti-inflammatories interferes with healing. But in fibromyalgia, the repair response often isn't there at all. The pain is real. The inflammation isn't. Something else is producing it, and that something else won't yield to anti-inflammatory logic no matter how pure the ingredient.

The distinction is not between natural and pharmaceutical. It is between suppression and resolution. Suppression, regardless of its source, works against the body's intelligence. Resolution requires acknowledging the pain as communication, identifying what precipitated the need for that communication, and honoring the body's wisdom in producing it. Only then do the practical interventions find traction.

## How to Explain It to a 6-Year-Old

Imagine you fall over and scrape your knee really badly, and it hurts so much that your whole body decides to stop feeling anything at all. No pain in your knee, but also no feeling when Mum hugs you, no ticklish feeling on your feet, nothing. Your body has gone quiet — like turning the volume all the way down.

But your body is smart. It knows that feeling nothing is dangerous, because if you can't feel anything, you won't notice when something is wrong, and you won't know to ask for help. So your body turns the volume back up — not just on your knee, but everywhere. Now lots of places hurt, even places that weren't hurt in the first place. Your body is doing this on purpose. It's saying: *stay awake, pay attention, don't go numb*.

The doctor sees you hurting everywhere and gives your pain a name — "fibromyalgia." And then gives you medicine to make the pain quieter. But the pain was your body trying to keep you awake and feeling. So making it quieter pushes you back toward the numbness your body was trying to escape.

What actually helps is different. It starts with remembering the scrape — the thing that hurt so much your body shut down. Then telling someone about it, in your own words: *this is what happened to me, this is where it hurts, this is what I feel*. Once you do that — once you own the story instead of hiding from it — your body doesn't need to shout anymore. The volume can come down on its own, because you're listening now.

## The Larger Terrain Picture

This essay has focused on one dimension of fibromyalgia — the emotional and biographical cause, the body's response to unprocessed trauma. Cowan's clinical observations centre on this dimension because

it is where he saw the therapeutic turning point occur: patients who owned their story recovered; patients who couldn't, didn't.

But emotional trauma is one of four fundamental insults to the body's terrain. The others — toxic exposure, nutritional deficiency, and electromagnetic disruption — operate simultaneously and compound each other. A woman carrying unresolved grief is also carrying decades of cumulative xenoestrogen exposure from plastics, PFAS from menstrual products, synthetic hormones from contraceptives, pesticide residue from food, and petrochemical contact from synthetic clothing against her skin. Her liver and lymphatic system are managing this burden continuously. Her elimination pathways are under pressure. Her sleep is disrupted. Her circulation is compromised by sedentary work patterns.

In an earlier essay (*Endometriosis, PCOS, and Fibromyalgia: The Conditions Medicine "Cannot" Explain*), I examined the physical terrain dimension in detail — the xenoestrogens, the PFAS, the synthetic clothing shift, the sedentary patterns, the manufactured ignorance that keeps environmental causation in darkness while the streetlight shines on genetics and pharmaceuticals. That essay argued that fibromyalgia represents what happens when toxic burden exceeds the body's capacity for local compensation: pain becomes diffuse because the burden is diffuse.

The two accounts do not compete. They describe different layers of the same terrain. Some women carrying a fibromyalgia diagnosis are primarily dealing with unprocessed trauma that has locked the body into a pain-over-numbness response. Some are primarily dealing with cumulative toxic burden that has overwhelmed systemic capacity. Most are dealing with both — because emotional stress acidifies the terrain, and a toxic terrain amplifies the body's stress responses. The causes are synergistic, not separate.

What both accounts share is the conviction that “fibromyalgia” names the suffering without explaining it, and that explanation — whether biographical or toxicological — is where resolution begins.

**Endometriosis, PCOS, and Fibromyalgia: The Conditions Medicine "Cannot" Explain**

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## What the Diagnosis Conceals

Fibromyalgia, as a diagnostic category, performs a specific function. It takes an individual’s complex experience — pain with a personal history, a precipitating event, a meaning — and strips it down to a generic label. The label enables pharmaceutical treatment, insurance coding, disability claims, and patient community membership. It also enables something less visible: the indefinite deferral of the actual question.

The actual question is always the same. What happened to you?

Not “what condition do you have.” Not “what are your symptoms on the severity scale.” Not “which of these FDA-approved medications would you like to try.” But: what happened in your life that your body is responding to? What is the anvil?

Modern medicine, organized around diagnostic categories and pharmaceutical interventions, is structurally incapable of asking this question. The ten-minute appointment doesn’t accommodate it. The insurance reimbursement model doesn’t cover it. The training doesn’t prepare for it. And the $4.6 billion in annual drug revenue depends on it never being asked.

The fibromyalgia patient walks into the clinic. They’ve been to multiple doctors. They’ve had blood work, imaging, referrals. Everything came back normal, which itself became part of the diagnosis — fibromyalgia is what you’re left with when nothing else explains the pain. They’ve

read the patient information. They know the terminology. They can describe what “people with fibromyalgia” experience. What they often cannot describe — until someone asks with sufficient patience and specificity — is what they themselves feel, where precisely it hurts, and what happened in their life when the pain began.

The diagnosis gave them a name for their suffering. What it could not give them — what no diagnostic label can — is the story of how the suffering began and what the body was trying to accomplish by producing it.

Cowan’s clinical experience suggests that getting the story back is not a supplementary element of treatment. It is the treatment. Everything else — the diet, the red light, the remedies — follows from it. Without it, nothing works. Not the pharmaceutical approach. Not the natural approach. The foundation is ownership, and the foundation must be laid first.

This is an uncomfortable proposition for a medical system built on the separation of diagnosis from biography, chemistry from meaning, body from mind. For the millions carrying a fibromyalgia diagnosis, the path forward runs not through better drugs or more refined diagnostic criteria, but through a question that the system is designed never to ask, and an answer that only the patient can provide.

The body chose pain over numbness — engagement over shutdown. Honoring that choice, rather than suppressing it with pharmaceutical or natural interventions alike, is where resolution begins. The diagnosis was never going to get there. It was designed to make sure nobody had to.

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## New Biology Clinic

For those of you looking for practitioners who actually understand terrain medicine and the principles we explore here, I want to share something valuable. Dr. Tom Cowan—whose books and podcasts have shaped much of my own thinking about health—has created the **New Biology Clinic**, a virtual practice staffed by wellness specialists who operate from the same foundational understanding. This isn’t about symptom suppression or the conventional model. It’s about personalized guidance rooted in how living systems actually work. The clinic offers individual and family memberships that include not just

private consults, but group sessions covering movement, nutrition, breathwork, biofield tuning, and more. Everything is virtual, making it accessible wherever you are. If you've been searching for practitioners who won't look at you blankly when you mention structured water or the importance of the extracellular matrix, this is worth exploring. Use discount code **"Unbekoming"** to get $100 off the member activation fee. You can learn more and sign up at newbiologyclinic.com